AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

S. HRG. 112–799

ROUNDTABLE DISCUSSION ON MEDICARE PHYSICIAN PAYMENT POLICY: PERSPECTIVES FROM PHYSICIANS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

JULY 11, 2012

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

82–118—PDF WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON FINANCE

MAX BAUCUS, Montana, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia
KENT CONRAD, North Dakota
JEFF BINGAMAN, New Mexico
JOHN F. KERRY, Massachusetts
RON WYDEN, Oregon
CHARLES E. SCHUMER, New York
DEBBIE STABENOW, Michigan
MARIA CANTWELL, Washington
BILL NELSON, Florida
ROBERT MENENDEZ, New Jersey
THOMAS R. CARPER, Delaware
BENJAMIN L. CARDIN, Maryland

ORRIN G. HATCH, Utah
CHUCK GRASSLEY, Iowa
OLYMPIA J. SNOWE, Maine
JON KYL, Arizona
MIKE CRAPO, Idaho
PAT ROBERTS, Kansas
MICHAEL B. ENZI, Wyoming
JOHN CORNYN, Texas
TOM COBURN, Oklahoma
JOHN THUNE, South Dakota
RICHARD BURR, North Carolina

RUSSELL SULLIVAN, *Staff Director*
CHRIS CAMPBELL, *Republican Staff Director*

CONTENTS

OPENING STATEMENT

	Page
Baucus, Hon. Max, a U.S. Senator from Montana, chairman, Committee on Finance	1

WITNESSES

Hoven, Ardis Dee, M.D., president-elect, American Medical Association, Lexington, KY	2
Stream, Glenn, M.D., president, American Academy of Family Physicians, Spokane, WA	3
Opelka, Frank, M.D., FACS, vice chancellor of clinical affairs and professor of surgery, Louisiana State University Health Science Center, New Orleans, LA	5
Weaver, W. Douglas, M.D., MACC, vice president and system medical director of heart and vascular services, Henry Ford Health System, Detroit, MI	6
McAneny, Barbara, M.D., CEO, New Mexico Oncology Hematology Consultants, Albuquerque, NM	7

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Baucus, Hon. Max:	
Opening statement	1
Prepared statement	33
Hatch, Hon. Orrin G.:	
Prepared statement	34
Hoven, Ardis Dee, M.D.:	
Testimony	2
Prepared statement	35
McAneny, Barbara, M.D.:	
Testimony	7
Prepared statement	43
Opelka, Frank, M.D., FACS:	
Testimony	5
Prepared statement with attachments	51
Stream, Glenn, M.D.:	
Testimony	3
Prepared statement with attachments	75
Weaver, W. Douglas, M.D., MACC:	
Testimony	6
Prepared statement	99

COMMUNICATIONS

American Society of Anesthesiologists	105
American College of Physicians	113

ROUNDTABLE DISCUSSION ON MEDICARE PHYSICIAN PAYMENT POLICY: PERSPECTIVES FROM PHYSICIANS

WEDNESDAY, JULY 11, 2012

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:09 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Bingaman, Wyden, Stabenow, Cantwell, Nelson, Carper, Cardin, Hatch, Kyl, and Thune.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

Albert Einstein once said, "A great thought begins by seeing something differently, with a shift of the mind's eye."

Today, we hold our third roundtable on Medicare Physician Payments. We have heard from former CMS administrators and from private payers. We are here now to see things through the eyes of those who receive the payments and provide the care; that is, our physicians.

Every year, the flawed sustainable growth rate, or SGR, leads physicians to fear dramatic reductions in their Medicare payments. Next year, physicians will face a 27-percent cut if we do not act.

While Congress has intervened to prevent these cuts each year, it is time we develop a permanent solution. We need to repeal SGR and end the annual "doc fix" ritual. The year-in and year-out uncertainty is not fair to physicians or the Medicare beneficiaries who need access to these doctors.

When thinking about new ways for Medicare to pay physicians, we must clearly focus on controlling health care spending. Physicians can help us find the solutions. They are, after all, on the front lines of health care delivery.

Ninety-seven percent of Medicare beneficiaries see a physician at least once a year, and beneficiaries with chronic conditions see their physicians at least monthly.

By ordering tests, writing prescriptions, and admitting patients to hospitals, physicians are involved in up to 80 percent of total health care spending. We need physicians to suggest changes to the Medicare physician payment system that will spur high-quality, high-value care.

I look to today's panelists to offer solutions both in the short-term and the long-term. And I hope, like Einstein said, they can help us come up with a great thought by seeing something differently.

We need solutions that will work for both primary care physicians and specialists, and they need to work for beneficiaries with chronic conditions. After all, these beneficiaries account for two-thirds of total Medicare spending.

I look forward to candid and direct suggestions from our panelists as to how we can begin to better control our health care spending.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch will be here in a moment. He is currently on the floor. In the meantime, I would like to introduce the panelists.

Beginning to my left, today we will hear from Dr. Ardis Hoven, president-elect of the American Medical Association. Next is Dr. Glenn Stream, president of the American Academy of Family Physicians. Third will be Frank Opelka, vice chancellor of clinical affairs and professor of surgery at Louisiana State University's Health Sciences Center. Fourth, Dr. Douglas Weaver. Dr. Weaver is vice president and systems medical director of heart and vascular services at the Henry Ford Health System. And finally, Dr. Barbara McAneny, chief executive officer of the New Mexico Oncology Hematology Consultants.

As a reminder, your written statements will be included in the record. Please limit your statements to about 3 minutes. Since we have a few more Senators here today, I would like to limit your comments to about 3 minutes each.

I would like this to be more in the nature of a roundtable, not a more formal hearing. That is, after each of you makes your statement, we will have a few questions, and I would like us to kind of interchange back and forth. If you want to say something, pipe up and say it. That goes for both our panelists as well as for Senators.

So you start, Dr. Hoven. We are very happy to see you here and happy to have you here.

STATEMENT OF ARDIS DEE HOVEN, M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION, LEXINGTON, KY

Dr. HOVEN. Thank you, Chairman Baucus and members of the committee, for convening this important roundtable discussion. As you know, I am Ardis Hoven. I am president-elect of the American Medical Association, and an internal medicine and infectious disease specialist in Lexington, KY.

We all know that the SGR has failed. It must be repealed and replaced with alternative payment and delivery models that support high-quality and high-value care.

As we move forward, two factors are critical. First, physician practices widely vary, and the development and dissemination of innovative practice and delivery models are proceeding at different paces. A large multispecialty practice is currently better positioned to implement broad-scale innovations than is a small, rural prac-

tice. Flexibility and a menu of multiple solutions are needed on a rolling basis.

And secondly, alternative models must cut across Medicare silos. When physician care achieves overall Medicare program savings, physicians and Medicare should share in those savings. Currently, additional physician services that prevent costly medical care drive steeper cuts under the SGR. This incentive structure has to change.

Physicians have already begun transitioning into alternative payment and delivery models. This includes, for example, 154 Medicare accountable care organizations. And the Center for Medicare and Medicaid Innovation is testing many new models. Many innovations are also being conducted in the private sector, as the committee heard at its June roundtable.

The AMA strongly supports these initiatives and is helping physicians with the transition. For example, our AMA-convened Physician Consortium for Performance Improvement has developed measures relating to outcomes and overuse of care, and is expanding its work in this area.

Congress can take immediate steps to help in the transition. First, Congress should require CMS and the Innovation Center to offer opportunities for physicians to enroll in new models on a rolling basis. Practices can then plan for needed changes and join as they become ready. This will increase physician participation in new models and significantly aid the transition for small, solo, and rural practices.

Second, Congress should require CMS to modernize its Medicare data systems. Due to CMS's antiquated systems, providing physicians with actionable real-time data to guide decision-making has been difficult. Physician access to such timely and relevant data was a key element behind the success of the private sector models discussed at the previous June roundtable.

Third, Congress should provide Medicare funding to CMS for quality measure development, testing, and maintenance, and for measure review and endorsement. This is critical to ensure that meaningful and up-to-date measures are available for Federal quality programs.

The AMA is eager to continue our work with the committee to transition to a new stable system that strengthens Medicare.

Thank you.

[The prepared statement of Dr. Hoven appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Hoven.

Dr. Stream?

STATEMENT OF GLENN STREAM, M.D., PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS, SPOKANE, WA

Dr. STREAM. Chairman Baucus and Senators, thank you for inviting the American Academy of Family Physicians to state our views on physician payment policy.

We believe health care in the United States is inefficient and delivers lower-quality care, largely because it undervalues primary care. The AAFP is convinced that no single alternative payment method will rebuild primary care. We need a combination of methods.

AAFP promotes the Patient-Centered Medical Home, or PCMH, supported by a blended payment system that includes fee-for-service, a care management fee, and a quality improvement payment.

We advocate for this reinvigoration of primary care because we know it works to improve health care and restrain costs in the long run. The evidence for this is accumulating rapidly, and our statement provides several examples. Findings from PCMH programs across the Nation are compelling, demonstrating success in improving quality and restraining health care costs.

Earlier this year, AAFP sent recommendations to the acting administrator of CMS. These were the result of an AAFP-sponsored task force on primary care evaluation. The key recommendation is that, in order to build a system of care that will be consistently more efficient and produce better health, we need to pay primary care differently and better.

We call to your attention the Medicare Physician Payment Innovation Act, H.R. 5707, introduced by Representatives Allyson Schwartz and Joe Heck. It makes a notable step towards recognizing this critical need to pay primary care differently.

The CMS Innovation Center has several programs testing systems that support primary care. For example, the Comprehensive Primary Care Initiative includes several health plans in various markets that will offer a per-patient, per-month care coordination fee for primary care physicians whose practices are effectively Patient-Centered Medical Homes.

The Primary Care Extension Service program administered by the Agency for Health Care Research and Quality deserves your attention. Currently without funding, this program is designed to disseminate up-to-date information about evidence-based therapies and techniques to small practices. The AAFP strongly recommends that Congress fund the Primary Care Extension Service program.

We ask for your continued support of the Primary Care Incentive Payment, PCIP, the 10-percent Medicare bonus payment to primary care physicians and providers for certain primary care services. The Commonwealth Fund recently published a study that the PCIP, if made permanent, would yield a more than 6-fold annual return and lower Medicare costs. The net result, according to this study, would be a drop in Medicare costs of nearly 2 percent.

Senators, we all want the same thing—better health care at less cost. There is a proven way to go a long way toward achieving that outcome: invest in primary care. We have ample evidence that doing so will not increase the overall cost of care per individual per year.

Thank you for your commitment to the health of this Nation. And family physicians are eager to assist you in making the difference we need.

[The prepared statement of Dr. Stream appears in the appendix.]

The CHAIRMAN. Thank you, sir.

Next, Dr. Opelka?

STATEMENT OF FRANK OPELKA, M.D., FACS, VICE CHANCELLOR OF CLINICAL AFFAIRS AND PROFESSOR OF SURGERY, LOUISIANA STATE UNIVERSITY HEALTH SCIENCE CENTER, NEW ORLEANS, LA

Dr. OPELKA. Chairman Baucus and Senators, thank you very much for this opportunity, and good morning to you today.

I come to you to speak on behalf of improving the care for the surgical patient and inspiring quality among surgeons. So, on behalf of the American College of Surgeons, there are a couple of key points I would like to make and share with you.

And to be brief, we have several programs and initiatives that we have been working on to inspire quality and to improve the quality of care, and we believe that that actually helps reduce the costs in health care today by reducing things like surgical site infections, readmissions, and complications that patients suffer.

There are two key programs that I would like to bring to your attention, one in the short term and one in the long term. The short-term approach is to look at the various clinical registries that we have developed over the years, and those go back 10–15 years' worth of work, where we have accumulated millions of data points on patients that drive quality improvement.

These registries are the cancer registry, where we have over 11 million lives that we actually track the outcomes of to drive improvement in cancer care; the trauma registry; and, to perhaps focus more explicitly today on, the national surgery quality improvement registry. That is a registry that began in the VA some 15 years ago and now, today, is in over 500 hospitals. It is driving quality improvement, reducing patient complications, and reducing costs related to those complications.

We have worked with CMS, and it is time to improve that work with CMS to bring those registries to this next level of the value proposition that CMS is working on so we can strengthen surgical care and improve the quality of care across the entire country. We would like to expand from those 500 hospitals to every hospital that has surgical care.

The long-term view and the long-term point I would like to make is actually, how do we actually replace the SGR? We have been working on a proposal that ties together all these value initiatives that we have been working with CMS on, all the value programs, into a value-based update using targets of improvement—targets of improvement in cancer care, targets of improvement in trauma care, targets of improvement in cardiology, targets of improvement in chronic and preventive care, targets of improvement in rural care—focusing those as the targets for updates, bringing physicians and hospitals in alignment on a set of targets that actually replaces the SGR with something that we value: improving the quality of care and reducing the costs related to bad care, to overuse of care, to unsafe care, to poor quality of care.

So we think that there is an opportunity to further explore this as a value-based update to replace the SGR within the context and the framework that we are currently using throughout all of our programs, both public and private, to stimulate a better health care system.

Thank you very much for this opportunity, and I look forward to our dialogue.

[The prepared statement of Dr. Opelka appears in the appendix.]

The CHAIRMAN. Thank you, Doctor.

Dr. Weaver?

STATEMENT OF W. DOUGLAS WEAVER, M.D., MACC, VICE PRESIDENT AND SYSTEM MEDICAL DIRECTOR OF HEART AND VASCULAR SERVICES, HENRY FORD HEALTH SYSTEM, DETROIT, MI

Dr. WEAVER. Chairman Baucus and Ranking Member Hatch, I am Dr. Doug Weaver, past president of the American College of Cardiology and system medical director for heart and vascular services for Henry Ford Health System in Detroit. Today I am pleased to speak to you on behalf of the American College of Cardiology.

If the College could make one suggestion for Medicare payment policy, it would be: create stability in the system. It is badly needed right now. The current uncertainty around Medicare physician payments, around the ACA legislation and its initiatives, are seriously impeding progress by physicians and hospitals towards delivery and payment reforms.

The College has had several decades of experience in developing and applying quality improvement tools, including producing clinical practice guidelines for diagnosis and treatment of common cardiac diseases; the appropriate use criteria, which allow physicians to better apply the right diagnostic testing and cardiac procedures; and then, our clinical registries, in which physicians and hospitals can submit their own data around cardiac procedures. They then get it back and are able to benchmark it against the whole Nation, as well as locally. We believe that broader use of these tools will improve quality, will produce better patient outcomes, and will lower costs.

Let me tell you some of the lessons we have learned in these years. Number one, data is key. Efforts to improve quality and efficiency must be grounded in the use of the best scientific evidence available. The collection of robust clinical data, measurement, and feedback to doctors on performance—doctors are data-driven. They have competed throughout their entire training to be the best, and they respond to credible data, and particularly when that is produced by their specialty societies that have identified particular problems that they feel need to be improved.

Number two, flexibility is necessary. New payment models must be crafted with collaboration of clinicians and payers. One size does not fit all. We applaud the beginning efforts to reward care coordination, but CMS needs to seek out additional local solutions that increase value and reduce costs.

Third, incentives must be aligned throughout the entire delivery system, to include the payer, the primary care physician, the specialist, the hospital, and the skilled nursing facility. Currently, we are too often competing with each other instead of being aligned.

Payers are trying to reduce costs, hospitals are trying to fill beds, and the physician is really uniquely positioned to ensure that patients get the highest quality care at the lowest cost if the current

system is revised to incent this approach. Rewarding physicians for providing the right care and using an appropriate amount of resources is essential to solving the Medicare spending crisis.

The College urges Congress to incentivize a greater expansion of and use of quality and utilization improvement tools such as ours.

I look forward to our dialogue.

[The prepared statement of Dr. Weaver appears in the appendix.]

The CHAIRMAN. Thank you, sir.

Dr. McAneny?

STATEMENT OF BARBARA McANENY, M.D., CEO, NEW MEXICO ONCOLOGY HEMATOLOGY CONSULTANTS, ALBUQUERQUE, NM

Dr. MCANENY. Thank you, Chairman Baucus, Ranking Member Hatch, and members of the committee. Thank you for the opportunity to participate in this important roundtable discussion.

My name is Barbara McAneny, and I am a medical oncologist practicing in New Mexico. I am here today on behalf of the American Society of Clinical Oncology, ASCO, which represents 30,000 oncologists.

ASCO supports your efforts to transform the Medicare payment system to encourage high-quality, high-value care for individuals with cancer. We hope that Congress will replace the SGR and soon. The SGR has created great instability in our practices and is eroding a very effective network of care.

ASCO's vision is that of a fair and responsible system that rewards evidence-based care and recognizes that many cognitive services, including end-of-life counseling, are critical to treating patients with cancer. Any new payment system must preserve quality, enhance access to care, and, first, do no harm.

Quality for cancer patients involves providing accurate diagnoses, appropriate evidence-based therapy delivered safely, and a strong support system for the human needs of the patients and their families.

ASCO has already developed a quality program in which thousands of oncologists already participate voluntarily. We call it the Quality Oncology Practice Initiative, or QOPI. I participate in this program, and I know from experience the beneficial effect it has had on supporting meaningful quality in my own practice.

It is frustrating, however, that I also have to report through Medicare's less practice-enhancing quality program. We believe that leveraging QOPI would be an immediate first step that Congress could take to promote quality and efficiency, while reducing the administrative burden on oncologists.

Secondly, we urge you to rely on the expertise of oncologists as you move toward transformation of cancer care payment and delivery. Policies that have the effect of dismantling community cancer care could exaggerate the existing disparities for rural patients.

Cancer care is generally delivered in the patient's home community, and cancer doctors have developed a sophisticated infrastructure that allows us to administer dangerous and toxic therapies safely, while allowing patients to remain at home with the people they love.

Therefore, we would like to emphasize that new oncology models must be tested through pilot programs that reflect the diverse pop-

ulations that we serve before they are generally implemented. Any change in the payment system has the potential for unintended consequences for a very vulnerable population.

However, oncologists are already involved in many pilot projects to test new payment mechanisms which could help control costs. I am a recent recipient of the grant from the Medicare Innovation Center to test a model based on the medical home concept and bundled patients. My project involves seven private practices of oncology from Maine to New Mexico.

We can save money for the system, while providing better health and better health care. I am happy to talk about that further, if you would like.

ASCO stands ready to assist you as you move forward. I am happy to answer any questions.

[The prepared statement of Dr. McAneny appears in the appendix.]

The CHAIRMAN. Thank you. One question—I have several. One is, since physicians are so involved with such a large percentage of payments, health care payments, in our country, it seems to me that maybe there is a little bit of a—I do not like this word—"disconnect," but between SGR, which is for physicians only, and yet, physicians are so involved in health care payments that are made elsewhere in the system.

Perhaps as we look at SGR, there might be some way where physicians are involved or reimbursed in a way that helps involve them in choosing the care given to patients more holistically.

Currently, people say we are too stove-piped, and one stove pipe, to some degree, is SGR. But any thoughts you might have on how we sort of collapse some of these pipes and especially the role of physicians, because physicians are so heavily involved. I think the figure I have is about 80 percent of health care dollars are related to decisions made by physicians.

Your thoughts on that, anyone who may want to pipe up?

Dr. Hoven?

Dr. HOVEN. I will start. Thank you for that question, because I think that is something we all chat about on a regular basis. And I think, as we start looking for value within the system, it will be the physicians in those practices who are looking at the models of care that are being used, be they in primary care medical home models, be they in bundled payments.

Wherever they are, we are going to be looking constantly at the value of each of those delivery reform issues going forward. We have to be accountable, as physicians, for making sure that we are getting the job done and for the outcomes and the quality of the work that is being done.

And the new models that will be tested, are being tested, that are on the road right now being looked at, are going to give us that information, because up to now, we have not had that information.

So it is very important going forward that we look at a variety of models, that we recognize the importance of the practice environment, be it a small practice, a large integrated group, or what have you. It is going to be very important that we look at all of those and take into consideration the practice.

The CHAIRMAN. You are always talking about models. What models are you talking about?

Dr. HOVEN. Well, we are talking about the primary care medical home model, for example. Glenn could speak to that as well. That is one of the models we are talking about. Bundled payments, again, another model, and Frank could probably speak to that.

So these are out there in play right now as we are talking.

The CHAIRMAN. How long until we know whether and which of these models might bear fruit, which ones work?

Dr. STREAM. I would speak to the CPCI, the Comprehensive Primary Care Initiative, currently recruiting practices through the Innovation Center. And its goal is to align the payment methodology to support the Patient-Centered Medical Home so that payment for support is continued fee-for-service. The care coordination fee that I had mentioned that provides payment not in the fee-for-service system—that has to do with coordinating care.

But the answer to your question, Senator, is that the shared savings component of that model breaks down those silos, and there is a potential for shared savings from reducing hospitalizations, reducing ER visits, reducing complications of chronic illness that result in expenses like the dialysis for diabetic patients.

If you only look at the shared savings in the medical home based on the physician services, there is too little skin in the game for the physician. But if the shared savings model looks across the silos, then there is a win-win for the physicians making the effort that the medical home cannot——

The CHAIRMAN. So you think there is potential——

Dr. STREAM. Absolutely. It is a game-changer.

Senator NELSON. Mr. Chairman, accountable care organizations, are they not to address this? Isn't that why we put them in the health care bill?

The CHAIRMAN. Partly, yes.

Dr. STREAM. Partly, but at a more global level. I mean, that is, systemwide—integrated delivery system, a large multispecialty clinic—that type of model. I am talking really down at the level of supporting the primary care that is necessary for a high-functioning system, whether it is in an ACO or separate.

Senator WYDEN. Mr. Chairman, I think what both of the doctors were talking about is the Independence at Home model that we got in the Affordable Care Act. You all and the oncologists are making the point that most of the Medicare bill today goes for the chronically ill. That is where most of the Medicare bill goes. And through approaches like Independence at Home—and we have seen these demonstration sites begin, and I was very pleased that it was in the AMA's testimony—we could take a much bigger population, number one; leave the patients in a position to be happier, as the oncologist noted; and start tiering the payment system to reward those kind of efforts.

And I really appreciate what the AMA has said, and let me hear from the oncologists as well.

Dr. MCANENY. Thank you, Senators. I do have the opportunity to approve a model with this Innovation Center grant which allows physicians to control those things that we really can take control

over. There are a lot of parts of health care, the cost of drugs, that we have no ability to manage.

But we can manage the site of service, and we all know that it is a lot less expensive to treat people in our offices than it is in emergency departments in hospitals.

And in this grant that we wrote, we used data—and I agree that data is key—from our own practice showing how much money we could save Medicare in one small practice in New Mexico by keeping people in the office, aggressively managing the disease and the side effects of treatment, so that we keep people out of the hospital, we keep them healthier, and we keep them out of emergency departments, and we can use less imaging.

Those are the things that doctors can control. And so, with six other practices across the country, we are going to demonstrate that, if we create ourselves as an oncology medical home, that we are ready to accept a bundled payment. Give us a payment that will allow us to take care of these patients.

It will cost more in the outpatient arena, but the costs are by far made up for in the inpatient setting when we keep people healthier. We think we can generate true savings in that manner and better care.

Senator STABENOW. Mr. Chairman?

Dr. Weaver, could you talk a little bit about—I know Henry Ford is part of one of the eight multi-payer primary care demonstration projects.

Dr. WEAVER. Yes. I want to give a couple of examples where we might have savings. And that is, one of the things that CMS is starting to do, which I must applaud—and Dr. Stream alludes to this—is paying for some care management. That means supporting the infrastructure, which may be nurses, medical assistants, part-time pharmacists, really not doctor stuff. This is stuff that keeps people on their right care plan, as well as keeps them out of the hospital.

In Michigan, the Blues, along with CMS and all of the payers, have rewarded physicians in primary care an extra $7 to $9 per member per month to do care management. They must meet certain quality standards. They must meet certain utilization standards to qualify.

The State itself this year, because of this project, thinks that the dual-eligible expenses to the State will drop $38 million. So that up-front investment to allow more care management has helped.

I will give another example. The Blues in Michigan fund cardiac procedure registries. And the only thing that they require is that you must submit all of your data and you must meet quarterly to discuss the data among all of the participating hospitals. It has led to huge reductions in procedure complications and improvements in quality.

They did the same thing for bariatric surgery, and they got together, they made a database, doctors got the data back from the patients on whom they operated, and complications from bariatric surgery have dropped 30 percent, and readmissions for patients who had bariatric surgery have dropped 35 percent.

So I point out that care management, as well as registry data—I will tell you, again, doctors are data-driven. If you give them the

infrastructure so that they have clinical data that they believe is credible, they will respond in ways to improve the quality of their patients. They all want to provide the best quality care.

Senator STABENOW. Just as a follow-up, though, Dr. Weaver, and maybe for anyone, we have this quality reporting initiative that we set up under Medicare, and we only have about a third of the physicians right now who are actually using it. And in 2015, it goes from an incentive to a penalty.

What are the barriers? Why aren't more physicians doing it, since we are talking about a data-driven system?

Dr. WEAVER. Well, let me respond to that, at least my feeling, and that is, CMS is currently promoting a lot more transparency with data. But the measures that are reported—readmission rates, smoking cessation, and these things—they are very, very crude measures of quality, and they do not really accurately tell you whether you have a good doctor, a great doctor, or someone who is not so good.

The CHAIRMAN. What should they report?

Dr. WEAVER. I think that they want—as others have suggested, they want to report the things that they think are important and that they have developed within their own specialty societies that they believe are the most important problems: here is how to measure them, give us the data back so we can benchmark against our peers, and they will improve.

Dr. MCANENY. If I might respond to that as well, oncology, for years before this came up, developed the Quality Oncology Practice Initiative, which was a bunch of oncologists sitting around asking, what can we do, what could we measure so that we can improve what we do?

This costs money for our practices to participate in, but thousands of oncologists have already participated, willingly spending that money to do a better job. And we can craft measures that really are pertinent to what we do every day, and when we complete one measure, then we can say, "Okay, everybody has that. Let's move on to the next thing. Let's do the next step." And each of the specialties can do that to create their own quality system instead of having a broad-brush, generic measure.

Dr. WEAVER. As well as, it will be more flexible. I think about—and I am sure all of you have heard about the time-to-treatment in people with heart attack. Well, the College of Cardiology put together a program many years ago, and hospitals moved from hitting the goal 50 percent of the time to essentially 100 percent everywhere.

Doctors want to move on to the next issue after that. You have that one done. And you cannot regulate this iterative process. You have to allow the specialty to see where are the voids right now and incent physicians to participate and make sure there is infrastructure in order to collect this kind of credible clinical data, and you will have a much more reactive and fast turnaround in improving quality.

The CHAIRMAN. Senator?

Senator BINGAMAN. One of the things we tried to put in the Affordable Care Act was a focus on reporting about outcomes, because it seems to me that a sort of underlying or overarching dataset that

should sort of span all of the various specialties would be, how do we get accurate reporting on outcomes for patients?

Is that realistic? Is there a way for someone, for CMS or the government or anybody else, to say, "Okay, here is what we want reported on that relates to how well people are doing after they get this treatment"?

Dr. Opelka?

Dr. OPELKA. If I could. Thank you very much for that question. The College of Surgeons' registry programs are risk-adjusted outcomes reporting, and it is very effective.

So, for example, in the field of general surgery and vascular surgery in over 500 hospitals, we collect roughly 100 to 130 data elements over 30 days on a patient's care. That data then churns out into a risk-adjusted expected outcome, and we measure the actual outcome against the expected.

That is very meaningful to the delivery system. And these are team-based care systems. It is not just the surgeon. It is the nurses, it is pharmacy, it is everybody there, it is primary care, it is linking to my colleague here.

I do not have good surgical outcomes unless I have a good patient to work with to begin with. So I can now measure and see what are the drivers for better care.

We have actually been working with CMS, and really I applaud their efforts in performance measurement. We had to start somewhere, and we started with measures that were less than perfect, but it has moved us all.

Data is a drug, and we are addicted to it. We cannot get enough data, and we want meaningful, actionable data. So we partnered with CMS and started to show them how the current datasets they have do not get them the answer they want, and we are showing them more meaningful datasets. And where we need help is, how do we actually expand this infrastructure beyond 500 hospitals into 4,000 hospitals, and how do we link this beyond surgery into surgery and primary care, across a patient continuum?

So it is not about how well I took someone's colon cancer out, but it is more about how well the 18 months of critical cancer care drove the best outcome for that quality. And we are closer today than we ever were, but there are a lot of things that we need to do, some infrastructure components we need to build upon and build into the business models, so everyone is aligned and we all have shared incentives.

We are really very excited about going forward, and we actually are looking forward to taking that next step.

The CHAIRMAN. Dr. Stream?

Dr. STREAM. Just as I do not think there is a single payment solution across all specialties—because there are unique differences in the question about quality—the issue for primary care is often about treatment of chronic illness, and the payback time to have good outcomes might be 5, 10, 15 years.

My good diabetic management of my patient today is to avoid them being on dialysis 10 years from now. So instead, these quality measures use proxy short-term measures: what is your blood sugar control, have you had your feet checked, have you had your diabetic eye examination?

So we end up using these proxy measures that are not truly outcome measures, because the timeline is too long. And then you get into a debate about, are the proxy measures the right measures?

And to Dr. Hoven's point about developing good measures, we want to make sure that those are valid measures that reflect reality, that they are the things we should be measuring and should be working to improve to get those eventual outcomes.

The CHAIRMAN. Go ahead, Jon.

Senator KYL. That is all right. Maria had her hand up.

The CHAIRMAN. Maria? Senator Cantwell?

Senator CANTWELL. I want to follow up, Mr. Chairman, on quality and outcomes.

You were talking about, obviously, quality and outcomes, and one of the things in the Affordable Care Act is moving to this value-based modifier system. And so, when you look at what some of the estimates are on Medicare waste—$120 billion per year due to unnecessary tests and procedures.

So, have we not proven that we can deliver better care at lower cost, and now it is just about figuring out how to implement that system so that people are, as you were saying, incentivized to do the right thing as opposed to the——

Dr. HOVEN. I can jump in on this, if I might. This is a good first step. I think, clearly, the concepts are in there. What we have to now do is look at the methodology, be sure that the methodology is appropriate for what we want to get accomplished, and that it gets us to a good place.

But I do think it is a good first step. We are in the process of reviewing all that. It just came out in the new rule. So I think we will be getting back to you all on that. But I do believe it is a good first step.

Dr. WEAVER. Let me make a couple of comments, Senator Cantwell, about this, and they are about value-based reimbursement. I personally am very worried about the way it is structured.

It plans to use Physician Quality Reporting System measures, some prevention measures, and as well, look at cost that is regional. And I have to tell you that what people have said today is, you need meaningful, credible data in order to do any adjustment for what the outcome or what the cost should be.

I lived in Seattle. When I moved to Detroit and I looked at patients who had heart failure, I had never seen a population like this before. They would never get adjusted for adequately with administrative data.

You have a population in which 25 percent of the people graduated from high school. They are working just to stay alive. You have people who have burned out their kidneys with longstanding hypertension when they are 35 years old. I never saw that in Seattle.

These patients in Seattle and Detroit both have heart failure, but they are very different people, very different kinds of people. And so, taking crude measures to try to adjust severity and adjust payments would be a huge mistake, in my mind.

And so the value, if you will, of some of these specialty initiatives is that people literally spend many, many, many hours trying to figure out what is going to be legitimate here when you do risk ad-

justment and what is not, and they are the experts. They understand the disease, and that you have to be very careful.

The other thing that the cardiologists have been using is Appropriate Use Criteria, and what these are are, a panel gets together, including a panel of payers and the physicians and other experts, and they look at a lot of conditions for which we really do not have solid guidelines. It is just the science is not there. And they say, "This seems to be reasonable, knowing what we know, and this is not so reasonable."

A year ago, we started providing feedback to the hospitals on the use of stenting, and there were a proportion of cases in which they were considered to be unnecessary or inappropriate. Now, we never expect that number to be zero because there are individual differences and so on, but you ought to be pretty close to what the national benchmarks are for these numbers. And so we have seen, since we have started producing this, a decline in that number. And, in fact, if you look, there has been a decline in stenting procedures the last year or 2 years in the U.S., and it is predicted to go down further.

So providing credible data, giving it back to those docs, will change the way in which they behave.

Senator CANTWELL. I certainly believe in credible data. And I do not know, Dr. Stream, if you want to weigh in on this.

When I think of Spokane, I think it is a great place, and I certainly think that the city title of "near nature, near perfect" is a good symbolism, but I do not know that we are talking about healthier populations here or we are talking about healthier practices. And I certainly think we have healthier practices in the Northwest, rewarding things that have driven down cost and produced better outcomes.

And frankly, people in our region are very frustrated that we deliver care that way and get less reimbursement, and less people want to go practice there, because somebody can go practice somewhere else where they can run up the bill to the America taxpayer. And my constituents, they will be happy with good data, but just to assume that they are healthier and that someplace else is sicker and we should just pay more, is not going to work.

And so I am glad we are moving down this track, and I guess we are just going to have to focus on what good data is.

So, if you have any comment on that, Dr. Stream, and also on what we need to do to encourage graduate medical education. If we are looking at the numbers that we are looking at to get medical homes in primary care, we have a big gap right now encouraging primary care physicians. And what do we need to do for graduate medical education to really get that workforce plugged in?

Dr. STREAM. So, several questions in there. Certainly, we need good data about all of these things, care practices, but populations do differ somewhat. Inner city populations with more poverty, less education—those social determinants of health have a huge impact on the health of our public.

So we need good data about both so that, if we are making risk adjustments, they are true and accurate.

I can speak to value-based purchasing as not necessarily a program, but as a concept that applies to primary care, and we abso-

lutely have to build a stronger primary care foundation if we are going to have any success improving the quality and cost-effectiveness of our health care system.

And that really is this blended payment model that supports the Patient-Centered Medical Home model, decreasing over time the importance of fee-for-service, having a meaningful care management fee that does this care coordination, prevention, and wellness.

And then the piece that gets to your question is that shared savings piece or, if it is pay for performance, it could include both quality measures and appropriate use efficiency sort of criteria. But that would be that third leg of the stool about payment to support primary care.

But you are also right, and I appreciate you teeing it up, about the workforce issue. And I would emphasize that decisions made that influence specialty payment have a huge influence on specialty selection of our medical students and currently have a strong disincentive for people to choose primary care. And we have to narrow that income gap between primary care physicians and median subspecialty income to have the impact we want.

Senator CANTWELL. And just for what everybody has been talking about, do we have the workforce now to implement the strategy that we are talking about?

Dr. STREAM. Absolutely not.

Senator CANTWELL. All right. Thank you.

Dr. HOVEN. If I could follow up on that, Senator. The whole issue of medical school education, graduate medical education: we at the AMA have been looking at this very critically. And this is a problem which preceded current issues surrounding payment and delivery. This is not new.

Looking at spots for graduate medical education, changing the curriculum in medical schools, making sure that primary care is being taught and rendered in places not necessarily traditional for primary care education, that we are opening and expanding the venues in which we can do the education, is really important.

So all of these things are on the table as we talk about it. It takes 7 to 10 years to grow a doctor, and we have to get those slots filled out. We have to have more funding towards that as well, and it is one of the priorities that is part of this whole discussion.

Senator CANTWELL. Thank you.

Senator KYL. Mr. Chairman?

The CHAIRMAN. Senator Kyl?

Senator KYL. Thank you very much. When I first started law school, one of the things that was impressed upon me was the difference between a profession and a business, and it was all about the individual client. You had to give your absolute commitment to that client, whether the client could pay or not and regardless of their idiosyncrasies and so on.

And I began to practice insurance defense work and found that it was true in spades of the medical profession. Data is collected to provide information about averages, but every patient is an individual. And I know that all of you are committed to treating every one of your patients as an individual.

The rub comes when you are treating patients who are paid for by the U.S. Government under a set formula of one kind or an-

other. And my question to you is, in devising—and we recognize that the formulas, the pay scales, however they are going to become embedded in a replacement for SGR, will need to be developed by the professions themselves to take into account individualized circumstances, including regional circumstances in the country, as Senator Cantwell was just pointing out.

But my question is, is sufficient attention being given to the requirement that the care really be patient-centered? When the patient walks in the door, I have one obligation and one obligation only: to take care of that patient to the best of my professional ability. But at the end of the day, I have to get paid, but not to have the payment drive the care.

And then a second sort of related question is, when we deal with this, because of our unique budget requirements here in the Congress, we have to set a 10-year plan out. And it is very hard for us to know whether the 8th and 9th and 10th year are going to work with what you are recommending for us in year 1, 2, and 3, and so on.

And just for our own purposes, I wonder if you have any suggestions for us. And if you want to think about this and get the information to the chairman later, how would we devise something that we think is going to work over a shorter period of time, even though we really do not know over the longer period of time? That was one of the problems with SGR to begin with.

Thank you.

The CHAIRMAN. Dr. Opelka?

Dr. OPELKA. Mr. Chairman, thank you. And, Senator Kyl, thank you for the question.

Two responses to this, in my mind. Where we begin with performance measurement and valuing services is still in the silos of care. It is in the various different performance programs, and it is not as patient-centric as it could be.

And, as we start to spread performance measurement across bundles and ACOs and we look at population-based performance, how well we are taking care in a continuum, and we start sharing the attribution, it becomes more patient-centric.

So where we were 3 or 4 years ago when we started really pushing hard on physician performance measurement was just at the beginning: how do we begin to measure individual physicians and reward them, the hospitals, and reward them?

We have grown over the last couple of years to start to understand some of the points made by my colleagues at this table and from input from all stakeholders, from the purchaser groups, from the private payers, from patients, who are helping us look at this and say, "Well, this is a better measure because it really is more meaningful to the patient."

And as we move to that, it does not necessarily fit within the payment structures or silos of payment. So we have to look at alternative payments, which is my second point, and that is where we have proposed replacing the SGR with a value-based update which says, let us pick a target. We want to improve cardiac care this way, and it is not just the cardiologists, it is primary care, the cardiologists, it is the cardiac surgeons, it is anesthesia, it is pulmonary, everyone who touches that patient will be involved in in-

centives; that is the target we want to get to, and let us strive to get to that target.

So I think we are becoming more patient-centered. We are not quite there yet, but we think replacing the SGR with something that actually is patient-driven targets—does it get to 8 to 10 years? I hope so, but it may take us 8 to 10 years to even get to that point.

Will it be something else, 12 years from now? We are always evolving this. So I am not going to say this is forever.

The CHAIRMAN. That is a fascinating question. Does anybody want to respond to that? Yes, Dr. Stream?

Dr. STREAM. I would like to respond to the patient-centered part. And I agree completely. When a physician is in an examination room with a patient, the patient's best interests should be the highest priority, making sure that that patient gets the treatment that they need that will improve their health, improve their quality of life.

But what we are finding is—and it goes to Senator Cantwell's comment—we know that our system currently provides care that people do not benefit from. And my responsibility as someone's physician is to make sure they get the care that they need but do not get care that does not enhance their health. And that is where I think—and it does not give an easy solution to the SGR problem, but it is a potential for cost savings, to eliminate care that does not contribute to people's health.

And that is an area where Dr. Weaver was mentioning stenting data, and the power of that information—physicians want to get A-plus in their scores, and so, when they are comparing themselves to one another, that is another aspect of professionalism, excellence in your profession. So we need that going forward.

The CHAIRMAN. Thank you. Dr. McAneny?

Dr. MCANENY. Thank you, Senator.

Senator Kyl, I think one of the answers to your question about, why is the care not as patient-centric as it could be, is in the silos of payment, that we pay by area of the country. So that areas such as our area in the west, New Mexico and Arizona, have lower payment rates for the same service.

There are differentials in the site of service; the same service in a different setting, a hospital, a physician office, is paid for differently.

If we had the payment follow the patient more, that would do a lot to go patient-centric in terms of how we focus on that care. And I think breaking down some of those silos so that the money can follow where the patient is best treated will allow us to move patients from more expensive sites of service to less expensive sites of service and make that a very valuable part for health care.

I am also very concerned about the whole workforce issue. ASCO, American Society of Clinical Oncology, did a study some years ago looking at the number of oncologists that we are currently producing versus the number that we are going to need in the next decade, and about a third of cancer patients may never be able to see an oncologist because there simply are not enough of us.

So we are working hard on trying to create new teamwork methods of care so that we can get the expertise we need out to those

patients, put them in the right side of service. I think the most expensive drug we give someone is one that does not work. We are hoping that with personalized medicine and with very good techniques of figuring out what will work on a given patient's cancer, we will be able to avoid a lot of those unnecessary processes that you are talking about.

Doctors are really interested in doing that. It does not benefit us at all to go to a patient and say, "I'm sorry, this didn't help."

The CHAIRMAN. Senator Hatch?

Senator HATCH. In my earlier life, I was a medical liability defense lawyer, defending doctors, hospitals, nurses, health care organizations. And we used to tell doctors, "You need to overdo everything. You need to make sure that that history of that patient shows that you went way beyond the standard of practice in the community," so that if you ever did get sued, you could at least say, "We went way beyond what really the average doctor would have done."

In the process, I became convinced that unnecessary defensive medicine—we all want necessary defensive medicine, but unnecessary defensive medicine is extremely costly.

If I was a doctor today, I would be doing exactly what my advice was 37 years ago, and really doing everything I possibly could. I do not expect you to opine on what it is costing the health care profession just for unnecessary defensive medicine, but it is a whopping amount of money, a lot more than the CBO says.

I remember the CBO Director said $10 billion a year. I chatted with him, and he finally came up with around $50 billion a year. But I think it is approaching $200 billion or $300 billion a year when you consider how health care is so important in our lives today. And a lot of that is because we just cannot seem in the Congress to resolve this issue so that doctors can handle it.

Now, I would like each of you to give some thought—I have really enjoyed your comments here today. But I would like each of you to give some thought and maybe even send in writing to us what we might do.

You have Democrats who do not want to offend their personal injury lawyers. You have Republicans who do not think there has ever been any reason to sue for medical liability, not many, but there are some. But you have the two extremes, in other words.

And it would be wonderful for us to get, especially from the American Medical Association, but from each of your groups, just what you think this is really unnecessarily costing our society because of medical liability concerns.

I would like to have you take the time and send that to me, if you would, but certainly to the committee.

Let me just ask one other question, because, interestingly, we hear about the death of the private practice today. Indeed, many experts who track the health sector have raised concerns about the uptick in hospital acquisitions of private practices. And this is for any of you who care to answer it. Do you believe hospital acquisitions are occurring at a greater rate, and, if so, what is causing the trend and is it likely to continue, and what are the implications for the cost of care in the Medicare programs?

Yes, ma'am?

Dr. MCANENY. Senator Hatch, I think you have hit the nail right on the head. I know that in 2010, about a quarter of oncology practices were sold to the hospitals, and I think the statistics were closer to 50 percent of cardiology practices.

Part of that, again, is the economics. Under the physician fee schedule, we are paid about two-thirds of what the same service is paid for under the hospital outpatient Prospective Payment System.

So a hospital outpatient department can be paid significantly more for the same service. And I think that we will discover—in our workforce study, we also looked at the volume of patient care given by a hospital-employed physician versus a small business private practice physician, and there was about a 60-percent difference.

At a time when we have a shortage, I am not sure we can afford that. I am not sure we can afford to pay more for the same service in this time of escalating health care costs.

I think we really need to look at very efficient mechanisms to rearrange how we deliver that care and go for the most cost-effective site of service.

Dr. HOVEN. If I could jump in on that as well, I think we have to be careful, though, because hospitals, along with physicians, if they are collaborating together to do improved outcomes, cut the cost. If what they have in place is working, we have to look at that side of the coin as well.

So I think this must be a balanced discussion going forward. We have great concerns about this. And I would agree with Dr. McAneny, but we must look at the balance of this, because I think there are some systems out there that are working to make it better for physicians and the hospitals and patients, most importantly, to get the job done.

Dr. WEAVER. I would just add to what my colleague said here, that there has been a major change in cardiology. It is not everywhere. But in Indiana, 95 percent of the cardiologists work for some health system or hospital, and there has been a great move.

And as best we can measure, a lot of it is due to just the uncertainty right now in finances. It is like, if you have a practice, and these are small businesses, what are you going to do at the end of the year if there is a huge change in physician payments?

I saw people in the Detroit area, some physician practices, for instance, when we had a delay in kicking SGR down the road and there was nothing coming from Medicare, it was either—it was like they were worried about paying their staff. They did not want to lay their staff off, whose husbands may already not have a job and that sort of thing, and they went bare for weeks. And that uncertainty says, maybe I should do something with a little more security to it and be part of a larger health care system.

So, if you want to integrate us all, that is a good way to do it: just create a lot of uncertainty. On the other hand, as Dr. Hoven points out, when you have doctors and hospitals working closely together—because now you have solved the alignment problem—they will align and try to create better value.

The CHAIRMAN. We have an SGR problem facing us, and it is not very far off when we have to extend. Do we just extend it again another year? If we do not, what changes do you suggest?

These are all great ideas. It is fascinating. It is very stimulating, this discussion. But we have a practical question looming, and that is, what do we do about all this in the short term, as well as long-term?

To me, I mean—Senator Kyl asked the question about more individualized treatment. I guess the question of personalized medicine, all this fancy stuff you read about in the papers, the genome sequencing and DNA sequencing, and especially in oncology——

There was a very interesting article a few days ago about a lady who got a very fancy treatment, a specialized cancer treatment, a unique cancer, and it actually cured her, but then she died 2 weeks later.

Then there is stem cell research developments that are going to occur over time. Things are just changing so quickly.

So how in the world—what should we do in the short term and what should we do long-term? What should the Congress do in the short term and the long term as we deal with this practical problem of extending the SGR?

Dr. OPELKA. Mr. Chairman, we have included in our testimony, the first bit, the foundational elements of our thoughts from the American College of Surgeons about replacing the SGR. Now, in terms of how to pay for it, I cannot go there.

The CHAIRMAN. Unfortunately, we have to go there.

Dr. OPELKA. Yes, sir. But that is a higher authority than I have. So, when I look at this though, what do we replace this with? Within this entire context of this discussion we are having today, we are all moving from the volume world to the value world, and we think that is the replacement. And we think it is a patient-centered approach that should be taken.

We think you set the updates by setting targets based on value. Did we achieve this value? And it is a patient-centered target. What do we need to do in the 10, 15, 20, 100 measures that we have in surgical care? What do we need to focus on for those patients as targets that then drive an update? And those have to have a down-side and an up-side.

What do we do in chronic and preventive care to drive improvement with my colleagues in primary care? What are those targets? What do we do across all of cardiac care? We need to set targets.

We have hundreds of measures today. If you look at the National Quality Forum's measure library, there are over 800 measures in there. Which ones are critical? Which ones are going to be meaningful and actionable and are meaningful enough to you as targets, that this is better quality care, safer care, and more affordable care? Let us set those out as targets and then award the SGR target, replacing it with a value-based target, and make it a patient-centric target.

That is our proposal, in short. And what do we need to do in the short run with that? Some initial pilot modeling and how we actually begin it. We are building the alliances across the specialties of medicine to do this. And then, how do we roll it out and phase it

in? And we have a 4- to 5-year phase-in plan that we think can be implemented with, yet, some roll-your-sleeves-up work.

The CHAIRMAN. Now, is this for surgeons, or is this for other specialties as well?

Dr. OPELKA. It is for the patients. It is across all patients.

The CHAIRMAN. All patients and all care.

Dr. OPELKA. It includes rural programs, it includes chronic care prevention programs, it includes—instead of being surgery-related, it is patient-centered. What is a digestive disease program that we need to improve, which would be gastroenterologists, primary care, and surgeons? What are cancer programs, which is not just oncology? It is radiation therapy, surgeons, and primary care.

You cannot get away from primary care. They are tied to every one of us. How do we set targets that actually—we can go out to the community at large and say, "We have a problem in this area in this country, and we are going to set a target to improve it."

The CHAIRMAN. Dr. Weaver?

Dr. WEAVER. Just a couple of comments. I think what you have heard from all of us this morning is, unfortunately, these improvements are going to be iterative. They are going to take time. They are not going to be there on January 1st.

I will give you an example, though, of something that did happen on January 1st of this year in southeast Michigan, and that is, the larger employers changed patient deductibles from very modest numbers to $3,000 and $4,000 per person. I can tell you that the amount of health care these people are getting dropped dramatically.

People's co-pays went up. They do not come to see the doctor. They decide when they are going to see the doctor. And unfortunately, I mean, it reduces costs a lot, it reduces utilization a lot, but patients do not have the ability to know what is valued and what is not valued in their care.

And so they put off prevention, they put off things that ultimately are going to cost us all a lot more. But increasing co-pays, increasing deductibles, will change the amount of health care dollars that are spent immediately.

The CHAIRMAN. Dr. Stream?

Dr. STREAM. You mentioned personalized medicine, and we have this fascination in America with high tech genomics and things. One of the most important features of people's health and wellness is having a personal physician, a usual source of care. They get their prevention and wellness, they get their acute care needs taken care of, their chronic illness care.

And the way that we are going to save money in the long run is in investing in primary care in this Patient-Centered Medical Home, and we need to align our payment system to do that. As Senator Cantwell mentioned, we do not have enough primary care physicians. And so we need to invest in our workforce, in reforming our graduate medical education system.

We are seeing this play out in the private sector with private health plans. The Patient-Centered Primary Care Collaborative is a national organization that is employers and payers and patient stakeholder groups that are really already documenting tremendous success in this direction.

Senator KYL. Mr. Chairman, you asked a key question that we asked these people to come here and advise us on. Are you ready to present to us, as the experts, a process, a methodology for payment that we could institute on January 1st with some assurance that the costs would be within a certain range to the Federal Government and meet the objectives that I think we all agree on here; or, if you are not going to be ready to do that then, what would you recommend we do?

Would you recommend we do an update, a positive update, of 1 percent or 2 percent, with some reporting requirements and phased-in pilot programs and so on during that year, so that January 1st a year later, we could make decisions about specific payment methodologies that would go across the board?

In other words, respond to the chairman's question here. We are going to have to make a decision in 6 months. What do we do?

The CHAIRMAN. Dr. McAneny?

Dr. MCANENY. Thank you. Again, a very important question. I do not think any of us are prepared to answer that very quickly. This is a huge—it is a 7th of the economy in health care. We are not going to be able to fix it by January 1, 2013.

I think a 30-percent cut will put many practices and many hospitals out of business, and that will cut the amount of health care that is delivered. But I do not think that is the intention of any of us.

So I think that, again, we are going to need another positive update. AMA data has shown that, for the physician fee schedule, we are currently being paid at 2004 levels. The light bill is not at 2004 levels in my practice.

I think we need some time and some stability where we can do some pilot projects, because what works—even in my practice in New Mexico, the things that work in my Gallup clinic in the heart of the Navajo Nation are not going to work in my Albuquerque clinic or in my hospital-based Silver City clinic. There are different mechanisms that will be there.

The Innovation Center got thousands of people, thousands of doctors, wanting to give ideas about how we knew we could save money in giving care. So we would like very much to know that we had some degree of a period of stability, where we know we could count on Medicare to not pull the rug out from under our practices and from under our patients, so that we could then work with various pilot projects that can be area-specific, part-of-the-country-specific, specialty-specific, or integrated across multiple specialties, to be able to do that.

I am hoping my Innovation Center grant will prove to you that we can take a bundle of payments, take care of patients through a continuum of care, and be able to save money. But it is going to take us some time to be able to rearrange this system.

The CHAIRMAN. Dr. Hoven?

Dr. HOVEN. Thank you. A very, very important question. Updates and stabilization, you have heard several now speak to that. I think the question of stabilization for practices is a huge and key issue going forward.

There is a huge amount of work out there already underway, Senator Kyl, on the models, the way we deliver care and how care

will be paid for. They are going to be multiple in type, not one size fitting all. These practices cannot endure that because they are different, based on the practice, the location, the patients served.

So we have to be willing to say there is probably going to be more than one delivery system. There may be more than one payment system to follow that delivery system as well. But we will not know until we do that.

One of the things which you all could do now would be to allow physician practices to roll into a model of whatever they choose to do when they are ready to do it so that there is not a limited window of time. Right now, the window opens and then it closes, and nobody can get in there and get the work done to get ready for the infrastructure changes to happen.

In rural and primary care practices in parts of this country, getting the funding out there to help them get the infrastructure is a key issue. It has to take place in order for them to be participants. But we cannot expect them to change overnight.

But we can get them enrolled in these programs if we provide them the wherewithal to do it and the timing allotment that will do it.

The other thing we have to do fairly quickly is the Medicare data system. And you have heard repeatedly now today, we have to have the data that we need in order to do the quality work.

Physicians want to participate in the quality programs and, in fact, in some of the earlier discussions, the relevance of the measures, et cetera, being used, the whole issue of the mechanics of the way these programs work—they do not work particularly well for physicians.

And then, again, another opportunity here is what we refer to as the deeming opportunity, which was in our written statement, which allows physicians who are already participating, like Dr. McAneny's program, in a very high quality program with improvement outcomes, let that count towards this entire issue of physician participation.

So those are some fairly straightforward things that could be done in the short term as we get to the final payment and delivery models that we are going to end up needing to use in this country.

The CHAIRMAN. What is the Medicare data problem that many of you are referring to? What is the problem?

Dr. McAneny?

Dr. MCANENY. I have an example that I can use from my own practice.

The CHAIRMAN. Sure.

Dr. MCANENY. We participated in the PQRS, since it was PQRI, from the beginning. I am a fully electronic practice. We have been paperless since 2002. So I know I have data on my practice of what is done.

Yet, last year, we filled in all the PQRS updates, and I can prove that I have the documents for each one of those. Yet, when I turned it in to Medicare, we did not get any of those updates. They said, "Your data was incomplete."

I said, "I have my data." They said, "No. Ours says you didn't do it." And that is just one small example of some of the flaws in the Medicare system in terms of rapid turnaround for data.

If we are going to manage a population of patients in the medical home, we have to have real-time, very good data where our patients are, what care they are accessing, what site of service they are doing it in, what are their complications, what are their comorbidities, who are their other doctors.

We have to have that data practically real-time if we are going to be able to save the system money. But if you get data from Medicare, you get it a year, a year and a half later, when it is history. We need it now.

So we really need Medicare, CMS, as a partner to work with the physicians to be able to——

The CHAIRMAN. So what does CMS say? "We don't have the money to update our systems." What is their response?

Dr. HOVEN. They are working with us.

The CHAIRMAN. Is there a legitimate reason?

Dr. OPELKA. There is a current structure, Mr. Chairman, that the way the data is pulled in and then analyzed, it is, for example, 2012, we are looking at 2010 data.

And so, how does that become actionable and meaningful? When you get your report, it is really just tied to an update in finances and not to clinical care. And we want it tied to clinical care so we can make actionable statements about patients.

So that is the problem, using claims data that then has to be aggregated and analyzed when that year is closed out. And by the time it is analyzed and presented, another year has passed. That is why we are looking at other data systems that will get to the target you are asking us to get to.

And, if we had access to these other data systems, they are real-time, they allow us to say, that happened last month, that cannot happen this month; we need to put an action plan in place to correct that. But that is part of the big disconnect, and it is not for lack of trying. It is just the wrong dataset to drive the goal that we are trying to reach.

Dr. WEAVER. The other place you can help us is the private insurance. Their data is much more rapid, but they are not very transparent with their data.

The CHAIRMAN. True.

Dr. WEAVER. And for us to manage ideally, we should have everybody's data on those patients whom we are trying to manage in order to do it best. It allows us to look at claims data and clinical data at the same time. We are prepared to do that, but it is almost like it is proprietary to some of these payers.

They do not want to share it with you, and yet, they are spending millions and millions of dollars collecting it.

The CHAIRMAN. I know that is true. I met with insurance companies not long ago and they showed me all this "gee whiz" technology they have on claims data.

Dr. WEAVER. Yes.

The CHAIRMAN. They know everything about everything. You pull back the screen, you would think that you were down in command central somewhere. I asked them, "What about outcomes?" And they were a little hesitant at that. I said, "Well, do you share that with your hospitals and with your practices?" The answer was, "Well, if they'll pay for it."

Dr. STREAM. And the challenge for the practice is, you might have 10 percent of your population in each of six different programs, and then you have your Medicare data and your Medicaid data, and it is not collated in any single place.

They use the claims data because it is what they have.

The CHAIRMAN. Exactly.

Dr. STREAM. But they really need, as we make the transition—to change more broadly in our practices, we need to move to providing more clinical data.

The CHAIRMAN. I would like to press you a little more, if I could, though. It is a question I asked and that Senator Kyl asked. What do we do short-term, long-term? We have to be consistent, but flexible in different parts of the country. And I think we have some understanding of all that. But we do need some ideas on what to do.

Dr. STREAM. I mentioned in my opening remarks H.R. 5707. It is a bipartisan House bill. I would encourage your consideration of its provisions.

You have heard from all of us the importance of providing some predictable stability in physician payment, particularly for primary care. It operates on a much thinner margin, particularly in our small practices.

The recurring annual, or sometimes multiple times per year, potential cliff in payment is a huge stifling factor in investing in practice transformation for this future that we know we need.

So this bill has a repeal, it has a positive update, and then it has declines in fee-for-service payments in the later years once we have these new models tested to take the place of pure fee-for-service.

Dr. OPELKA. To the specifics of Senator Kyl's question, can we have something ready for January, it would be a really big push for us to push our model to that point. We are just now trying to sort through, how do we actually score this and show you the ability that this has to reduce cost and improve quality at the same time?

So, in short, I think we are going to need a bridge, but also, we could use help from the Innovation Center as to how we are looking at data and how we actually get that data at a meaningful point so that we get adequate scoring in the value-based update model that we are proposing.

So there is an opportunity for us to work more closely with the Centers for Medicare and Medicaid to actually do the work we need to get the scoring of the modeling so that we can, by that subsequent year, give you a more complete package. And we think it is in alignment with our entire conversation about value and about patient-centeredness.

So we do believe we can do it, and we are ready to roll our sleeves up on it, but we could use some help in getting access to and partnering with the knowledgeable side of the Innovation Center and what they could do to add to this.

Dr. HOVEN. One of the other things I would throw in on this—and I agree with what Dr. Opelka has said—is the whole issue around care coordination and transition of care.

The new codes need to be in place. Payment for this—I mean, there are going to be some up-front expenditures, but care coordination is extremely important. You have heard that earlier in our

discussions today. It will result in long-term savings, but we have to get the ball rolling and make it meaningful.

We could talk for hours about how folks fall through the cracks. That is not patient-centered, necessarily, although we try like heck to make it so. But we do need help in that particular area as well.

The CHAIRMAN. Senator Thune?

Senator THUNE. Thank you, Mr. Chairman. Thank you all for your insights.

I know most of you represent more populated areas of the country or work in those areas, but I wanted to just raise an example of some of the challenges that we are facing in rural parts of the country when we talk about SGR reform and financial stability for our health care providers.

In South Dakota, it should not be any surprise that most of our providers are highly dependent upon government payer sources, and here is an example of one of the towns in my State. This is Chamberlain, SD. It has a population of 2,300 people. It has a payer mix of about 40 percent Medicare, 20 percent Medicaid, 20 percent IHS, and 20 percent private insurance.

So you have 80 percent of the revenue tied to what tend to be unstable Federal payment systems, and they are struggling to keep up with reinvesting in critical facility upgrades and nursing recruitment and all those sorts of things.

And the other point I wanted to make about that is, it is very hard to recruit and retain providers, physicians, in some of these rural areas. And I am curious to know—I am going to give you another example. In South Dakota, we have an estimate that 27 percent of the population resides in areas that lack sufficient family practice, internal medicine, or OB/GYN, which is 48th in the Nation. And so, recruiting and retaining quality physicians has traditionally been a challenge for hospitals in rural communities.

I am wondering what your thoughts are about the lack of an ability in rural settings to cost-shift. Most people in more urban settings cost-shift to your private payers. And because the margins are so thin with regard to government reimbursements to physicians, and particularly in the primary care area, that is impacting the ability of rural areas to recruit and retain physicians.

You have this high amount of the payer mix that is government sources. The cost-shifting that many areas can do is not available, at least not on the same level, in some of these rural areas. But it strikes me that that is really impacting our ability in the rural parts of the country to be able to get people to come out and practice.

Again, it comes back to the whole point of payment reform and what we can do to incentivize physicians to work in these areas.

I am just curious if any of you have observations about that.

Dr. STREAM. I currently practice in a small metro area, but my first practice was in a community of 2,700 in central Washington, 12 miles from the nearest hospital. I understand the problem that you are referring to.

And it is largely primary care physicians who are out in those rural areas. In most practices, even in primary care, only 20 or 25 percent of their practice is Medicare with a small Medicaid portion. And so it is the measures you describe, but upside down.

I think what we have to do is, again, realign payment so that it supports primary care and use the innovations that we have seen in the commercial market, which is, unfortunately, for many of your folks, a smaller piece of their business.

But the medical home pilots conducted around the country and coordinated with employers and insurers through the Patient-Centered Primary Care Collaborative and others, show huge improvements in health care quality measures, but also, cost efficiencies. And it is the reason that we need the Federal payers to be involved in that.

It is why the Comprehensive Primary Care Initiative is such a unique, potentially game-changing program for primary care, including in rural areas, because it is a collaboration between CMS and private payers in the local market to pay this blended payment model, to support that necessary practice transformation.

And we know, not only are those practices more efficient and provide better care, but the people who work there are happier, and that is an important factor in recruiting to a rural area.

Dr. McAneny. Thank you, Senator Thune, for that question. I come from New Mexico. We are rural and frontier. So I can relate.

In the small towns where I provide oncology services—one is in the heart of the Navajo Nation, another is in the southern part of the State—the primary care doctors ask us to please provide those services, because patients were electing to stay home and die rather than drive for hours to get cancer care, which is just too sad in this country.

One of the things that I find is that it actually costs more to recruit doctors, nurses, physical therapists, radiology technicians, et cetera, to a rural area than it does to an urban area. In an urban area, a doctor who shows up with a spouse, both can generally find a job. In a rural area, often, one cannot. And we have to work harder and pay more in rural areas.

Yet, the Medicare system is set up with the geographic price-cost indicators, which penalize those of us who have been in rural areas, who have kept costs down. So that, when we try to recruit people, we are paid less for someone who costs us more. And one thing that Congress could do is to take a very strong look at the geographic price-cost indicators that adjust all of our payments for these rural areas and look at whether or not they truly still reflect the cost of providing care.

I am an oncologist. If I have to have oncology nurses, I am recruiting through a national market. I advertise nationally for people to come to Gallup, NM. It is not easy, and we struggle with that.

We have set up our own training programs inside the practice to train nurses, to pay them more to become oncology-certified. But these are things that we are taking on.

Your description of the payer mix is exactly my payer mix in Gallup, maybe not quite as good as what you described, and that practice is losing money, and I am struggling in a private practice to keep it alive.

If the payments were higher for rural and under-served areas and populations with severe health disparities to reflect the increased work it takes to take care of people who are socially dis-

advantaged, then you would be able to move some of the doctors and nurses and others from the more urban areas into these rural areas, and we desperately need your help with that.

The CHAIRMAN. Would the rest of you agree with Dr. McAneny: pay more for those who practice in rural areas?

Dr. WEAVER. I would not say it is just in rural areas. I would say, many inner cities have the same problem.

Dr. HOVEN. Equal pay for equal work.

Dr. MCANENY. Right.

The CHAIRMAN. What about loan forgiveness?

Dr. WEAVER. I think that is effective.

Dr. HOVEN. Yes. We do it in Kentucky.

Dr. STREAM. There are good State and Federal programs for that that are very successful.

Dr. HOVEN. The other point to this question, as well, is empowering those practices not just with payments, but empowering them to be engaged in the whole delivery reform process, and that is going to be a challenge.

The advanced payment program, so they can get their IT-health information technology up to speed, is a very important one. The other thing is working on mechanisms for them to be able to connect to specialists, other folks not just in their primary care role, but the specialists they need to help them manage their patients. And I think we could do a better job in working out systems to allow that to happen so that they get the support and they do not feel like they are hung out to dry, like in eastern Kentucky where I am from, and that they can provide the care they really want and are able to do.

Senator THUNE. How much EMR interoperability is there with facilities?

Dr. HOVEN. That is a huge issue, a huge, painful issue. There is no interoperability.

Senator THUNE. It has always been that that was one of the things that we were addressing and getting better at. We have people come in, experts, and testify that that is not happening.

Dr. HOVEN. It is not happening.

Dr. OPELKA. What they are saying and what we are seeing is just completely opposed, even within the same vendor, where there is a vendor who is version 1.1, and then this institution over here is version 2.2. They do not talk even within the same vendor. So there is a major barrier there.

The CHAIRMAN. So how do we incent getting them to work better together? I do not think much is going to change until they get proper incentives, the vendors.

Dr. OPELKA. I think there is a lot going on from the Office of the National Coordinator in this effort to try to set data standards and try to move more consistent data across all these areas.

Again, the initial move of getting the EHRs out there was, let us get everybody digital, and now we have to get digital communication. We have to get the movement of data, and then we have to get the meaningful movement of data.

So ONC is now at the point of data-to-data movement, and their next step is, how do we get to meaningful data? We are the content-context experts who can give you meaningful data. We

need to have the ONC standards go out there and say, we will get you movement of data, and then we can front-end load that with content and context. That will give us actionable data.

Dr. WEAVER. The other area you can help us with is—I mentioned this before—criteria for, like, appropriate use of testing and that sort of thing, which could increase utilization. That is done on the side right now. It needs to be in workflow. It needs to be in the EMRs. And the EMR vendors are not stepping up to incorporate these kind of decision support tools.

And that is where we will see changes occur, when we do not have to pay extra to collect the data and distribute it versus having it part of the EMR.

The CHAIRMAN. Maybe we should have the vendors here.

Dr. WEAVER. Maybe.

Dr. HOVEN. It might help.

The CHAIRMAN. We can talk to them about this with you here, as well.

Dr. OPELKA. We actually had a meeting with them 2 days ago over at the Institute of Medicine, and it is the very first step in how do we get there. And again, any direction you can help give ONC to get us there would move us that much faster.

Dr. STREAM. One of the issues is the intermediary that exchanges that information, the health information exchanges, and there are a number of successful and some not so successful ones around the country. And a lot of the issue is, what is the business model or payment model that supports them, and they often look to the physicians to subscribe to a service that then is going to exchange information.

But it is the system, particularly the private health payers, that benefits from that exchange of information. I think we need to promote a payment model for those health information exchanges that is not asking small practices to contribute in order to get information exchanged.

The CHAIRMAN. Go ahead.

Dr. OPELKA. I was just going to comment very quickly on Senator Thune's comments about the rural issue. And we do not have a solution in surgery, but we are very concerned. And there is decreasing access to surgical care, and, when that happens, you have problems with trauma, you have problems with acute surgical needs and transporting patients.

I really want to support what Dr. Hoven had said about creating partnerships and new ways of delivering care into the rural environments. Partnerships from these delivery systems that are forming create some new connectivity, like telemedicine out to the specialty areas, so that there is early intervention and prevention of avoidable, preventable adverse patient events.

It is deeply troubling in surgical care what we are seeing in the absence of surgeons in rural America, and it is something we are tracking, but I do not know that we have a solution for it.

The CHAIRMAN. If we were to have a solution, what might it tend to be?

Dr. OPELKA. Well, I think finding out what the barriers are to creating the kind of partnerships we need, getting the right surgeon to the right environment for the right time, matching the sur-

gical needs. There could be a sense of, how do we actually create regionalization of key parts of surgery, and then, how do we get rural surgeons out into those rural environments?

Some of that may be loan forgiveness. Some of that is going to be recruiting from the medical schools themselves. As a person in Louisiana, a rural State, with medical education, we find when we pull in students from the rural areas, there is a good chance that they will go back to the rural areas.

So we are looking for best-in-breed opportunities to come in from the rural areas, and we are giving them incentives to come into medical school. So it begins very early in the career, but there are other steps, too, Mr. Chairman, that you have mentioned, and we endorse those.

Senator THUNE. How much is occurring with patient or surgical consults via tele-technology, telemedicine-type approaches that might—I mean, that, to me, is one of the partnerships that we have seen be at least moderately successful in South Dakota, and I think other rural States are doing that too. But there are some, I think, limitations to that.

And I guess to the chairman's question, are there barriers that we could knock out of the way that would enable better use of the technology to deliver care to these—obviously, you have to have a surgeon there at some point if you have to have that kind of intervention, but it seems like there are a lot of things that could be done on the preventive side and in advance of that that could be accomplished through other means.

Dr. OPELKA. Senator, in short, I would have to do more homework on that and get back to you. I do not have a sense of what kind of penetration there is. There is more than just a case report of this being out there. It is emerging. But I do not know that we have clear data to answer your question.

Dr. HOVEN. I am not going to speak to the surgical issue, but I know in medicine, internal medicine, and in the specialties of medicine, particularly in neurology, critical care, pulmonary medicine, infectious disease, which I do, a great deal of outreach is now being done into rural parts of Kentucky via telemedicine programs and other communication tools.

The technology needs to be improved. The standardization needs to be improved. But it does work. And recently, in one of our communities, actually, every day, a member of the critical care ICU team met video-wise with TeleMed, with a team in a little, small community hospital taking care of critical-type patients, and actually arranged transfer, determined what diagnostic studies would be helpful, and began to move that train before it became a catastrophe, before someone was seriously hurt because they were not able to get to care.

So the movement is out there. I think we need the tools, the technology, and the standards to get this to a place that makes it what it should be.

The CHAIRMAN. Senator Carper?

Senator CARPER. Let me jump in here, if I can. I apologize for missing your comments. I have a simultaneous hearing in the Committee on Homeland Security and Governmental Affairs, and it is the 10th anniversary of the creation of the Department on the

heels of 9/11. And it was an opportunity for us to look back and look forward at the threats that we are facing around the country, around the world. So I apologize for missing much of what you said.

My colleagues would probably tell you that my focus on health care reform has been not just, how do we extend coverage to people who do not have it, but how do we realize better health care outcomes for less money or for the same amount of money, because, if we do not do that, we are not going to be able to extend coverage long to people who do not otherwise have it.

Among the focuses that I have had and, actually, a focus shared by Senator Baucus and Senator Enzi, as well as by others of our colleagues, is, is it possible to reduce the incidence of medical malpractice litigation? Is it possible to also reduce the incidence of defensive medicine? And is it possible, in doing both of those, to get better health care outcomes?

And one of the things we put in the health care reform bill was a $50-million authorization to incentivize States to experiment boldly on different approaches. It could be health courts, it could be safe harbors, it could be panels of merits, or it could be the kind of thing we did up in Michigan; we saw that it works. And like what the University of Illinois has done, they have taken the Michigan idea, saw that it works, and they put it on steroids to see if it is possible to reduce the incidence of medical malpractice, reduce the incidence of defensive medicine, and get better results.

And the answer, in about the last 2 years of good work that they have done, is yes, yes, and yes. I would just throw that at your feet and ask you to comment, please.

Dr. OPELKA. Senator, if I could. And Senator Hatch raised this issue moments ago. We really did not dig into it at the time. But there is a disconnect from the conversation we are having about improving the value and how we purchase health care and this whole aspect of defensive medicine.

And there is no way that we can actually fully achieve the value we wish unless we actually have evidence-based clinical care matched with evidence-based tort. If we do not have evidence-based tort reform, then physicians and hospitals are going to continue to have to defend their profession with defensive medicine. And that is the missed opportunity.

If we are setting standards for better performance, if we are using them for public reporting and payment, then why are we not using those as the evidence basis for the decisions we make?

I do not want to say that malpractice does not occur. I wish it never, ever occurred to anyone in any specialty anywhere. But it does. We are all human. And when it does occur, people deserve to be compensated.

But if the best evidence was followed and everything was proper, then we just understand that is part of our own human frailties.

We desperately need to look at everything you proposed, whether it is health courts, whether it is safe harbors, whether it is evidence-based tort reform, as a necessary adjunct to this value proposition. If we do not, we are going to be forever struggling with trying to contain that cost, and it is a significant cost. I do not know if it is $50 billion or more, but it is not chump change.

Senator CARPER. I spent quite a few years of my life as a naval flight officer back during the Vietnam War and then subsequent to that and during the Cold War. I am struck by how we have taken an idea that we used all the time in airplanes—checklists—and are actually applying it to the delivery of health care, and with regular good effect.

And the other thing we did in naval aviation, and I am sure we do it in the other branches of the military as well, is, if we had a problem in a Navy P–3 airplane with one of the systems, crew, air, or whatever, we did not hide it. We just broadcast it throughout the Navy and said, this happened on this flight, on this mission, these are the conditions, the circumstances, this is what was done well, this is what was done badly, and, frankly, that is a smart thing to do with respect to these issues—defensive medicine and medical malpractice mistakes that are made.

And one of the beauties about what they are doing in Illinois is putting a spotlight on it. They are not hiding this stuff—immediate disclosure, folks who are hurt, harmed in some way, financially or their health, apologies, and it is really a smart approach, I think. I am very encouraged with the work that is going on.

Do you have any comments on this?

Dr. STREAM. Well, you bring up a good point, Senator. It really is about a system of care and not necessarily just individual performance. And the checklist comment that you made is exactly on point.

But we need to look at those incidents, near misses, as the FAA looks at accidents for aircraft. How can we learn from mistakes rather than try to hide them because of concern about litigation, and how can we use them as learning opportunities to continuously improve the quality of care that we give?

And we need to nurture that environment, and, unfortunately, we, for the most part, do not do that.

The CHAIRMAN. This has been a good hearing. I would like, though, for each of you, the best you can, to submit to us your written suggestions on what we do about SGR; that is, short-term, mid-term, long-term, knowing that we have to act one way or another. And there are many ways to skin a cat, there are gray areas here and there are bridges and there are all kinds of solutions that you can come up with, but we do need some help.

I just tend to think, the more you give us some suggestions and solutions, the more likely it is that you will like them. So, please, let us know what you think. And we deeply—I mean that, we really need your help.

Thanks very much. The hearing is adjourned. A very good hearing. Thank you.

[Whereupon, at 11:51 a.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted for the Record

Roundtable Statement of Senator Max Baucus (D-Mont.)
Regarding the Medicare Physician Payment System

Albert Einstein once said, "A great thought begins by seeing something differently, with a shift of the mind's eye."

Today, we hold our third roundtable on Medicare physician payments. We have heard from former CMS administrators and from private payers. Now we are here to see things through the eyes of those who receive the payments and provide the care – physicians.

Every year, the flawed sustainable growth rate, or SGR, leads physicians to fear dramatic reductions in their Medicare payments. Next year physicians will face a 27 percent cut if we don't act. While Congress has intervened to prevent these cuts each year, it is time we develop a permanent solution.

We need to repeal SGR and end the annual "doc fix" ritual. The year-in and year-out uncertainty is not fair to physicians or the Medicare beneficiaries who need access to their doctors.

When thinking about new ways for Medicare to pay physicians, we must focus on controlling health care spending. Physicians can help us find the solutions. They are on the front-lines of health care delivery.

Ninety-seven percent of Medicare beneficiaries see a physician at least once a year, and beneficiaries with chronic conditions see their physician at least monthly.

By ordering tests, writing prescriptions and admitting patients to hospitals, physicians are involved in up to 80 percent of total health care spending.

We need physicians to suggest changes to the Medicare physician payment system that will spur high quality, high value care.

I look to today's panelists to offer solutions, both in the short and long term. I hope, like Einstein said, that they can help us come up with a great thought by seeing something differently.

We need solutions that will work for both primary care and specialists as well. And they need to work for beneficiaries with chronic conditions. These beneficiaries account for two-thirds of total Medicare spending.

I look forward to candid and direct suggestions from our panelists on how we can begin to better control our health care spending.

###

STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER U.S. SENATE COMMITTEE ON FINANCE HEARING OF JULY 11, 2012 ROUNDTABLE DISCUSSION ON MEDICARE PHYSICIAN PAYMENT POLICY: PERSPECTIVES FROM PHYSICIANS

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, today released the following statement during a committee roundtable discussion on the sustainable growth rate (SGR) formula within the Medicare physician fee schedule:

Chairman Baucus, thank you for convening today's roundtable. Over the past few months, this Committee has had an opportunity to hear from former CMS Administrators and leading private sector health organizations about physician payment and efforts to reform and improve the payment system.

We all know our current physician payment system is broken. We must do better by our physicians treating Medicare patients. However, improving the physician payment system is no easy task.

Today, we turn our attention to the physician community. You have the most direct experience with our current Medicare payment system. As we look for fiscally-responsible ways to move beyond the flawed SGR payment system, I urge the physician community to help us find a better path. True reform of the Medicare payment system must occur with the partnership of the physician community.

I look forward to hearing the perspectives of some of our nation's leading physicians on today's panel. Hopefully, our panelists will be able to build on the robust discussion this Committee began with our previous roundtables. I hope this is the first of many conversations with treating physicians to develop realistic and meaningful policy advancements for the Medicare program.

Senator Baucus, thank you again for convening this roundtable today.

###

STATEMENT

of the

American Medical Association

before the

Senate Committee on Finance

Re: Medicare Physician Payment Policy: Perspectives from Physicians

Presented by: Ardis D. Hoven, MD

July 11, 2012

The American Medical Association appreciates the opportunity to present our views to the Senate Committee on Finance concerning "Medicare Physician Payment Policy: Perspectives from Physicians." There is strong bipartisan agreement that the sustainable growth rate (SGR) must be repealed and replaced with an alternative, more viable system. The SGR has been plaguing patients and physicians in Medicare and the TRICARE military health program for over a decade, and its repeal is long past overdue. We now have a unique opportunity to improve and restructure care delivery and payment policy. Many ground-breaking innovations are already underway, and it is critical that we continue on this path. As we move forward, we must keep in mind that physician practices widely vary, by size, specialty, practice type, and community. Large, multi-specialty practices may initially be better positioned to quickly implement these innovations than small, rural, solo or two-physician practices. Because of the wide differences in physician practices, both structural and geographic, practices operate at a different pace, reflecting variations in practice capabilities at this point in time. This means we need multiple solutions, including a menu of innovation options available on a rolling basis for varying physician practice types, allowing practices as they are ready to participate in an option most scalable to their practice.

Restructuring our Medicare payment and delivery system is an enormous undertaking that requires initial immediate steps that can advance us further down the road, combined with a long-term strategy that takes us to the finish line. The AMA looks forward to working with the Committee and Congress as we work to develop and implement multiple solutions to the problems of the current Medicare physician payment system.

TRANSITIONING TO A NEW MEDICARE PAYMENT AND DELIVERY SYSTEM

In transitioning to a new Medicare payment and delivery system, several key factors must be taken into account:

- The flawed SGR must be repealed. Physicians face yet another steep payment cut of about 30 percent on January 1, 2013. This vicious cycle must come to an end, and it must be replaced with a new system that moves physicians forward into a coordinated delivery and payment system that is better for patients, physicians, and the Medicare program overall.

- A flexible approach, rather than one-size fits all, is needed during a transition to a new system, including a menu of options to best address patient need of a particular practice, depending on the specialty, practice type, capabilities and community. This menu should go beyond Medicare shared savings and Accountable Care Organizations (ACOs) based on total costs, and should also include innovations such as bundled payments, performance-based payments, global and condition-specific payment systems, warranties for care, and medical homes.

- Alternative payment and delivery models must cut across Medicare silos. When physician delivery of care achieves overall Medicare program savings, physicians (and the Medicare program) should be able to share in those savings. Part B physicians' services often are necessary to prevent patients from needing more costly medical care down the road. While this is good for patients and Medicare spending overall, under the SGR, more physicians' services (even to create overall program savings) drives steeper payment cuts for physicians. This perverse incentive structure has to change as part of a transition to a new system.

- A positive and stable payment structure is needed as we make this transition so that physicians have the financial ability to make up-front capital investments—such as employing additional staff to improve care coordination and adoption of health information technology.

PHYSICIANS HAVE ALREADY BEGUN TRANSITIONING TO ALTERNATIVE PAYMENT AND DELIVERY MODELS

Physicians have already begun transitioning into alternative payment and delivery models, both in Medicare and the private payer market, which can guide the development of a new Medicare physician payment system. This trend should be supported and incorporated into action by Congress and the Centers for Medicare and Medicaid Services (CMS), as discussed below.

Medicare

In April of this year, CMS announced that 27 organizations had been selected to participate in the Medicare Shared Savings Program (MSSP), also referred to as ACOs. These ACOs are geared toward providing coordinated care and chronic disease management while lowering Medicare program costs, with ACOs sharing in a percentage of achieved savings. The first ACO performance period began on April 1, 2012. These ACOs will serve about 375,000 beneficiaries in 18 states. The total number of organizations participating in Medicare shared savings initiatives thus far is 65, including the 32 Pioneer Model ACOs announced last December and six Physician Group Practice Transition Demonstration organizations that started in January 2011. These programs cover more than 1.1 million Medicare beneficiaries.

In addition to Medicare ACOs, the Center for Medicare and Medicaid Innovation (CMMI) is rolling out a number of alternative payment and delivery models, such as the *Comprehensive Primary Care Initiative*, the *Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration*, and the *Bundled Payments for Care Improvement Initiative*, which would include a model to test gainsharing, wherein payments may be made across Medicare silos as a result of collaborative efforts to improve quality and efficiency among physicians, hospitals, and other providers. The CMMI has also selected 16 practices to participate in the *Independence at Home Demonstration* for testing the delivery of comprehensive primary care services at home for Medicare beneficiaries with multiple chronic conditions.

Further, under the CMMI *Advanced Payment Initiative*, physician-based and rural providers can receive upfront and monthly payments for use in making important investments in their ACO care coordination infrastructure. As of April 2012, five organizations (in NC, KY, NH, FL, and TX) are Advanced Payment ACOs, with more organizations expected to begin this month, as well as in January 2013.

Under the *Health Care Innovation Awards* program, CMS is awarding up to $900 million toward innovative projects that test new payment and service delivery models to deliver high-quality health care services and lower costs. In a recent announcement of initial awardees, CMS stated that, in this one program alone, the agency received about 3,000 applications across all states. **This demonstrates the significant physician level of interest and readiness to engage in innovative, alternative payment and delivery models.**

Also, the ongoing three-year Acute Care Episode (ACE) demonstration tests the use of a global payment for an episode of care, covering all Part A and B services associated with a patient's inpatient stay. The episodes of care are for specified cardiovascular and orthopedic procedures only, and participating sites must meet procedure volume thresholds, have established quality improvement mechanisms, and be located in Texas, Oklahoma, New Mexico, or Colorado. The demonstration design allows the hospitals to share savings from the efficiencies they are able to achieve with the treating physicians and with patients.

The five-year Physician Group Practice (PGP) demonstration tested incentives for encouraging better care coordination, improving quality, and lowering Medicare expenditures. Ten group practices were competitively selected to participate and after the first year of the PGP demonstration, two of the 10 sites had achieved sufficient savings to receive performance payments from Medicare. By the end of the fourth year, five of the 10 sites were eligible for performance payments. All 10 of the sites were able to meet quality benchmarks.

Joint Private Sector and Physician Initiatives

Numerous and similar innovations are simultaneously being conducted in the private sector. As the Committee heard at its June roundtable discussion, Blue Cross Blue Shield (BCBS) of Massachusetts has developed the *Alternative Quality Contract*. Under this model, a single payment amount is established to cover all costs of care for a population of patients, with adjustments for types and severity of conditions, along with annual bonuses based on the quality of care delivered. UnitedHealth Group (UHG) is also developing these types of contracts, and the AMA is working with UHG on this effort.

Further, Regional Health Improvement Collaboratives bring together stakeholders in a community and provide the data and technical assistance these stakeholders need to design and implement better payment and delivery systems customized to the needs of their communities. Regional collaborative projects currently underway include an accountable medical home program in Washington State and the Maine Health Management Coalition.

Blue Cross Blue Shield of Michigan has developed the *Physician Group Incentive Program* (PGIP), which brings together physician organizations to encourage health care information-sharing and collaboration on initiatives to improve the health care system in Michigan. Each initiative offers incentives based on clearly defined metrics to measure performance improvement and program participation. Participating physician organizations can choose from more than 30

PGIP initiatives, based on: (i) practice improvement efforts (ii) opportunities to standardize treatment and improve outcomes for certain diseases or health conditions; (iii) targeting services or procedures that have a wide variation in practice patterns, tracking of needed services, implementing processing for test tracking and follow-up; and (iv) accelerating the adoption of electronic prescribing or implementing patient registries.

The Geisinger Health System's ProvenCare program provides a bundled payment with a warranty that covers all related pre-admission care, inpatient physician and hospital services, related post-acute care, and care for any related complications or readmissions for an entire 90-day period.

As the Committee heard at its June roundtable discussion, CareFirst's Patient-Centered Medical Home (PCMH) is another innovative program to provide primary care providers with incentives and tools to provide higher quality while lowering the cost of care. Panels that produce a savings against their total global cost-of-care target share in the savings. CareFirst recently announced that of the nearly 3,600 participating primary care providers caring for nearly a million patients, almost 60 percent of eligible PCMH Panels earned increased reimbursements for their 2011 performance.

The AMA strongly supports these Medicare and private sector initiatives and urges their continuation in the future. As these models develop, along with distribution of lessons learned and best practices, physicians can then adapt their practices to these new payment and delivery models as their practices, including those in rural areas, become ready to enroll in a structure that makes the most sense for their specialty, practice type, and patient mix. As discussed further below, there are immediate steps Congress can take to help build on this momentum.

AMA INITIATIVES TO ASSIST IN TRANSITION

The AMA has been actively engaged in developing a number of initiatives to assist the physician community transition to alternative physician payment systems. These initiatives focus on the development and use of quality measures, payment for care coordination, data sharing between physicians and payers, promoting adoption of electronic health records, improving patient safety, and identifying innovative delivery and payment models for distribution to the physician community. The following are some key examples of these AMA initiatives.

- To prepare physicians to utilize data for overall system improvement, the AMA has developed Guidelines for Reporting Physician Data (Reporting Guidelines) to increase physician understanding and use of their cost and quality data for practice improvement. These Guidelines outline a course for health plans and other reporting bodies to standardize the format used for physician data reporting and provide physicians with patient-level detail to enhance the utility of data reports. Implementation of the Reporting Guidelines will enhance the effectiveness of the reports and increase physician understanding and use of the data. The AMA released the Reporting Guidelines in June. UHG has endorsed them and we are actively engaging other payers on these guidelines, including CMS and Blue Cross Blue Shield Association and their member plans. We have also convened workshops to help physicians learn how to analyze claims data to identify opportunities to improve care.

- In June 2011, the AMA formed the Innovators Committee, an advisory group of physicians with hands-on experience in the development, management, and operation of innovative delivery and payment models. The initial group of Innovators has already identified several

novel approaches to improving care delivery, and the AMA is working to disseminate this information to physicians.

- Cloud-based data sharing systems offer the potential to achieve significant quality and efficiency gains for a fraction of the cost of integrated EHRs. A group in Massachusetts has applied cloud-based data sharing and other infrastructure support services to smooth its physicians' transition to global payment models. Most significantly, patients covered under these new models have realized further improvements in quality and efficiency compared to their unmanaged counterparts.

- We also highlight the Virginia Cardiac Surgery Quality Initiative. This program, which represents 17 hospitals and 13 cardiac surgical practices providing 99 percent of the open-heart procedures in the Commonwealth, has achieved dramatic reductions in complications and costs of cardiac surgery for cardiac patients.

- The AMA's CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) created a Chronic Care Coordination Workgroup (C3W) to recommend new codes and values to better recognize and pay physicians for care coordination. The C3W also recommended that the CPT Editorial Panel create new coding mechanisms for care transition from the hospital to the community and to describe care management for the complex chronically ill patients. Recommended codes and cost information will be available to the Medicare program to begin payment for these services on January 1, 2013. In the proposed physician fee schedule rule for calendar year 2013, CMS has proposed to provide Medicare coverage for these care coordination services, as recommended by the AMA, and we will support adoption of this coverage in the final physician fee schedule rule.

  The AMA has also been urging CMS to consider payment for services provided that are not currently paid for, such as anticoagulation management and team conferences. To date, CMS has not adopted these requests. In the proposed physician fee schedule rule for calendar year 2013, CMS discusses its intention to explore other potential refinements for valuing care coordination services (in addition to the care transition from the hospital to the community proposal discussed above). **We recommend that the Committee urge CMS to adopt these types payment policies that incentivize practice patterns, such as care coordination, that can lead to higher quality and lower costs.**

- The AMA-convened Physician Consortium for Performance Improvement™ (PCPI®), which brings together over 170 organizations, including all disciplines of medicine, other health care professions and quality improvement organization, has developed and made publicly available more than 280 clinical performance measures and specifications, covering 46 clinical areas that account for a substantial portion of Medicare services and spending. Many PCPI measures have already been adopted in both the public and private sectors, including the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Program, United Healthcare and Highmark BlueCross BlueShield, and the American Board of Internal Medicine. **Further, the PCPI measure portfolio already includes a growing number of intermediate outcome measures, as well as measures focused on the overuse of care. Ongoing PCPI projects are placing a greater emphasis on the need for patient reported and clinical outcome measures, and measures of health care efficiency to align quality measurement with cost of care.**

- The AMA has developed internal teams to re-focus our work toward improving health outcomes. We seek to ensure health equity, reduce unwarranted variation in care, advance

the quality and safety of the health care delivery system, partner with families and communities to enable healthy choices, and contribute to the appropriate use of finite health care resources.

- The AMA is involved in a project, led by Brandeis University, to define and measure episodes of care that capture the vast majority of Medicare payments and include quality as well as cost data. The results of this project are in part aimed at informing Medicare regarding transitions toward innovative approaches, such as bundled payments and ACOs, that require the aggregation of services into larger units of care.

CONGRESS AND CMS CAN HELP: IMMEDIATE STEPS TO ASSIST IN TRANSITIONING TO NEW MEDCIARE PHYSCIAN PAYMENT AND DELIVERY SYSTEM

Congress and CMS can take immediate steps to help transition to a new Medicare physician payment and delivery system. Additionally, existing laws and regulations can be adapted to better facilitate fundamental delivery reform, instead of acting as barriers to reform. Examples are as follows:

- The CMMI should expand the initiatives discussed above, including the payment advances under the CMMI *Advanced Payment Initiative*.

- **Congress should require that CMS and CMMI make opportunities to engage in new models available on a rolling basis so physician practices can plan for the needed changes and join as they become ready.** To date, those wishing to participate in new Medicare payment and delivery reform pilots have had to respond to requests for applications made available on a one-time basis with a short turnaround time. It is difficult to plan ahead for these announcements and organize the projects and resources necessary for a successful proposal. **This will increase overall physician participation in new models, and will significantly aid the transition for small, solo and rural practices.**

- **CMS feedback to physicians must be improved. To help achieve this goal, Congress should require CMS to modernize its Medicare data systems so the agency can bridge significant gaps in efforts to transition to alternative models.** Currently, because of its antiquated data systems, CMS has had great difficulty providing timely incentive payments and feedback reports, as well as actionable, real-time data to physicians that is correctly attributed, appropriately risk-adjusted, and relevant. These are key elements in effectively implementing quality improvement programs. Providing timely data to physicians is critical so they can verify the accuracy of performance reports and more accurately engage in data-driven decision-making.

- **Congress should require CMS to establish models that coordinate Medicare and private payers efforts.** Multi-payer initiatives hold much promise when Medicare and private payers align their programs so physicians can implement reforms in the way they deliver care to all their patients, with a consistent set of financial incentives and quality metrics. **For example, CMMI is doing this now with the Comprehensive Primary Care Initiative to improve care coordination among advanced primary care practices. Congress should require CMS to establish other initiatives, modeled on existing initiatives such as the BCBS Alternative Quality Contract discussed above, that engage physician specialties beyond**

primary care and include a range of settings—in cities and rural areas, and for large and small group practices and solo practitioners.

- **Congress should require CMS to implement certain PQRS improvements.** In 2010, 24 percent of Medicare eligible professionals participated in the program, and 69 percent of those professionals successfully received an incentive payment. Certain steps can be taken to improve these percentages:

    - **Congress could require CMS to reduce the number of measures required for inclusion in a PQRS measures group to a minimum of three measures, rather than four.** This would expand the number of measures groups and allow physicians to further focus quality performance activities on clinical conditions relevant to their practice.

    - **Congress could also provide CMS with authority to establish a process that allows physicians and other eligible professionals to be deemed successful PQRS participants if they successfully participate in other meaningful quality improvement activities.** Some physician practices reporting on specific quality measures to facilitate improved patient outcomes at the local level, through a regional health improvement collaborative or state-initiated health care improvement programs. Many of these efforts have been successful, allowing these practices to appropriately measure and improve upon those health care services and treatments most relevant to their communities, *e.g.,* diabetes, maternity care, HIV. CMS should have the authority to identify a deeming entity, such as Quality Improvement Organizations, that would determine if a physician practice successfully participated in a regional or local quality improvement program. If so, CMS could deem these practices as having met the requirements for the PQRS and meaningful use programs. A deeming process would allow meaningful quality improvement efforts at the regional and local level to move forward unencumbered by conflicting federal requirements.

- **Congress should provide Medicare funding to CMS for quality measure development, testing, and maintenance, along with review and endorsement of measures.** In recent years, Congress has directed CMS to implement various quality reporting and value-based purchasing programs, including for example the PQRS, Physician Resource Use Feedback Program, and Physician Value-Based Payment Modifier. These programs are intended to improve quality of care while helping to transition to a new Medicare delivery and payment structure. The development, testing, and maintenance of evidence-based quality measures, along with measure endorsement and review, are critical aspects of these programs. Development and testing of measures creates a continuous pipeline of measures, including advancement to subsequent generations of measures, such as outcomes or efficiency measures. Measure maintenance is also just as critical to ensure measures remain accurate, evidence-based, and meaningful. Endorsement and review of measures is meaningless without continuous measure development, testing and maintenance, and vice-versa. And, both aspects are critical as we move into a new Medicare payment and delivery structures, rooted in quality and value-based purchasing approaches.

- **Congress should require CMS to establish models that focus on limited bundles for physicians' services or episodes of care (with warranties) and care coordination/case management activities, with limited up-front risk for physicians.** For example, physicians should be able to propose bundled payments for chronic conditions like diabetes,

hypertension, or inflammatory bowel disease even when there is no hospitalization involved. This approach was recommended to the Committee by former CMS Administrators.

- **Certain existing laws and regulations are not compatible with many new payment models.** These laws include the physician self-referral law (or "Stark law"), the federal anti-kickback statute, the civil monetary penalties law prohibiting hospital payments to physicians to reduce or limit services (gain-sharing CMP), and the CMP prohibiting beneficiary inducements. **Congress should waive these laws and regulations when they post barriers for physicians who seek to engage in and lead innovative delivery models that promote quality, increase coordination, and reduce costs, based on the flexible approach taken by CMS/Office of Inspector General (OIG) for the MSSP. Congress should also require the current waivers for EHRs be made permanent, instead of allowing them to expire in 2013.** Currently, when a hospital provides physician practices with EHR systems, this permissible donation does not run afoul of the Stark law and the Medicare anti-kickback statute under a temporary safe harbor that is in effect through 2013. Congress should make this waiver permanent since this would foster EHR adoption.

- CMS has established 2013 as the performance year for applying 2015 PQRS penalties, citing its own data processing system as an obstacle to calculating performance closer to or during the penalty year stipulated in statute. CMS has also extended this "back dating" policy to the electronic prescribing, meaningful use, and value-based modifier programs, thereby pushing up participation deadlines by up to two years due to CMS' own administrative data processing issues. This will unfairly subject a significant number of physicians to financial penalties and slow down EHR adoption and implementation rates. **Congress should require CMS to use a performance year that is the same as the actual penalty year. An updated CMS data processing system could enable the agency to use the actual penalty year as the performance period.**

- **In addition, Congress should pass the *Medicare Patient Empowerment Act* (S. 1042 and H.R. 1700), which would establish an additional Medicare payment option to allow patients and physicians to freely contract, without penalty, while allowing patients to use their Medicare benefits.** This would allow patients and physicians to develop their own innovative arrangements that enhance patient care.

The AMA appreciates the opportunity to provide our comments on these critical matters, and we look forward to working with the Committee to repeal the flawed SGR formula and assist in the transition to a new health care payment and delivery system that provides more coordinated care that improves health outcomes and slows the growth of costs in the Medicare program.

Testimony of Barbara McAneny, MD
CEO, New Mexico Oncology Hematology Consultants,
Albuquerque, NM

for

The American Society of Clinical Oncology

before

The United States Senate Committee on Finance Roundtable

"Medicare Physician Payments: Perspectives from Physicians"

July 11, 2012

Thank you for the opportunity to participate in this important Roundtable discussion. My name is Barbara McAneny, and I am a medical oncologist practicing in New Mexico. I am here today on behalf of the American Society of Clinical Oncology (ASCO), which supports the Finance Committee's efforts to transform the Medicare payment system in a way that encourages and rewards high-quality, high-value care for individuals with cancer. Chairman Baucus and Ranking Member Hatch, we appreciate your leadership and attention to this issue.

The treatment of cancer is evolving rapidly. Great strides have been made toward more effective treatments and improved quality of life. But along with the promise of today's science have come some of the most significant challenges ever faced by our field in delivering care to our patients. Today, more than 60% of cancer occurs in Medicare beneficiaries. By 2030, due in large part to the aging of our population, that number will grow to 70%. At a time when demand for cancer care is peaking, we anticipate a 30% shortfall in the number of oncologists needed to provide care. Community oncology practices already are struggling to survive.

Clearly, Medicare will continue to be an important partner in overcoming the physical, social and economic burden cancer poses for our patients and our nation. The current fee for service Medicare payment system does not necessarily reward high quality, cost effective care and the annual debate over the sustainable growth rate (SGR) formula has created instability in physician practices—a situation that is eroding what has been a highly effective network of care. Oncologists, like all physicians, hope that Congress can achieve a more rational and sustainable system of payment—and soon. We look forward to working with you toward our vision of a fair and responsible system that rewards evidence-based care and recognizes the many cognitive services, like end of life counseling, that are critical to treating patients with cancer.

As the world's leading specialty society representing over thirty thousand physicians who treat people with cancer and conduct cancer research, ASCO is committed to working with you and other policy makers to ensure oncologists are equipped to provide every cancer patient the highest quality care. We welcome the opportunity to share with you information about ASCO's initiatives to incentivize and enable oncologists to provide high quality, high value care, and I am eager to share my experience as a practicing oncologist. We look forward to working closely with you in the coming weeks and months toward our shared goals.

Below is a summary of my testimony:

Any alternative to the current Medicare payment system should incentivize quality and efficiency. Achieving these important goals depends in large measure on successful establishment of a unified, comprehensive and cancer-focused quality program for Medicare. Already, thousands of oncologists practice in sites participating in ASCO's Quality Oncology

Practice Initiative (QOPI), which promotes quality. I am an active participant in QOPI and have experienced its ability to support meaningful quality improvement in my practice. But regardless of the investment oncologists make in QOPI—and it is significant—we must also report on quality through Medicare's less comprehensive PQRS program. We urge policy makers to capitalize on the considerable progress that has already been made in defining, measuring and supporting the delivery of high-quality, high-value oncology care. We stand ready to work with you toward a more rational payment framework and leveraging QOPI could be an immediate first step toward that end.

Oncology professionals are in the best position to lead transformation of care delivery and payment for oncology and more likely to adopt an oncologist-developed system. The aging of the Medicare population and the complexity of cancer represent unique challenges to the health care system, challenges that are best faced by the people who treat cancer. When engaging in payment reform discussions, we bring: the necessary clinical expertise; unique understanding of the realities of care for the cancer population; and established relationships with important stakeholders like patients and patient advocacy organizations. A reform of the payment system for oncology will be more likely to be embraced if it is done in collaboration and cooperation with the field of oncology.

New oncology care models must be tested through pilot programs and new policies should be transitioned over a reasonable period of time. However well-intentioned and well-planned, any dramatic change in the payment system has the potential for unintended consequences. Preserving continued access to care must be a guiding principle for any transformation of the payment system and can only be achieved through careful testing and measured transitions. Cancer care occurs across a wide range of practice settings and communities. We must take the time to understand how proposed policies affect all settings and the often vulnerable populations they serve. For example, many patients living in rural areas are unable to travel and depend on care close to home. Policies that have the effect of dismantling community care could exaggerate disparities that are already difficult to overcome.

Discussion:

Payment System Reforms Should Build on Investments Already Made by Physician Leaders

The foundation of any payment system should be to incentivize the best quality care. ASCO's quality improvement registry, QOPI, offers providers a way to judge performance against their peers and against established quality benchmarks. It promotes the six aims for high quality care outlined by the Institute of Medicine: safe; timely; effective; efficient; patient-centered;

and equitable. QOPI was designed to be highly adaptable and nimble; the quality measures change based on emerging scientific evidence and clinical guidelines, the program can evolve to meet the needs of insurers, and QOPI can be embedded within any payment system—including Medicare.

The QOPI program is robust. Its more than 100 measures of quality of cancer care have been developed and are maintained by experts in oncology and in the science of quality measurement. QOPI has been widely adopted by the oncology community, with nearly 800 practices nationwide registered. Data from more than 25,000 medical records are submitted to ASCO at each data submission. We are currently planning for integration of patient reported outcomes into ASCO quality programs.

The success of QOPI has led to demand from oncologists to continually raise the bar on quality measurement and improvement programs at ASCO. In 2010, ASCO launched the QOPI Certification Program, which offers a formal, three-year certification for oncology practices that satisfy quality measure scoring thresholds and pass a rigorous site visit assessing safety of chemotherapy administration. Since January of 2011, more than 120 oncology practices, including mine, have achieved certification. We have also tested alternate registry models, such as our recent breast cancer registry pilot. Oncologists and team members at 20 diverse practice sites submitted data on every breast cancer patient treated, and facilitated the collection of clinician and patient survey data. The breast cancer registry system reinforced data entry by generating real-time clinical treatment plan and summary documents for patients and other health care providers. These summary documents can be time-intensive to populate during routine clinical care, but are highly valued and were specifically requested in an Institute of Medicine report. The physician-patient and provider-to-provider communication enhanced through the ASCO breast cancer registry pilot are core elements of many pilot projects supported by CMMI and are essential to coordinating high quality, cost effective care.

Our experience with QOPI also has positioned ASCO as a leader in measure development for oncology. We have partnered with other national organizations (such as the AMA Physician Consortium for Performance Improvement, American Society for Radiation Oncology, and the National Comprehensive Cancer Network) to develop measures intended for use in accountability programs, including pay for performance. ASCO is actively involved in promoting cancer measures for endorsement by the National Quality Forum (NQF). We are in the process of testing electronic data submission to QOPI via electronic health records. QOPI has been acknowledged by private payers as a valuable program and many recognize QOPI participation through means such as quality designations in provider directories, reduced prior authorization requirements, and payment incentives.

A Medicare payment system that truly rewards quality and efficiency must be nimble enough to reflect rapidly changing science and practice standards. It requires a robust infrastructure, including measure development and a system for detailed clinical data submission, reporting and analysis. ASCO—like many specialty societies—has invested heavily in its quality measurement and improvement programs and is well on the way to building the next generation. The depth of disease specific expertise and investment is not one CMS is likely to duplicate—nor should it. We urge policy makers to take advantage of the work that is already being done in oncology in the area of quality measurement and improvement.

We consistently hear from oncologists that it is challenging to participate in the multiple Medicare programs intended to promote quality and adoption of HIT. These programs include the Physician Quality Reporting System (PQRS), e-Prescribing (eRx) Program, EHR Incentive Program, and Quality Resource Use Reports (QRURs) on which the new value-based modifier will be based. While ASCO strongly supports the goals of these initiatives, we have shared with CMS that these programs are often duplicative and subject to unrealistic timelines. The use of QOPI could serve as a central program to replace or streamline most of the existing CMS reporting requirements, save significant resources, and provide much more granular and meaningful information beyond what can be achieved with CMS-directed programs.

Long term, ASCO envisions a true rapid learning system, furthering our need to ensure that the right care is provided at the right time in the right setting for every patient. Within a rapid learning health care system, health information technology is leveraged to allow routinely collected, real-time clinical data to drive the process of scientific discovery, which becomes a natural outgrowth of patient care. A rapid learning system will promote evidence-based oncology practice, even as scientific discovery continues to reveal that "common cancers" actually comprise numerous distinct subtypes with unique treatment recommendations. By harnessing the power of electronic records, we can deliver decision support tools to oncologists, receive data about treatments and outcomes, analyze data to create better treatment recommendations, and modify the guidance based on resulting clinical insights. The oncology care system learns as part of ordinary practice and engages in rapid-cycle improvement. A rapid learning system will reduce unnecessary variation in care. Value will be maximized. Resources will be used far more optimally. Savings should be calculated and shared with the participants. ASCO is currently working to make such a system a reality in cancer care.

<u>Physicians are best able to lead a transformation of the delivery of care and payment system, and more likely to adopt a physician-led effort.</u>

ASCO recognizes that the current fee–for-service model of payment does not reward judicious use of resources, and we have been working with our expert volunteers to develop feasible alternatives for cancer. New models are just that: new. They are untested. Much is at stake for our patients, and it is critical that oncology providers, working with a diverse team of stakeholders including patients, take the lead in testing and assessing their sustainability and their impact on quality and access to care. Many oncologists are already exploring or participating in demonstrations through Medicare or private payers to test alternative payment models, and we believe the following models may have promise:

Patient-Centered Medical Homes (PCMHs): ASCO has a strong history of working with other groups to help frame and define the concept of a medical home within oncology. Often when patients are diagnosed with cancer, their oncologist becomes the "primary" physician during the time they are under active treatment—and frequently for sustained periods following active treatment and transition to survivorship. These patients usually require ongoing care for pre-existing medical conditions, whether from their primary care physician or other specialists. Coordination of this care is critical in order to ensure patient safety, the highest quality treatment, and patient satisfaction with and engagement in their care.

A PCMH model has potential to provide real savings to both payers and patients. Such models emphasize consistent coordination of care, aggressive symptom management, increased access to qualified professionals via a system of telephone triage or electronic means, and increased patient engagement in care decisions. They focus on avoiding emergency room visits, decreasing hospital admissions, and allowing less costly interventions when symptoms are addressed immediately. The PCMH model can result in significant savings, but its robust implementation can require significant investment by practices, including expanded health IT (EHRs, tools for patients), additional staffing for after-hours care and aggressive symptom management, focused telephone triage by trained clinical providers, and enhanced patient treatment plans and summaries. Practices have spent millions on EHRs alone, only to be left disappointed—and out of pocket—when these technologies do not adequately meet the special needs for oncologic record keeping and decision support. Demonstrations of the PCMH model in oncology are called for, but they should involve "shared savings" between practices and payers, similar to the existing Medicare Shared Savings Program.

CMS has other projects underway in which the agency has in advance provided to practices or institutions a certain percentage of anticipated savings; we believe such a model is worth considering in the context of an oncology PCMH.

Case Management Fees. In oncology, much of the cognitive work and the services that go into the management of patients are under-recognized and under-valued. Development of treatment plans and summaries—especially for complex and serious diseases such as cancer—takes time and requires experienced medical decision-making. As mentioned above, coordination of patient care among multiple physicians and disciplines is important to optimizing cancer treatment outcomes and patient satisfaction. In many circumstances, Medicare does not recognize (and hence does not reimburse) important services and activities that do not necessitate face-to-face time with the patient. A case management fee—tied to the appropriate quality indicators—could be tested in certain areas of oncology. We expand on this idea below.

Mixed models: Some models blend a case management fee, clinical care pathways, and quality incentives. In such models, physicians agree to follow predetermined treatment protocols (pathways) and are reimbursed at invoice cost for the drugs that are used. They receive a case management fee and must meet certain quality objectives. Positive updates to payments are based on meeting progressively more numerous and/or rigorous quality measures; savings are anticipated as a result of the slower growth in management fees compared to the higher expected growth in drug costs.

Bundling: ASCO earlier approached CMS with a potential demonstration project that would consist of a bundled payment, including a case management fee, for certain groups of patients with colon cancer. We would be pleased to revisit this project as we believe it could be expanded to include elements of a PCMH, along with quality measurement. Piloting such a project is critical for "proof of concept," and necessary to point the field to other pilots that could be developed, tested and—if successful—adopted more widely. We believe that this project would lead to savings first, as discussed above, due to the slower growth in management fees compared to more rapid growth in drug costs; second, depending on the menu of PCMH options included, we would expect savings from decreased emergency room use and/or decreased hospitalization rates.

For any model that contains bundled payments, episode-of-care payments, flat management fees or any other similar arrangement, it is crucial that quality of care is measured and monitored, in order to give physicians the continuous opportunity to improve practice quality and efficiencies and to ensure patient satisfaction with care.

<u>Any new payment model for oncology must be tested to avoid unintended consequences.</u>

Emerging science holds great promise for new and more effective therapies, but cancer is still an extremely complex and costly disease. It occurs largely in our most vulnerable citizens—the elderly. Advancing untested models of care could jeopardize not only quality and access to care, but further erode the increasingly fragile system that delivers care today. We urge policy makers to allow for demonstrations of promising payment systems, taking time to understand their impact and consequences.

I am a recent recipient of a grant by the Centers for Medicare and Medicaid Innovation (CMMI). Through this grant seven community oncology practices across the United States will conduct a three-year test of a medical home model of care delivery for patients with breast, lung, or colorectal cancer. Through comprehensive outpatient oncology care, including patient education, team care, medication management, and 24/7 practice access and inpatient care coordination, the medical home model will improve the timeliness and appropriateness of care, reduce unnecessary testing, and reduce avoidable emergency room visits and hospitalizations. We will explore the potential for broader application in oncology over the next three years, understanding its advantages, limitations and ability to produce savings. This deliberate and thoughtful approach—this same level of examination—should be applied to any potential model of reform before national implementation. We are prepared to partner with the Administration in that effort.

In addition to the issues we are focusing on today, there are many difficult challenges that will require ongoing collaboration among Congress, ASCO and other stakeholders. These issues include the current crisis involving shortages of clinically important oncology drugs and the anticipated future shortage of medical oncologists. We look forward to working with you as you engage in this difficult task of implementing payment reform and working to address the additional challenges that we face. Please do not hesitate to contact Shelagh Foster at shelagh.foster@asco.org or 571-483-1612 with any questions or follow up. The health care system is at a critical point and together we can transform oncology for our patients.

Statement of the
American College of Surgeons

Presented by

Frank Opelka, MD, FACS

before the
Senate Finance Committee
United States Senate

RE: Medicare Physician Payments: Perspectives from Physicians

July 11, 2012

Chairman Baucus, Ranking Member Hatch, and Members of the Committee, on behalf of the more than 78,000 members of the American College of Surgeons (ACS or the College), I wish to thank you for inviting the College to participate in today's roundtable. The ACS appreciates your recognition that the current Medicare physician payment system and its sustainable growth rate (SGR) formula are fundamentally flawed and we wish to be a partner in the effort to develop a long-term solution that improves the quality of care while helping to reduce costs. The testimony today will focus on the new ACS Medicare physician payment proposal called the Value Based Update (VBU)[1] and the College's leading efforts in the areas of quality improvement.

I am Frank Opelka, and I am a Fellow of the ACS and a colorectal surgeon from New Orleans, Louisiana. I am the Vice Chancellor of Clinical Affairs and Professor of Surgery at the Louisiana State University (LSU) Health Science Center. Within the ACS, I serve as Assistant Medical Director, and am also the Chair of the Surgical Quality Alliance, which is a collaborative effort of the ACS and 25 surgical specialty societies to promote and improve the quality of surgical care in the United States.

The College recognizes that developing a long-term solution to the Medicare physician payment system is a challenging, yet essential undertaking, especially given the need to limit the growth in health related spending. The College understands that the current fee-for-service model as the predominant form of physician payment is unsustainable. The ACS asserts that any new payment system should focus on individual patients and populations and rely upon physician leadership to achieve improved outcomes, quality, safety, efficiency, effectiveness, and patient involvement. Improving outcomes and care processes holds promise to reduce the growth in health care spending, complementary objectives that are too often addressed separately.

The ACS has a rich history of quality improvement efforts and our belief is that any new payment system should be part of an evolutionary process that achieves the ultimate goals of increasing quality for the patient and reducing growth in health care spending. We continue to assert that quality improvement and cost reduction are directly related objectives, and over the past year we have developed our quality improvement principles into the VBU, our Medicare physician payment reform proposal. Our proposal is predicated upon Congress finally addressing the flawed sustainable growth rate (SGR) formula and fully offsetting a permanent repeal. I will caution you that this is still very much a draft proposal, and we look forward to working with Congress and other stakeholders to continue to develop this option.

---

[1] See attachment for visual depiction of the Value-Based Update (VBU) proposal.

The Value Based Update Proposal

The Value Based Update (VBU) proposal is built upon a few key concepts. The proposal must be patient-centric, flexible, responsive to the changing needs of the health care system, inspired by quality, and be politically viable for all key stakeholders. Specifically, the proposal should:

1. Complement the quality-related payment incentives *in current law and regulation* while making necessary adjustments in the current incentive programs to facilitate participation by specialists. This includes the Physician Quality Reporting System (PQRS), e-Prescribing (eRx), and meaningful use requirements for electronic health records (EHR).

2. Incorporate the *improvement of quality and the promotion of appropriate utilization of care* into the annual payment updates, first by utilizing existing quality measures but also by developing practice-specific quality priorities and measures in the future.

3. Account for the *varying contribution of different practices* to the ability to improve care and reduce costs. To do this we have shifted the focus to the patient and created the concept of Clinical Affinity Groups (CAG), each with its own evidence-based quality measures.

4. And finally, create a mechanism to incentivize the provision of appropriate services that *primary care* can bring to the management of an increasingly more complex medical population.[2]

The VBU accomplishes these goals by allowing physicians who successfully participate in CMS quality programs to choose quality goals for the specific patients or conditions they treat. Rather than basing compensation on overall volume and spending targets, the VBU bases performance on carefully designed measures. It also makes sustained investments in primary care in the early phases of implementation.

Implementation of the VBU can be accomplished in four steps: The first is to immediately and permanently repeal the SGR formula, which must be done independent of the VBU. While we are confident in the ability of quality improvement to save funds moving forward, the VBU does not seek to address paying down the accrued debt of the SGR, and therefore the ACS continues to advocate the use of savings in the Overseas Contingency Operations (OCO) account to offset this cost and allow a new system to be implemented.

Other individual physician-level payment adjustments for participation in quality programs including the PQRS, EHR and e-Rx adjustments are left in place and incorporated in further implementation of the VBU. While there is value in these programs, they are by no means perfect. In order for this proposal to proceed as

[2] There are significant physician workforce issues that must be addressed to ensure continued access to care across the country. The ACS believes that we must address these issues as a whole and not pit certain segments against one another.

efficiently as possible, we believe significant changes must be made to each of these programs. We believe there are four areas in which Congress can act swiftly to improve these programs:

1. The payment adjustment year and the performance period MUST be tied closer together to better align behavior changes with payment incentives;
2. Measures specific to specialists must be better incorporated into the programs or those specialists whose measures are not incorporated into the programs should receive exemptions from the payment penalties;
3. The quality measures currently used in the PQRS and EHR Incentive Program must be better aligned in order to prevent duplication and reduce unnecessary administrative burdens; and finally;
4. Incorporate clinical data registries into these programs since current claims data do not provide sufficient insight into the quality of care provided by a physician. Aligning clinical data with improvements to claims data is the most robust path forward toward true quality improvement.

The second phase of implementation approximates the "period of stability," which would grant physicians an opportunity to transition to the new system without the threat of unmanageably steep cuts. Simultaneously, the stability period would allow time for consultation with specialty societies and other stakeholders to properly make the adjustments listed above.

In this phase, the VBU adjustment is implemented based upon overall physician participation in PQRS, HER, *and* e-Rx programs.[3] Physicians who successfully participate in these three programs, in addition to avoiding any associated penalties, will be eligible for both an inflationary adjustment and the VBU adjustment, which, in this phase, will be based solely on the percent of physicians successfully completing the first step. For example, if 90 percent of physicians comply with the PQRS, EHR and e-Rx programs, the VBU adjustment might be 1.5 percent. If only 40 percent comply, that adjustment could be closer to 0.5 percent.[4]

During this phase, in the interest of addressing the unique need for improved patient access to primary care services and because of the availability of relevant quality measures, the primary care/chronic care Clinical Affinity Group will be introduced. Primary care physicians who successfully meet the above mentioned requirements would be eligible receive an additional adjustment of between 0.5 and 1.5 percent based upon quality measures specific to primary and chronic care.

The third phase is essentially a transition period, in which the Clinical Affinity Groups (CAGs) are introduced for all physicians. In concept, a CAG is a group of physicians and providers who care for a specific condition, disease or patient population. CAGs are the core of this proposal, and might include categories such as cancer care, surgery, cardiac care, frail elderly/end of life, digestive diseases, women's health,

---

[3] The ACS is also exploring how surgical registries could be integrated in the VBU proposal.
[4] The percentages in our testimony are for illustrative purposes only.

rural and the previously mentioned primary care/chronic care group implemented in the second phase.

Each CAG will have its own patient-oriented, outcomes-based, risk-adjusted quality measures designed to foster continuous improvement and help lower costs. These measures will be crafted in close consultation with relevant stakeholders including the specialty societies, who in many cases are already developing measures and other quality programs on their own.

Providers will self-select their CAG, providing they meet certain eligibility requirements based on the patients they see and conditions they treat. The Secretary of Health and Human Services will be tasked with creating CAGs and ensuring that there are a sufficient number and variety to accommodate all physicians.

During this phase, physicians will still need to reach the hurdle of successfully participating in the aforementioned CMS quality programs. Those who do will once again be eligible for both VBU and inflationary adjustments. However, the VBU adjustment will now be based upon the average performance of all CAGs, and if these measures were not met, this adjustment could be negative. In the case of a negative VBU adjustment, the MEI increase would also be eliminated.

In the fourth and final phase, physicians would continue to strive to meet both the individual and CAG quality measures, and application of the inflationary MEI update would still be based upon the overall performance in all CAGs. However, providers in each CAG would now have their VBU adjustment applied based on the performance of their specific CAG(s). Furthermore this update could be a blended number based half on national performance and half on the CAG's performance in the provider's Hospital Referral Region to emphasize the importance of local quality improvement efforts. This would allow regional variations in the provision of care to be captured and reflected in each physician's reimbursements.

Once fully implemented, physicians will have the opportunity to select their CAG(s) on an annual basis, and goals can be adjusted regularly to ensure that the quality of care provided to the patient is continuously improving.

Continuous Quality Improvement

The College strongly believes that improving quality and safety offers the best chance of transforming our health care system in a way that expands access and improves outcomes while slowing the accelerating cost curve. Quite simply, improving quality leads to fewer complications, and that translates into lower costs, better outcomes, and greater access. We offer a caveat – cost reduction cannot be the driving force of change; change must be driven by quality measurement. With the right approaches, we *can* both improve the quality of patient care and, at the same time, reduce health care costs.

The College has proven physician-led models of care that have allowed us to use clinically meaningful data to measure and improve surgical quality, reduce costs, and thereby increase the value of health care services. For nearly 100 years, the American College of Surgeons has led national and international initiatives to improve quality in hospitals overall, as well as the more specific fields of trauma, bariatric surgery, cancer, and surgical quality. These initiatives have been shown to significantly reduce complications and save lives.

Complex, multi-disciplinary care – such as surgical care – requires a commitment to continuous quality improvement. Surgeons have a long history of developing standards and holding themselves accountable to those standards. Four years after ACS was founded in 1913, leaders such as pioneering surgeon Earnest Codman of Boston helped to form the Hospital Standardization Program in 1917, which became The Joint Commission in 1951. Dr. Codman believed it was important to track patient "end results" and use those results to measure care, learn how to improve care, and set standards based on what was learned.

Since then, the College has helped establish a number of key quality programs, including the Commission on Cancer in 1922, the Committee on Trauma in 1950, the American College of Surgeons Oncology Group in 1998, the National Surgical Quality Improvement Program or "ACS NSQIP" in 2004, and the National Accreditation Program for Breast Centers and the Bariatric Surgery Center Network Accreditation Program, both in 2005.

Based on the results of our own quality programs, we have learned that there are four key principles required for any successful quality program to measurably improve the quality of care and increase value. They are:

- Setting appropriate standards
- Building the right infrastructure
- Using relevant, timely data to measure performance
- Verifying the processes with external peer review

Establishing, following, and continuously improving **standards** and best practices is the core for any quality improvement program. Standards must be set based on scientific evidence so that surgeons and other care providers can choose the right care at the right time given the patient's condition. It could be as fundamental as ensuring that surgeons and nurses wash their hands before an operation; as urgent as assessing and triaging a critically injured patient in the field; or as complex as guiding a cancer patient through treatment and rehabilitation.

The right **infrastructure** is absolutely vital to provide the highest quality care. Surgical facilities must have in place appropriate and adequate infrastructures, such as staffing, specialists and equipment. For example, in emergency care, we know hospitals need to have the proper level of staffing, equipment such as CT scanners, and infection prevention measures such as disinfectants and soap dispensers in the right quantity and in the right locations in their emergency departments. If the

appropriate structures are not in place, the risk for the patient increases. Our nation's trauma system is an example of the importance of having the right infrastructure in place. The College has established trauma center standards for staffing levels and expertise, processes, and facilities and equipment needed to treat seriously injured patients. Trauma centers are independently verified by the Committee on Trauma and receive a Level I, II, III or IV designation, based on the care they are able to provide. Ideally, the most challenging cases are immediately rushed to the nearest Level I or Level II center. There is good scientific reason for this: Patients who receive care at a Level I trauma center have been shown to have an approximately 25 percent reduced mortality rate.

We all want to improve the quality of care we provide to our patients, but hospitals cannot improve quality if they cannot measure quality, and they cannot measure quality without valid, robust **data**. The College has learned that surgeons and hospitals must have sufficient relevant data to yield a complete and accurate understanding of the quality of surgical care. This data must also be comparable with that provided by similar hospitals for similar patients. Therefore, it is critical that quality programs collect information about patients before, during, and after their hospital visit in order to assess the risks of their condition, the processes of care and the outcome of that care. Today, patients' clinical charts – not the current insurance or Medicare claims – are the best source for this type of data. Eventually, capturing the relevant data from electronic health records should enhance accuracy and timeliness.

The fourth principle is to **verify.** Hospitals and providers must allow an external authority to periodically verify that the right processes and facilities are in place, that outcomes are being measured and benchmarked, and that hospitals and providers are responding appropriately to the findings. The best quality programs have long required that the processes, structures, and outcomes of care are verified by an outside body. The College has a number of accreditation programs that, among other things, offer a verification of standards that help ensure that care is performed at the highest levels. Whether it is a trauma center maintaining its verification as Level I status or a hospital's cancer center maintaining its accreditation from the Commission on Cancer, the College has long stressed the importance of review by outside authorities. Undoubtedly, increased emphasis on such external audits will accompany efforts to tie pay to performance and to rank the quality of care provided.

Together, these principles form a continuous loop of practice-based learning and improvement in which we identify areas for improvement, engage in learning, apply new knowledge and skills to our practice and then check for improvement. In this way, surgeons and hospitals become learning organisms that consistently improve their quality – and, we hope, inspire other medical disciplines to do so as well.

ACS NSQIP is built on these principles. The ACS NSQIP program, which has its history in the Veterans Health Administration, is now in more than 400 private sector hospitals around the country. ACS NSQIP uses a trained clinical staff member to collect clinical, 30-day outcomes data for randomly selected cases. Data are risk

adjusted and nationally benchmarked, so that hospitals can compare their results to hospitals of all types, in all regions of the country. The data are fed back to participating sites through a variety of reports. Guidelines, case studies and collaborative meetings help hospitals learn from their data and implement steps to improve care.

ACS NSQIP hospitals have seen significant improvements in care; a 2009 *Annals of Surgery* study found 82 percent of participating hospitals decreased complications and 66 percent decreased mortality rates. Each participating hospital prevented, on average, from 250 to 500 complications a year. Given that major surgical complications have been shown in a University of Michigan study to generate more than $11,000 in extra costs on average, such a reduction in complications would not only improve outcomes and save lives, but greatly reduce costs.

If ACS NSQIP can be expanded to the nation's more than 4,000 hospitals that perform surgery, we could prevent millions of complications, save thousands of lives, and recoup billions of dollars each year. ACS NSQIP's success will require collaboration from the broader surgical community; other providers, including hospitals; healthcare policy experts; and government officials and elected representatives. We need to get ACS quality programs into more hospitals, more clinics, and more communities.

Implementation of the *Patient Protection and Affordable Care Act* is intensifying the focus on quality by requiring hospitals and providers to be increasingly accountable for improving care through measurement, public reporting and pay-for-performance programs. By taking an outcomes-based approach that relies on setting and following standards, establishing the right infrastructure, collecting the right data, and outside verification, we have shown that complications and costs can be reduced and care and outcomes improved on a continual basis.

The College welcomes the focus on quality and believes it offers an extraordinary opportunity to expand the reach of our programs and, most importantly, puts the country's health care system on a path towards continuous quality improvement. The evidence is strong: We *can* improve quality, prevent complications, and reduce costs. That's good for providers and payers, government officials and taxpayers. Most of all, that's good for patients.

Again, while we acknowledge the need to further develop the VBU proposal, we strongly believe in the concept of tying physician Medicare reimbursements to the quality of the care provided as reflected in quality measures that are meaningful and directed specifically at the type of care that a physician provides to his or her patients. We believe that controlling health care costs in Medicare should be achieved not through methods that would endanger patients' access to care[5], but

[5]The College is concerned about the impact of the Independent Payment Advisory Board (IPAB), which is scheduled to make recommendations on overall Medicare spending in 2014. The College remains vitally concerned that, should the SGR remain in place when the IPAB takes effect, physicians will be subject not only to the SGR but also to further reductions in Medicare reimbursement based on IPAB's authority. In tandem, we

through improving quality and value, and we are confident that the ACS's Value Based Update proposal is a step in that direction. The ACS appreciates the opportunity offered by the Chairman and the committee to share the College's draft proposal and comments about its quality programs.

---

believe the IPAB and SGR hinder the ability to transition to a new physician payment system; acting as blunt and flawed budgetary axes, and endangering seniors' access to high quality care in the Medicare program.

AMERICAN COLLEGE OF SURGEONS

VALUE BASED UPDATE (VBU) DRAFT PROPOSAL

Draft

THE NEED FOR A PROACTIVE ACS PAYMENT REFORM PROPOSAL

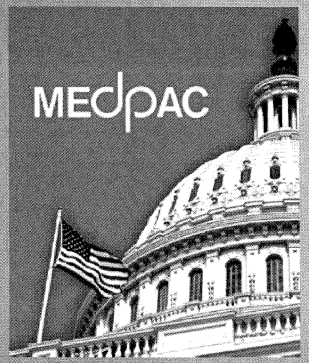
Over the last year the ACS has succeeded in promoting the *Inspiring Quality* campaign to illustrate our ability to improve quality and engage patients through ACS initiatives.

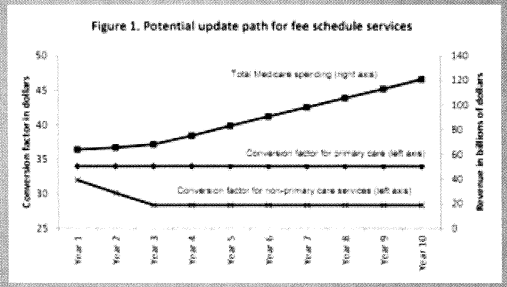
The Value Based Update proposal expands this effort to show how we can incorporate quality improvement into payment reform.

Real people touched by surgical improvements.
Together we can make health care better.

Learn how ACS is inspiring quality. Watch the video

THE NEED FOR A PROACTIVE ACS PAYMENT REFORM PROPOSAL





The few concrete proposals to replace the SGR that exist utilize blunt across-the-board cuts to physicians. Most notably, the MedPAC proposal would cut payments to non-primary care physicians by 5.9% each year for three years and then freeze payments at the reduced rate for 7 more years.

PRINCIPLES FOR THE CREATION OF A MEDICARE PAYMENT ALTERNATIVE

(1) Complement the current quality-related payment incentives *in current law and regulation* while making necessary adjustments in the current incentive programs to facilitate participation by specialists

- *PQRS, eRx, EHR, all of which are individual measures*

(2) Develop a model that is immune from the outcome of the Supreme Court case related to the *Affordable Care Act*

- *Payment reform will happen with or without the ACA*

(3) Incorporate the *improvement of quality and the reduction of overutilization* into the annual payment updates

- *1st Phase: utilize existing quality measures*
- *2nd Phase: practice-specific quality measures*

(4) Account for the *varying contribution of different practices* to the ability to improve care and reduce costs

- *Phase in the concept of Clinical Affinity Groups with appropriate quality measures*

(5) Create a mechanism to incentivize the provision of appropriate services that *primary care* can bring to the management of an increasingly more complex medical population

PRINCIPLES FOR THE CREATION OF A MEDICARE PAYMENT ALTERNATIVE

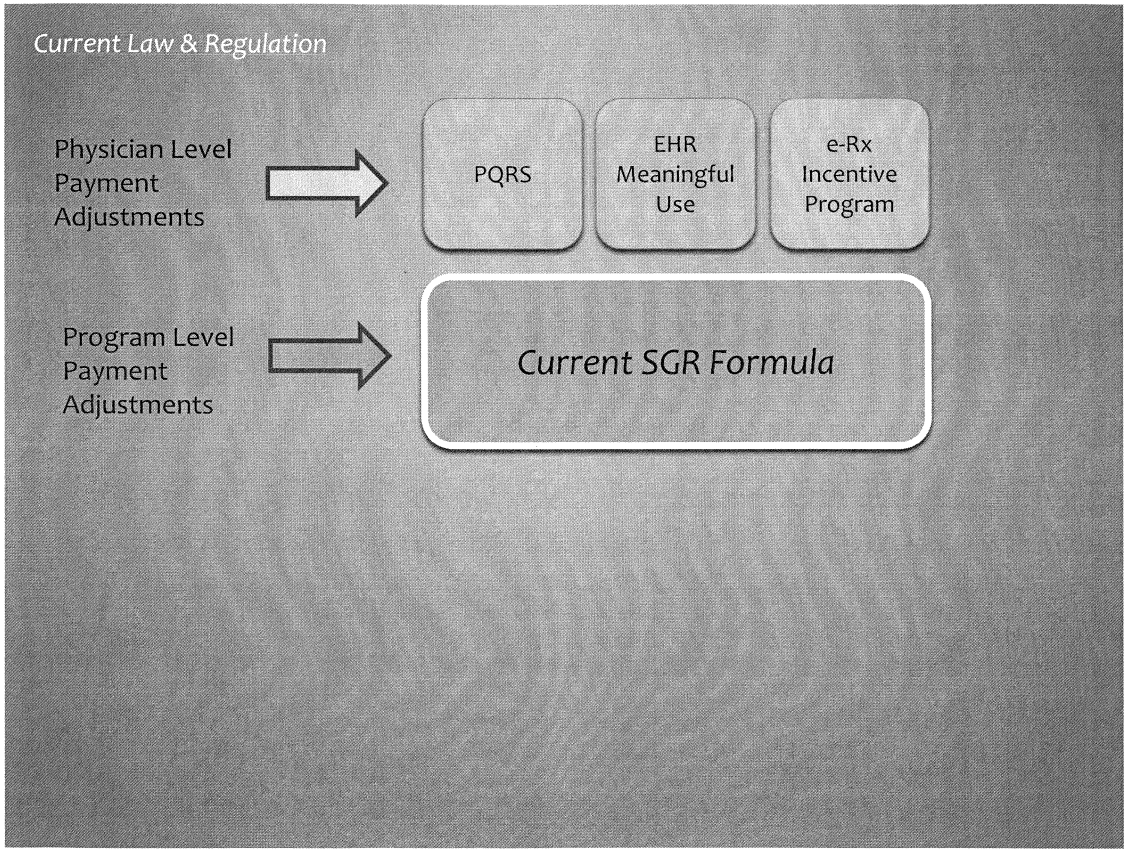
In short . . .

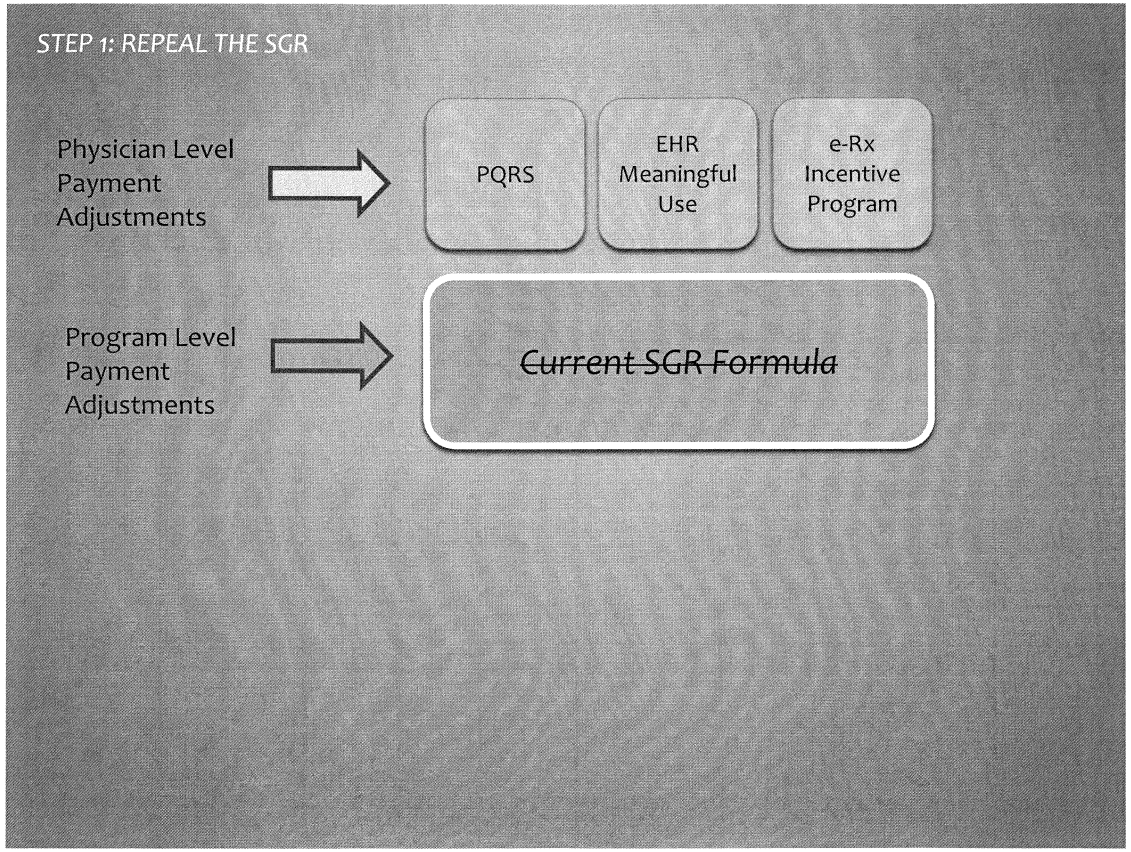
There is a demonstrated need for the ACS to develop an alternative to the SGR that is focused, patient-centric, politically viable, responsive to the changing needs of the health care system, and inspired by quality.

VALUE BASED UPDATE (VBU)
ACS PROPOSAL
DRAFT

STEP 1

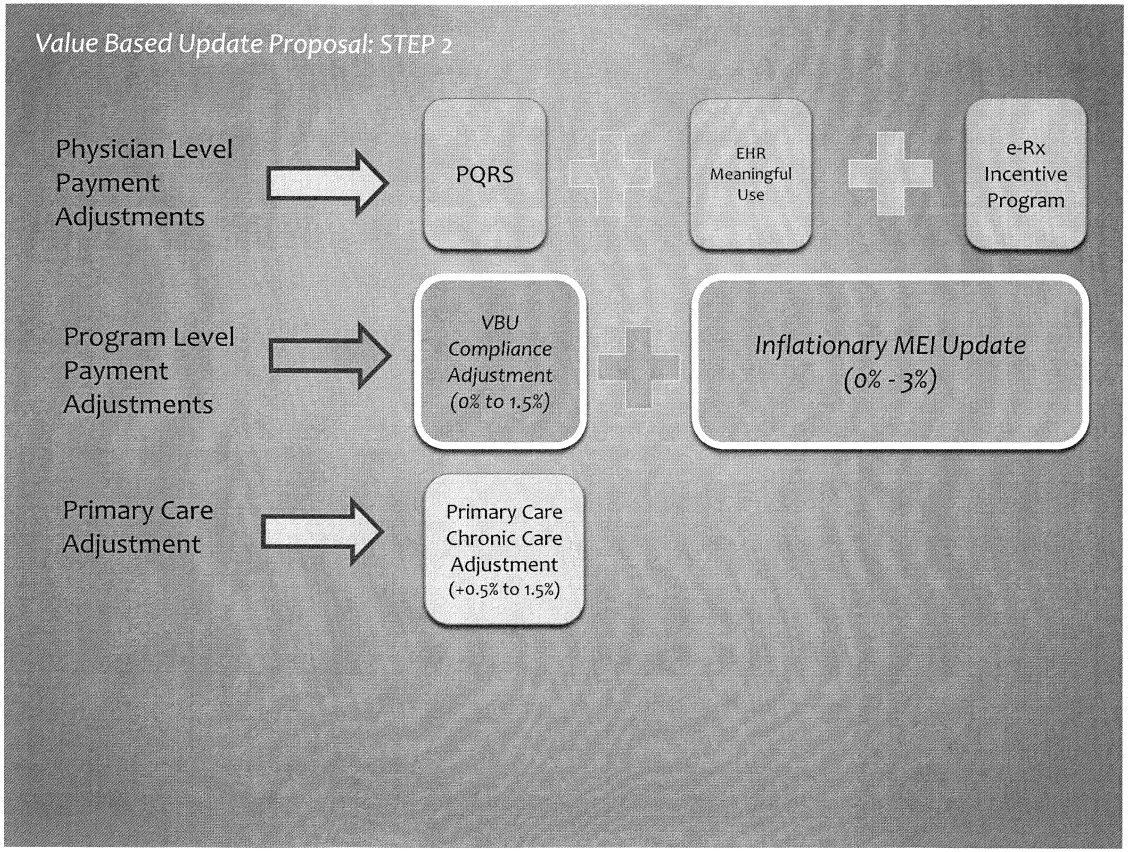
- Continues the current individual measure programs under current law
- SGR Formula still exists under current law
- Utility of our proposed Value Based Update is predicated on the removal of the SGR Formula
- The Value Based Update does not propose to address paying down the debt of the SGR
- The ACS continues to advocate for paying down the SGR debt by the use of the Overseas Contingency Operations (OCO) funds available to Congress.


Current Law & Regulation
Physician Level Payment Adjustments
PQRS
EHR Meaningful Use
e-Rx Incentive Program
Program Level Payment Adjustments
Current SGR Formula


STEP 1: REPEAL THE SGR
Physician Level Payment Adjustments
PQRS
EHR Meaningful Use
e-Rx Incentive Program
Program Level Payment Adjustments
~~Current SGR Formula~~

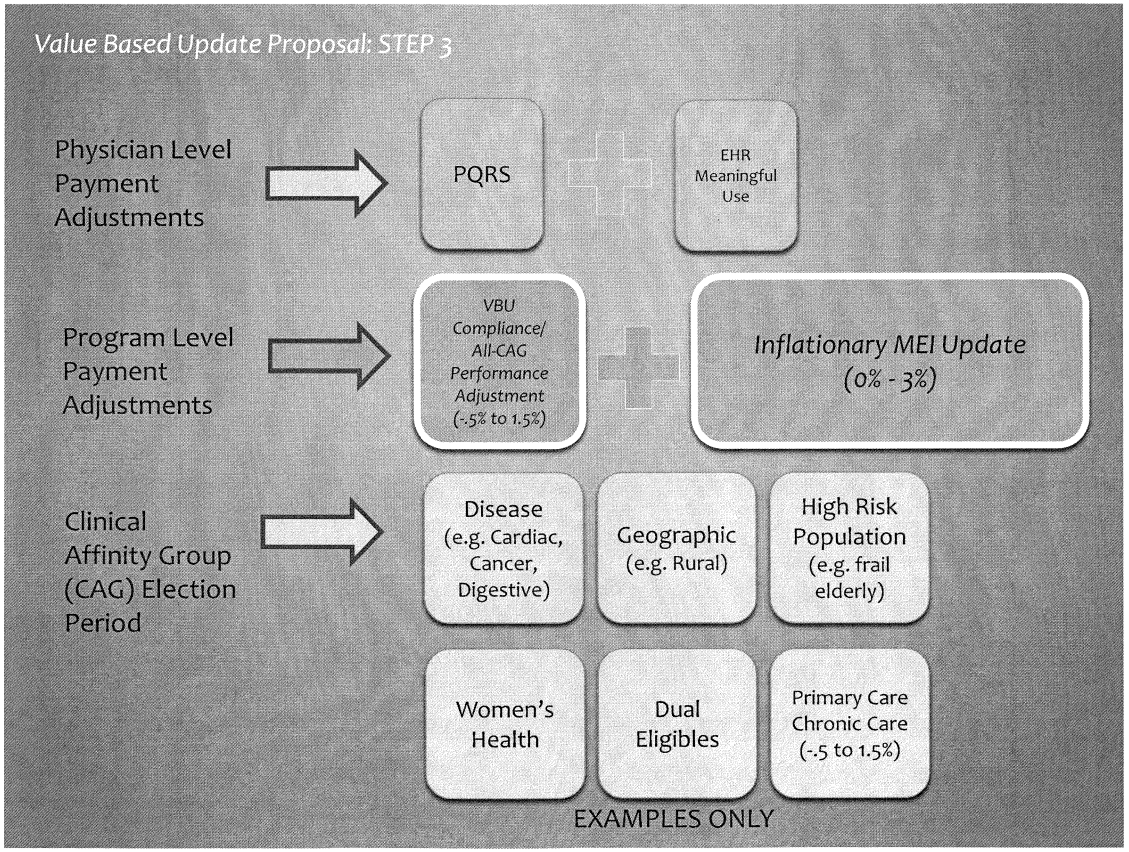
STEP 2

- Value Based Update linked to compliance with PQRS, EHR, and e-Rx programs
- If compliant, program-level inflationary adjustment of the Medicare Economic Index (MEI) plus VBU adjustment
- Introduces Primary Care Chronic Care Adjustment based on performance measures


Value Based Update Proposal: STEP 2
Physician Level Payment Adjustments
PQRS
EHR Meaningful Use
e-Rx Incentive Program
Program Level Payment Adjustments
VBU Compliance Adjustment (0% to 1.5%)
Inflationary MEI Update (0% - 3%)
Primary Care Adjustment
Primary Care Chronic Care Adjustment (+0.5% to 1.5%)

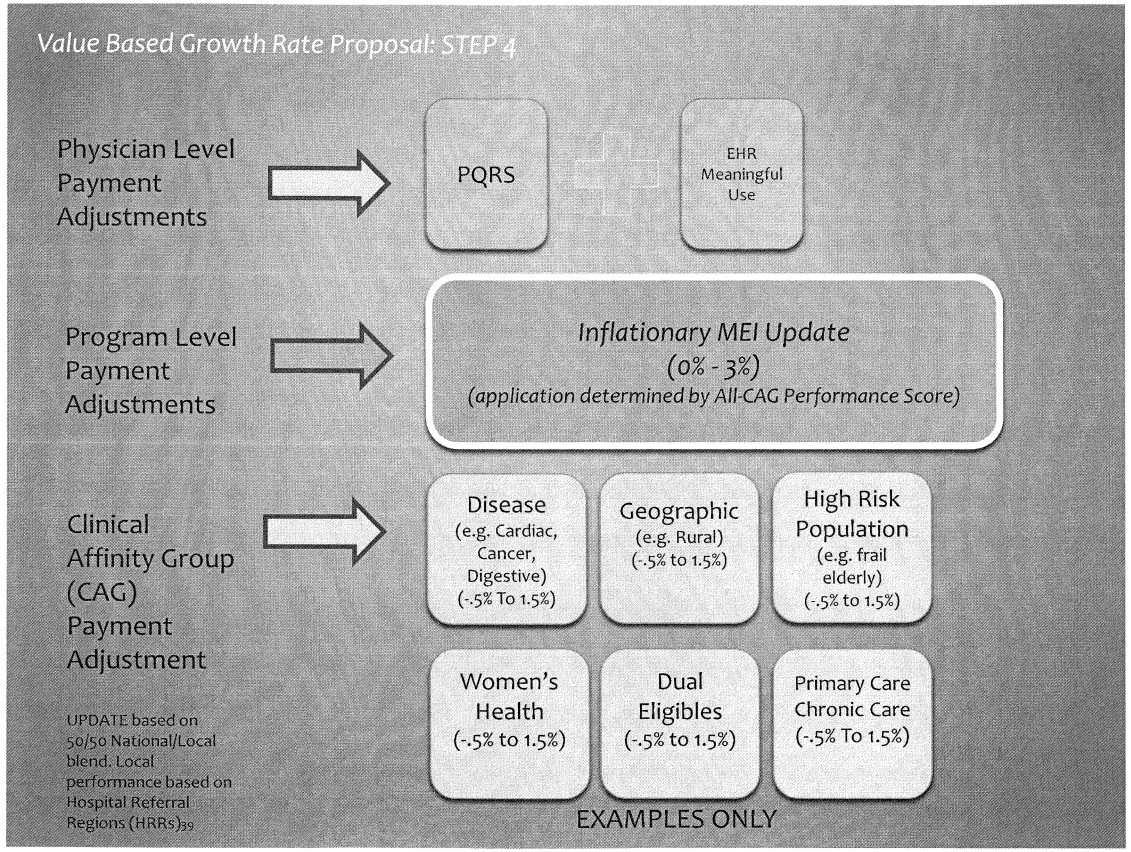
STEP 3

- Individual physician level adjustments simplified
- Program level adjustment: continues the MEI update and introduces additional updates based on the concept of the "*Clinical Affinity Group*"
- "*Clinical Affinity Group*" measures can be based on disease, geographic designations, types of care (e.g. primary care or geriatrics), etc and will determine the program level adjustment provided in addition to the MEI update.
- "*Clinical Affinity Groups*" are yet to be determined but will be designed to incentivize physicians to work collectively toward a quality or utilization goal.


Value Based Update Proposal: STEP 3
Physician Level Payment Adjustments
PQRS
EHR Meaningful Use
Program Level Payment Adjustments
VBU Compliance/ All-CAG Performance Adjustment (-.5% to 1.5%)
Inflationary MEI Update (0% - 3%)
Clinical Affinity Group (CAG) Election Period
Disease (e.g. Cardiac, Cancer, Digestive)
Geographic (e.g. Rural)
High Risk Population (e.g. frail elderly)
Women's Health
Dual Eligibles
Primary Care Chronic Care (-.5 to 1.5%)
EXAMPLES ONLY

STEP 4

- Individual physician level adjustments only determine eligibility, not amount of program level adjustment
- Program level adjustment: MEI update if minimum overall Clinical Affinity Group performance levels met
- Clinical Affinity Group categories and quality measures can be altered from year-to-year


Value Based Growth Rate Proposal: STEP 4
Physician Level Payment Adjustments
PQRS
EHR Meaningful Use
Program Level Payment Adjustments
Inflationary MEI Update
(0% - 3%)
(application determined by All-CAG Performance Score)
Clinical Affinity Group (CAG) Payment Adjustment
Disease (e.g. Cardiac, Cancer, Digestive) (-.5% To 1.5%)
Geographic (e.g. Rural) (-.5% to 1.5%)
High Risk Population (e.g. frail elderly) (-.5% to 1.5%)
Women's Health (-.5% to 1.5%)
Dual Eligibles (-.5% to 1.5%)
Primary Care Chronic Care (-.5% To 1.5%)
UPDATE based on 50/50 National/Local blend. Local performance based on Hospital Referral Regions (HRRs)39
EXAMPLES ONLY

AMERICAN ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

TO THE SENATE COMMITTEE ON FINANCE

PRESENTED BY

GLEN STREAM, MD, MBI, FAAFP
PRESIDENT

AMERICAN ACADEMY OF FAMILY PHYSICIANS

JULY 11, 2012

AAFP Headquarters
11400 Tomahawk Creek Pkwy.
Leawood, Kansas 66211-2680
800.274.2237
913.906.6000
fp@aafp.org

AAFP Washington Office
2021 Massachusetts Avenue, NW
Washington, DC 20036-1011
202.232.9033
Fax: 202.232.9044
capitol@aafp.org

Chairman Baucus and Senators, thank you for inviting the American Academy of Family Physicians (AAFP) to provide the Committee with a statement on our views of physician payment policy. The AAFP, with 105,900 members, is the only organization comprised entirely of primary care physicians or those training to become primary care physicians. Approximately, one in four of all office visits are made to family physicians. That is 240 million office visits each year – nearly 87 million more than the next largest medical specialty. We represent the foundation of health delivery in this country. However, health care in the United States is inefficient and delivers lower quality care because it undervalues the delivery of primary care.

The Finance Committee has done an excellent job in examining the causes of this systemic flaw. You well know the source of much of the problem, and that is the fee-for-service payment system. Fee-for-service pays for procedures and encourages volume over value in the delivery of health care. As a nation, we have tried alternatives to pure fee-for-service: managed care with capitated payments was one alternative. But that promoted less service and financially based denials and deferrals of medical care. Other payment methods focus on only part of the health delivery challenges, like efficiency or quality, and end up exacerbating the underlying problems, at least in part because of their claims-based reporting structure.

The AAFP has become convinced that no single alternative payment method will rebuild primary care. Instead, we need a combination of payment methods. AAFP, along with the other three major organizations that include primary care physicians – namely, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association – promote the Patient-Centered Medical Home, which is based on a blended payment system that includes:

- fee-for-service to pay for needed procedures, treatments and services
- care management fee to pay for the necessary and important functions of primary care – continuity and care coordination – over time between visits and when patients need care elsewhere in the health care system
- quality improvement payment to encourage effective review of a physician's patient data and consequent changes in practice.

In turn, the primary care physician has to transform the practice of primary care medicine. The demands of primary care in the Patient-Centered Medical Home (PCMH) are greater and more varied. The physician can no longer be the single source of health care, but rather must be part of a team that provides services, monitors care and advocates for the patient in different settings. Team-based care retains the personal relationship between the physician and the patient that is key to effective and efficient health care delivery, but the care of the patient includes other health care providers. The team uses electronic health records and health information technology to coordinate the care of the patient in different delivery settings and to provide more patient-centered service, like same-day appointments, asynchronous communication by way of e-mail, and educational tools. When the patient sees a non-primary care physician, that practice has access to a current and complete medical history and treatment record. The patient-centered medical home offers a variety of counseling, coaching and health improvement tools for each patient's use, tailored to that patient's need.

We advocate for this reinvigoration of primary care because we know it works to improve health care and restrain costs in the long run. The evidence for this is accumulating rapidly. One example is WellMed, a network of practices in San Antonio, which developed a highly effective Accountable Care Organization to care for Medicare Advantage patients. In a comparison of their patients with a matched sample of Medicare beneficiaries from Texas, the Robert Graham Center found that WellMed patients in a medical home are 35 percent less likely to be hospitalized and 37 percent less likely to visit an emergency department. There were also significant difference in whether patients received preventive screening and chronic care services including age-appropriate colon cancer screening (53 percent vs. 9.8 percent); annual cholesterol screening for patients with diabetes (77 percent vs. 71.7 percent); and annual cholesterol screening for people with ischemic heart disease (76 percent vs. 63.5 percent).

Private sector payers, largely in response to employers demanding it, also have begun several demonstration programs that are producing impressive results. For example, according to Steven Peskin, MD, the Senior Medical Director for Clinical Innovations, Horizon Blue Cross/Blue Shield of New Jersey has a patient-centered medical home demonstration that includes 24,000 members. In its first year, it has already shown notable improvement in the quality of care. Specifically, the plan has demonstrated an 8 percent higher rate in diabetes control, a 6 percent higher rate in breast cancer screening and a 6 percent higher rate in cervical cancer screening. Emergency room visits fell by 26 percent; hospital readmissions fell by 25 percent; and hospital in-patient admissions dropped by 21 percent. Cost indicators also are declining. The per-member, per-month cost of care declined by 10 percent.

Blue Cross/Blue Shield of Michigan reports, from a similar demonstration program, a reduction of 17 percent in in-patient admissions, a 6 percent decline in the 30-day readmission rate and 4.5 percent decrease in ER visits. Advanced imaging declined by 7 percent. Blue Cross/Blue Shield of Texas has noted a 23 percent lower rate of hospital readmissions and savings of approximately $1.2 million in annual health care costs. Idaho Blue Cross/Blue Shield reported $1 million savings in medical claims for its patients in a PCMH.

We have included additional findings from PCMH programs across the nation as an addendum to this statement. The results are compelling. Regardless of geographic location, the PCMH is demonstrating success in improving quality and restraining health care costs – specifically in the areas of emergency room visits and hospital readmission. (These results will be included in a larger report, being prepared by the Patient-Centered Primary Care Collaborative, which will be published later this month.)

Additionally, as members of the Finance Committee are aware from the June 14 roundtable discussion on "Medicare Physician Payment Policy: Lessons from the Private Sector," these are but a few examples of the ROI that can be achieved with an increased investment in primary care. The previous roundtable featured executives from Blue Cross Blue Shield of Massachusetts, Humana, Aetna, CareFirst BlueCross BlueShield, Washington, DC; and Hill Physicians Medical Group, San Francisco, CA. Each member of the roundtable described a variation of the same theme: greater investment in primary care. And each explained how this investment was operationalized and what return was realized.

- **Massachusetts BCBS** – unprecedented improvements in the quality of patient care and a 2-percent slower rate of growth in medical spending.

- **Humana** – the majority of their payment innovations center on engagement with primary care physicians.

- **Aetna** – provider reimbursements, tied to improved population health and reductions in the total cost of care, averaged 45 percent fewer acute hospital admissions, 50 percent fewer acute hospital days, and 56 percent fewer readmissions in 2011 compared to statewide unmanaged, risk-adjusted Medicare populations.

  In a study involving a large-scale commercial population of 200,000 members, ActiveHealth disease management achieved a 2.1 percent decrease in the cost trend in members meeting criteria for disease management interventions and an overall reduction in covered charges of $3.10 per member per month across the entire population.

- **CareFirst BCBS DC** – the Patient-Centered Medical Home (PCMH) was offered as an innovative program designed to give primary care providers new incentives and tools to provide higher quality, lower cost care to plan members.

  Incentives to primary care providers, including an immediate 12-percent increase in their fees as well as additional compensation for the development and monitoring of patient-specific care plans for their sickest patients, reinforce the central role of primary care. Incentive awardees achieved an average 4.2 percent savings against expected 2011 care costs; the cost of care for all CareFirst members attributed to PCMH participants was 1.5 percent lower than had been projected for 2011.

- **Hill Physicians** – primary care physicians are paid using a hybrid model of fee-for-service and performance-based compensation. The (lower-than-Medicare) fee-for-service component is supplemented by a quarterly primary care management fee that results in network physicians being paid at an average rate that is considerably higher than Medicare.

To understand why these programs that depend on greater emphasis on primary are so successful in holding back cost increases and improving health, it is important to understand the difference between primary care, specialty care and surgical care. The definition of primary care encompasses certain core values, including first contact, continuity, comprehensiveness and coordination of care. Specialty care focuses on a limited disease condition or organ system. A surgeon, of course, is trained to treat a specific episode of an acute disease that threatens the health of the whole person. These general medical categories require different skills and different relationships with the patient. It makes sense to pay them differently.

On March 12, 2012, the AAFP sent a series of recommendations to the Acting Administrator of CMS, Marilyn Tavenner. (A copy of that letter is appended to this statement.) These recommendations were the result of an AAFP sponsored Task Force on Primary Care Valuation, which included representatives of family medicine and other primary care organizations (i.e., the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association). It also included representatives from employer groups, private payers, and health policy organizations. In the short term, the Task Force urged CMS to create new codes for evaluation and management (E/M) services provided by primary care physicians. These codes would have their relative values pegged to the median values from the 2005 survey of E/M codes done by the primary care and other 'cognitive' specialties at that time. These new codes would be specifically for use by primary care physicians only.

The Task Force also recommended that eligibility for an enhanced payment option for primary care physicians be established following fundamental precepts; namely that the eligibility requirements reward a physician's practice that demonstrates it is carrying out three definitional functions of primary care, namely (1) first contact; (2) continuity; and (3) comprehensiveness.

Additionally, a claims-based measure of coordination of care should be developed since there is currently none ready for use. As pediatric data is not available from Medicare data, further study of state Medicaid for other claims-based data is needed

The key Task Force recommendation is that to build a system of care that will be consistently more efficient and will produce better health, we need to pay primary care differently and better. The AAFP has supported the *Medicare Physician Payment Innovation Act* (HR 5707), which Reps. Allyson Schwartz (D-PA) and Joe Heck, DO (R-NV) introduced. We do so for several reasons, one of which is that it takes a notable step toward recognizing this critical need to pay primary care differently. The legislation would specify a fee-for-service payment rate that is 2-percent higher for primary care services for four years. The bill also includes strong incentives for physicians to commit their efforts to better health care delivery. In later years, for example, the legislation begins reducing fee-for-service payment rates for those practices that have not transitioned to an alternative health delivery model that CMS has certified either reduces costs without reducing quality or improves quality without increasing costs.

The mechanism that CMS will use to determine effective alternatives is the Center for Medicare and Medicaid Innovation. The AAFP commends this committee for your farsightedness in including the Innovation Center in the *Affordable Care Act*. This office provides CMS with a degree of nimbleness and creativity that is unusual in the private sector, much less the federal government. The AAFP is working closely with the Innovation Center, for example, to encourage selected family physicians to participate in the Comprehensive Primary Care Initiative that includes several health plans in various markets that will offer a per-patient, per-month care coordination fee for primary care physicians whose practices are effectively Patient-Centered Medical Homes. We hope this initiative will quickly show the same levels of quality improvement and cost restraints that have become clear in other single-payer tests. The importance of this initiative is that it contains more than just Medicare patients. Since only about 20-25 percent of the patients in an average family physician's practice are in the Medicare

program, it has been difficult for many of these practices that want to transform themselves into a PCMH to find the up-front finances needed to pay for the required investments. By including all payers in a specific market, the chances that the family physician will have access to the necessary capital are greatly increased and practice transformation is much more feasible.

The AAFP commends the Innovation Center for adapting the Accountable Care Organization (ACO) concept to the small primary care practice. The Innovation Center recognized this requirement for up-front investments when it developed the concept of the Advance Payment ACO. This ACO model specifically reduces the risk to the small (and even solo) practice that wants to become an Accountable Care Organization by providing shared savings in advance so that the small practice will have additional access to capital. CMS should be encouraged to continue exploring options for alternative payment that will allow the nation's health care system to escape the hamster-in-the-wheel reality driven by pure fee-for-service.

The *Affordable Care Act* included another provision that will be very helpful to small primary care practices, especially in rural and underserved areas. This is the Primary Care Extension Service, administered by the Agency for Healthcare Research and Quality (AHRQ). Currently without funding, the Primary Care Extension Program is designed to disseminate by local agents the most up-to-date information about evidence-based therapies and techniques to small practices in much the same way as the federal Cooperative Extension Service provides small farms with the most current agricultural information and guidance. One of the crucial values of this extension service is that it would be able to support small family medicine practices that want to become a Patient-Centered Medical Home. We would recommend an extended timeline for the transformation of these practices into a PCMH, but we see the Primary Care Extension Service as a vital tool to help make this transformation possible. The AAFP strongly recommends that Congress fund the Primary Care Extension Service program.

We have an another feature of the ACA that is worth noting and deserves your continued support; namely, the Primary Care Incentive Payment (PCIP), which is the 10-percent bonus payment to primary care physicians and providers for certain primary care services they provide to Medicare patients. According to CMS data, it is an average annual payment to a family physician of about $3500. This modest payment sends an important signal not just to family physicians and other primary care providers, but also to medical students who must decide whether to pursue a career in primary care. The Robert Graham Center for Policy Studies in Family Medicine and Primary Care, in a study for the Macy Foundation, determined that growth in the income gap between primary care and specialty care is the strongest factor in predicting student and resident career choice. Both public and private payers must continue to find mechanisms that will close this gap even further.

The Commonwealth Fund recently published a study that the PCIP, if made permanent, would modestly increase costs of primary care but save much more in other health care costs. James Reschovsky, PhD, and colleagues, in a study published on March 21, 2012, found that making the primary care bonus permanent would boost the number of primary care visits by 8.8 percent, while also raising the overall cost of primary care visits. But these increases would yield more than a six-fold annual return in lower Medicare costs for other services—mostly

reductions in hospitalizations, outpatient services, and post-acute care—once the full impact on treatment patterns is realized. The net result, according to this study, would be a drop in Medicare costs of nearly 2 percent.

Related to the PCIP, there is a similar feature of the health reform law that will be in place only for 2013 and 2014, unless Congress acts to extend it. This is the provision that increases Medicaid payment for primary care and some preventive health services to a rate at least equal to that of Medicare for the same services. Again, this sends a message to medical students that primary care matters for all patients, regardless of their income and health status. The AAFP believes that Congress should extend both payment provisions to assure that they will have the long-lasting effect of encouraging medical students to choose primary care careers.

Senators, we all want the same thing: better health care at less cost. There is a proven way to go a long way toward achieving that outcome – invest in primary care. Our most important recommendation is that we must pay primary care differently and better – and we have ample evidence that doing so will not increase the overall cost of care per individual per year.

Thank you again for your commitment to the health care of this nation and family physicians are eager to assist you in making the difference we need.

Outcomes of Implementing the Patient Centered Medical Home (PCMH)
A Review of the Results - 2012

These findings will be published in July 2012 as part of a larger report prepared by the Patient Centered Primary Care Collaborative (PCPCC).

Results of Patient-Centered Medical Home Initiatives, by State or Agency				
Initiative	**Health Care Cost & Acute Care Service Outcomes**	**Health Outcomes & Quality of Care Results**	**Years of Data Review**	**Report Type**
Air Force (2011)[i]	• 14% fewer emergency department (ED) and urgent care visits • Hill Air Force Base (UT) saved $300,000 annually through improved diabetes care management	• 77% of diabetic patients had improved glycemic control at Hill Air Force Base	2009-2011	Agency Congressional testimony
Alaska: ***Alaska Native Medical Center (2012)***[ii]	• 50% reduction in urgent care and ER utilization • 53% reduction in hospital admissions • 65% reduction in specialist utilization		? - 2012	Industry Report via public presentation
California: **BCBS of California ACO Pilot (2012)** [iii]	• 15% fewer hospital readmissions • 15% fewer inpatient hospital stays • 50% fewer inpatient stays of 20 days or more • Overall health care cost savings of $15.5 million		2010	BCBS Industry Report
Colorado **Colorado Medicaid and SCHIP**[iv]	• $215 lower per member per year for children.	• Increased provider participation in CHIP program from 20% to 96%. • Increased well-care visits for children from 54% in 2007 to 73% in 2009.	2007-2009	Alliance of Community Health Plans: Care Management Handbook
Florida	• 40% lower inpatient hospital	• 250% increase in primary care	2003-?	IHI Report

Capital Health Plan, (Tallahassee, FL) 2012 [v]	days • 37% lower ED visits • 18% lower health care claims costs	visits		
Idaho: **BCBS of Idaho Health Service (2011)**[iii]	• $1 million reduction in single year medical claims • ROI of 4:1 for disease management programs			BCBS Industry Report
Maryland: **CareFirst BlueCross BlueShield (2011)**[vi]	• 4.2% average reduction in expected patient's overall healthcare costs among 60% of practices participating for 6 or more months • Nearly $40 million savings in 2011	•	2011	BCBS Industry Report
Michigan: **BCBS of Michigan (Physician Group Incentive Program) (2011)**	• 13.5% fewer emergency department (ED) visits among children in PCMH (vs 9% non-PCMH) • 10% fewer ED visits among adults in PCMH (vs. 6.5% non-PCMH)[vii] • 7.5% lower use of high-tech radiology.[viii] • 17% lower ambulatory-care sensitive inpatient admissions • 6% lower 30-day readmission rates[iii]	• 60% better access to care for participating practices that provide 24/7 access (as compared to 25% in non-participating sites)[iii]	2008-2011	BCBS Industry Report, Factsheet,
Minnesota **HealthPartners**[ix,xxvi] **(Bloomington, MN)**	• 39% lower ER visits • 24% fewer hospital admissions • 40% lower readmission rates • 30% lower length of stay • 20% lower inpatient costs due to outpatient case management program for behavioral health.	• Reduced appointment wait time by 350% from 26 days to 1 day. Improved quality of services • 129% increase in optimal diabetes care • 48% increase in optimal heart disease care. Changed provider	2004-2009	Industry Report

	• Overall costs decreased to 92% of state average in 2008. • Reduced outpatient costs of $1282 for patients using 11 or more medications.	behavior • 13% increase in generic prescribing • 10% decrease in diagnostic imaging scans		
Nebraska: **BCBS of Nebraska 2012)[x]**	• 10% fewer hospitalizations • 27% fewer emergency visits		2011	BCBS Industry Report
New Jersey: **BCBS of New Jersey (Horizon BCBSNJ) 2012[xi,xii]**	• 10% lower per member per month (PMPM) costs • 26% fewer ED visits • 25% fewer hospital readmissions • 21% fewer inpatient admissions • 5% increase in use of generic prescriptions	Better diabetes care • 8% improvement in HbA1c levels • 31% increase in ability to effectively self-manage blood sugar Better prevention • 24% increase in LDL screening • 6% increase in breast and cervical cancer screening	2011	BCBS Industry Report, Press release
New York **Capital District Physicians' Health Plan (Albany, NY)[xiii]**	• 24% lower hospital admissions • 9% lower overall medical cost increases resulting in savings of $32 PMPM.		20082010	Industry Report - Press Release
New York **Independent Health[xiv] (Buffalo, NY)**	• Reduced ER visits from 198 to 124 per 1,000 patients. • Cost savings of $2.9 million due to a 0.02 decrease in the total cost index.	• Increased preventive care from 70% to 78% • increased usage of generic statins from 52% to 74%. • Improved satisfaction with 2% increase in satisfaction among patients and 19% among staff.	2009	Alliance of Community Health Plans
New York **Priority Community Healthcare Center Medicaid Program[xv] (Chemung County, NY)**	• Cost savings of 11% overall in first 9 months of approximately $150,000 • Reduced hospital		2010	

	spending by 27% and ER spending by 35%			
North Carolina **Blue Quality Physician's Program (BCBSNC) 2011**[xvi]	• 52% fewer visits to specialists • 70% fewer visits to the ER		2011	BCBS Industry Report, Press release
North Carolina **Community Care of North Carolina (Medicaid)**[xvii]	• 23% lower ED utilization and costs • 25% lower outpatient care costs • 11% lower pharmacy costs • Estimated cost savings of $60 million in 2003 • $161 million in 2006 • $103 million in 2007 • $204 million in 2008 • $295 million in 2009 • $382 million 2010.[xviii]	Improvements in asthma care • 21% increase in asthma staging • 112% increase in influenza inoculations	2003-2010	Peer reviewed journals: Health Affairs, Annals of Family Medicine; Agency report
North Dakota **BlueCross BlueShield of North Dakota – MediQHome Quality Program 2012**[xii]	• 6% lower hospital admissions • 24% fewer ED visits • 30% lower ED use among patients with chronic disease • 18% lower inpatient hospital admission rates compared to general North Dakota population	Better diabetes care: • 6.7% improvement in BP control • 10.3% improvement in cholesterol control • 64.3% improvement in optimal diabetes care. Better coronary artery disease management • 8.6% improvement in BP control • 9.4% improvement in cholesterol control • 53.8% improvement in optimal diabetes control. Better care for hypertension • 8% improvement in	2005-2006	BCBS Industry Report

		blood pressure control		
Ohio: **Humana Queen City Physicians (2012)**[xix]	• 34% decrease in ER visits	• 22% decrease in patients with uncontrolled blood pressure	2008-2010	Industry Report
Oklahoma **Oklahoma Medicaid (Year)**[xx]	• Reduced per capita member costs by $29 PPPY.	Improved access over one year period • Reduction from 1,670 to 13 patient inquiries related to same-day/next-day appointment availability • 8% increase in patients "always getting treatment quickly."	2008-2010	
Oregon **Bend Memorial Clinic & Clear One Medicare Advantage (PacificSource Medicare Advantage) 2012**[xxi]	Lower hospital admission rates • 231.5 per 1000 beneficiaries (compared to state/national averages of 257 and 351 per 1000, respectively). Lower ER visit rates • 242 per 1000 beneficiaries (compared to state/national averages of 490 and 530 per 1000, respectively).		2010	Press Release
Oregon **CareOregon Medicaid and Dual Eligibles (Portland, OR)**	• 9% lower PMPM costs[xxii] • Reduced PMPM costs by $100.[xxii]	Better disease management among diabetics in one clinic • 65% had controlled HbA1c levels vs. 45% pre-PCMH.[xxiii] • 10% increase HbA1c testing over a six-month period[xxiv]	2007-2009	Common-wealth Foundation, Journal article
Pennsylvania **Geisinger Health System ProvenHealth Navigator PCMH**	• 23% reduced hospital length of stay • 25% lower hospital admissions • 53% lower	Improved quality of care • 74% for preventive care • 22% for coronary artery care	2005-2010	Congressional testimony, PCPCC Outcomes Report, Peer

model (Danville, PA) 2010, 2012	readmissions following discharge[xxv] • Estimated net savings of $3.7 million equaling an ROI of 2:1.[xxvi] • 18% reduced inpatient admissions • 36% lower readmissions • 7% lower cumulative total spending (from 2005 to 2008.)[xxvii] Longer exposure to medical homes resulted in lower health care costs. • 7.1% lower cumulative cost savings (from 2006 to 2010) with an ROI of 1.7.[xxviii]	• 34.5% for diabetes care.[xxix]		Reviewed Journal: American Journal of Managed Care
Pennsylvania **UPMC[xxx] (Pittsburgh, PA) YEAR**	• 13% fewer hospitalizations by 2009. • Medical costs nearly 4% lower.	Improved patient outcomes for diabetics • Increases in eye exams from 50% to 90% • 20% long-term improvement in control of blood sugar • 37% long-term improvement of cholesterol control	2009	Press interview
Pennsylvania: **BCBS of South-eastern Pennsyl-vania (Independence Blue Cross - Pennsyl-vania Chronic Care Initiative) 2012[xii]**		Better diabetes care • Increased diabetic screenings from 40% to 92% • 49% improvement in HbA1c levels • 25% increase in blood pressure control • 27% increase in cholesterol control • 56% increase in patients with self-management goals	2008-2011	BCBS Industry Report
Pennsylvania	• 0% 30-day hospital readmission rate		2011	Industry Report Press

PinnacleHealth (2012)[xxxi]	for PCMH patients vs. 10-20% for non-PCMH patients			Release
Rhode Island **BCBS of Rhode Island (2012)**[xii]	• 17-33% lower health care costs among PCMH patients.	Improved quality of care measures • 44% for family & children's health • 35% for women's care • 24% for internal medicine	2008-2011	BCBS Industry Report
South Carolina **BCBS of South Carolina (Palmetto Primary Care Physicians) 2012**[xii]	• 14.7% lower inpatient hospital days • 25.9% fewer ED visits • 6.5% lower total per member per month (PMPM) medical and pharmacy costs		2008-2011	BCBS Industry Report
Tennessee **BCBS of Tennessee (2012)**[xii]		Increased screening rates • 3% for diabetes exams • 7% for diabetes retinal exams • 14% for diabetes nephropathy exams • 4% for lipid exams. Increased prescription rates • 6% for coronary artery disease medications.	2009-2012	BCBS Industry Report
Texas **BCBS of Texas (2012)**[iii]	• 23% lower readmission rates • $1.2 million estimated health care cost savings		2009	BCBS Industry Report
Texas **WellMed Inc.**[xxxii] **(San Antonio, Texas)**		Improved disease management • Increased control of HbA1C levels from 81% to 93% of diabetic patients • LDL levels under control from 51% to 95% from heart disease patients • Increased control of BP levels from 67% to 90%.	2000-2008	Peer Review Journal: Journal of Ambulatory Care Management

		Improved preventive care: • Increased screening rates for Mammography from 19 to 40% • Colon cancer from 11 to 50% • HbA1c from 55 to 71% • LDL screenings for all patients increased from 47 to 70% • LDL screenings for diabetic patients increased from 53 to 78% • LDL screenings for ischemic heart disease patients increased from 53 to 76%. • BP screening rates for all patients increased from 38 to 76% • BP screenings for high BP patients increased from 46 to 88%.		
Vermont **Vermont Blueprint for Health (2012)**[xxxiii]	• 27% reduction in projected cost avoidance across its commercial insurer population		2010-2012	Industry Report as part of public presentation
Vermont **Vermont Medicaid**[iv]	• 21% decreased inpatient use • 22% lower PMPM inpatient costs • 31% lower ED use • 36% lower PMPM ED costs		2008-2010	
Veterans Health Administration and VA Midwest Healthcare Network, (VISN 23) 2012	• 8% lower urgent care visits • 4% lower acute admission rates by 4% [xxxiv] • 27% lower hospitalizations and ED visits among chronic disease patients • $593 per chronic		2011 2007-2009	Press Interview

	disease patient cost savings.[xxxv]			
Washington **Regence Blue Shield (Intensive Outpatient Care Program with Boeing) 2012**[iii]	• 20% lower health care costs	• 14.8% improved patient-reported physical function and mental function • 65% reduced patient reported missed workdays	2007-2009	BCBS Industry Report
Washington **Group Health of Washington (Seattle, WA) 2009, 2010**	• 29% fewer ED visits[xxxvi] • 11% fewer hospitalizations for ambulatory care-sensitive conditions[xxxvi] • Cost savings of $17 PMPM • $4 million in transcriptions cost savings through the use of EHRs • $2.5 million in cost savings through medical records management • $3.4 million in cost savings through medication use management program • 40% cost reduction through use of generic statin drug[xxxvii]	Improved medication management • 18% reduction in use of high-risk medications among elderly • 36% increase in use of cholesterol lowering drugs • 65% increase in use of generic statin drug.[xxxviii] Improved quality of care • Composite measures by 3.7% to 4.4%.[xxxvi] Improved provider satisfaction • Less emotional exhaustion reported by staff (10% PCMH vs. 30% controls).[xxxvi] Improved patient experiences in one clinic • 83% of patient calls resolved on the first call compared to 0% pre-PCMH.[xxxix]	2006-2007[xxxvi] 2008[xxxvii-57] •	Common-wealth Fund, Peer Reviewed Journal: Health Affairs

[i] Green, C. B. (2011, May 11). FY 2012 Medical Programs. Statement of Lieutenant General (Dr.) Charles B. Green. *Testimony Before the House Appropriations Committee, Subcommittee on Defense*. United States Air Force.

[ii] Asinof, R. (2012, May 28). A new model of health care. Retrieved June 14, 2012 from Providence Business News: http://www.pbn.com/A-new-model-of-health-care,67796

[iii] Blue Cross Blue Shield Association: Building Tomorrow's Healthcare System.

[iv] Takach: Reinventing Medicaid.

[v] Institute for Healthcare Improvement. (2012). *Report from Tallahassee Memorial HealthCare on Enhancing Continuity of Care.* Retrieved April 12, 2012, from IHI Knowledge Center: http://www.ihi.org/knowledge/Pages/ImprovementStories/ReportfromTallahasseeMemorialHospitalonEnhancingContinuityofCare.aspx

[vi] Sun, L. (2012, June 7). *CareFirst says experimental program improves primary care, reduces costs.* Retrieved June 14, 2012 from The Washington Post: http://www.washingtonpost.com/national/health-science/carefirst-says-experimental-program-improves-primary-care-reduces-costs/2012/06/07/gJQAAK3XMV_story.html?wpisrc=emailtoafriend

[vii] Sammer, J. (2011, December 1). *Medical homes move from pilots to real-world implementation.* Retrieved April 30, 2012, from Managed Healthcare Executive: http://managedhealthcareexecutive.modernmedicine.com/mhe/News+Analysis/Medical-homes-move-to-real-world-implementation/ArticleStandard/Article/detail/750641

[viii] BCBS of Michigan. (2011, December 14). *Patient-Centered Medical Home Fact Sheet.* Retrieved April 12, 2012, from BCBS Blue Care Network of Michigan: http://www.valuepartnerships.com/pcmh/pcmh_factsheet.pdf

[ix] HealthPartners. (2009). *HealthPartners BestCare: How to Deliver $2 Trillion in Medicare Cost Savings, and Improve Care in the Process.* Retrieved April 16, 2012, from HealthPartners: http://www.healthpartners.com/files/47979.pdf

[x] Reutter, H. (2012, April 2). *Medical Home: Better Health at Same or Reduced Cost?* Retrieved April 16, 2012, from Lexington Clipper-Herald: http://lexch.com/news/statewide/article_33fc4628-7cca-11e1-ae83-001a4bcf887a.html

[xi] Horizon Healthcare Innovations. (2012, April 10). *Early Results Show Patient-Centered Medical Homes Drive Quality and Cost Improvements*. Retrieved April 16, 2012, from News & Media: http://www.horizonhealthcareinnovations.com/news-media/press-releases/20120410-early-results-show-patient-centered-medical-homes-drive-quality-a?utm_source=Patient+Centered+Primary+Care+Collaborative+List&utm_campaign=3629b33e8b-Thursday+Call+March+1&utm_

[xii] BCBSA. (2012). *Patient-Centered Medical Home Snapshots.* Chicago: BlueCross Blue Shield Association.

[xiii] CDPHP. (2011, March 22). *CDPHP Medical Home Pilot Results in Substantial Quality Improvements and Cost Savings. Pilot Practices Cost Growth Reduced to 2/3 That of Other Regional Providers.* Retrieved April 12, 2012, from Vocus/PRWEB: http://www.prweb.com/releases/CDPHP/medical_home_pilot/prweb8224444.htm

[xiv] Fachko, M., Fecher, K., Szeglowski, S., & Taylor, D. (2011). Alliance of Community Health Plans Key Informant Interview. (R. A. Malouin, Interviewer)

[xv] Chemung County Government. (2011, April 18). *Medicaid Medical Home Realizing Positive Results in First Year.* Retrieved April 16, 2012, from Chemung County News: http://www.chemungcounty.com/index.asp?pageid=105&nid=650

[xvi] Blue Cross and Blue Shield Association. (2012, June 4). Blue Cross and Blue Shield Companies' Patient-Centered Medical Home Programs Are Improving The Practice and Delivery of Primary Care in Communities Nationwide. Retrieved June 14, 2012, from PRNewswire: http://www.marketwatch.com/story/blue-cross-and-blue-shield-companies-patient-centered-medical-home-programs-are-improving-the-practice-and-delivery-of-primary-care-in-communities-nationwide-2012-06-04

[xvii]Steiner, B. D., Denham, A. C., Ashkin, E., Newton, W. P., Wroth, T., & Dobson, L. A. (2008, July/August). Community Care of North Carolina: Improving Care Through Community Health Networks. *Annals of Family Medicine, 6*(4), 361-367.

[xviii] Mahoney, P. (2011, December 21). *Our Results: Making headway on cost and quality.* Retrieved April 30, 2012, from Community Care of North Carolina: http://www.communitycarenc.com/our-results/

[xix] Carey, M.A. (2012, May 17). Senate Panel Looks at Innovative Health Care Strategies. Retrieved June 14, 2012 from Kaiser Health News: http://capsules.kaiserhealthnews.org/index.php/2012/05/senate-panel-looks-at-some-innovative-health-care-strategies/

[xx] Takach: Reinventing Medicaid

[xxi] Bend Memorial Clinic. (2012, January 4). *Bend Memorial Clinic Reduces Hospital Admissions and Emergency Visits.* Retrieved April 30, 2012, from Bend Memorial Clinic: http://www.bendmemorialclinic.com/aboutus/bmc_in_the_news/newsblog/12-01-04/BMC_reduces_hospital_admissions_and_emergency_room_visits_through_Medical_Home_Pilot.aspx

[xxii] Klein, S., & McCarthy, D. (2010, July). *CareOregon: Transforming the Role of a Medicaid Health Plan from Payer to Partner.* Retrieved April 16, 2012, from The Commonwealth Fund: http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2010/Jul/Triple%20Aim%20v2/1423_McCarthy_CareOregon_triple_aim_case_study_v2.pdf

[xxiii] Miller, J. (2009, May 1). *Unlocking Primary Care: CareOregon's Medical Home Model.* Retrieved April 12, 2012, from Managed Healthcare Executive: http://managedhealthcareexecutive.modernmedicine.com/mhe/article/articleDetail.jsp?id=595822

[xxiv] Alliance of Community Health Plans. (2011, July). *Care Management Handbook: Improving Population Health through Community Engagement.* Retrieved from Alliance of Community Health Plans: http://www.achp.org/

[xxv] Steele, G. D. (2009). Reforming the Healthcare Delivery System. *Committee on Finance: United States Senate* (pp. 1-7). Washington, D.C.: Geisinger Health System

[xxvi] Grumbach, K., Bodenheimer, T., & Grundy, P. (2009, August). *The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Cost from Recent Prospective Evaluation Studies.* Retrieved April 16, 2012, from Patient Centered Primary Care Collaborative: http://www.pcpcc.net/files/Grumbach_et-al_Evidence-of-

[xxvii] Gilfillan, R., Tomcavage, J., Rosenthal, M., Davis, D., Graham, J., & Roy, J. e. (2010). Value and the Medical Home: Effects of Transformed Primary Care. *American Journal of Managed Care, 16*(8), 607-614.

[xxviii] Maeng, et al. Reducing Long-Term Costs.

[xxix] Geisinger Health System. (2009). Advanced Models of Primary Care. *White Roundtable.* Washington, D.C.: Geisinger Health System.

[xxx] Mamula, K. B. (2011, May 20). *UPMC expands medical home model.* Retrieved April 30, 2012, from Pittsburgh Business Times: http://www.bizjournals.com/pittsburgh/print-edition/2011/05/20/upmc-expands-medical-home-model.html?page=all

[xxxi] Pinnacle Health Hospitals. (2012, June 1). PinnacleHealth Expands Patient-Centered Medical Home Model. Retrieved June 14, 2012 from PinnacleHealth News: http://www.pinnaclehealth.org/General/About-Us/News/PinnacleHealth-News-Releases/PinnacleHealth-Expands-Patient-Centered-Medical-Ho.aspx

[xxxii] Phillis, R. L., Bronnikov, S., Petterson, S., Cifuentes, M., Teevan, B., Dodoo, M., . . . West, D. R. (2010, Jan-Mar). Case Study of a Primary Care-Based Accountable Care System Approach to Medical Home Transformation. *Journal of Ambulatory Care Management, 34*(1), 67-77.

[xxxiii] Ibid.

[xxxiv] Arvantes: US Military Implements PCMH.

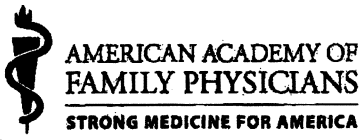
[xxxv] Grumbach and Grundy: Outcomes of Implementing PCMH.

[xxxvi] Reid, R. J., Fishman, P. A., Yu, O., Ross, T. R., Tufano, J. T., Soman, M. P., & Larson, E. B. (2009). A patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. *American Journal of Managed Care, 15*(9), e71-e87.

[xxxvii] McCarthy, D., Mueller, K., & Tillmann, I. (2009, July). *Group Health Cooperative: Reinventing Primary Care by Connecting Patients with a Medical Home.* Retrieved April 16, 2012, from The Commonwealth Fund: http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2009/Jul/1283_McCarthy_Group%20Health_case_study_72_rev.pdf

[xxxviii] Ibid.

[xxxix] Meyer, H. (2010, May/June). Group Health's Move to the Medical Home: For Doctors, it's Often a Hard Journey. *Health Affairs, 29*(5), 844-51.



March 12, 2012

Ms. Marilyn Tavenner
Acting Administrator and Chief Operating Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Tavenner:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents 100,300 family physicians and medical students nationwide. We are recommending that the Centers for Medicare and Medicaid Services (CMS) adopt a series of short term strategies for improving primary care payment as part of the proposed rule on the 2013 Medicare physician fee schedule that is currently under development by CMS.

The inadequate and dysfunctional payment system for primary care services remains one of the major barriers to the revitalization and transformation of primary care in the United States today. While many examples of payment reform are beginning to occur, most payment for primary care remains fee-for-service, with rates based on Medicare's physician fee schedule. Faced with increasing demands and inadequate financial resources, primary care practices are in an increasingly tenuous position, unable to redesign themselves into the model of the Patient Centered Medical Home using the teams and technology necessary to improve the quality and cost efficiency of care. As a result there are serious implications for access to care by patients throughout the country, and for the future physician workforce in the US. It is important to note that the strategies recommended below will not "save" primary care. However, if adopted by CMS, they will provide some desperately needed short-term help that family medicine and primary care needs until payment reform efforts are complete and long-term strategies can be identified and implemented.

In June 2011, the AAFP Board of Directors created a Task Force on Primary Care Valuation whose charge was to review and make recommendations to the AAFP Board of Directors for an alternative methodology(s) to value primary care services (evaluation and management services) provided by family physicians and other primary care physicians. The task force included representatives from other primary care organizations (i.e. American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association). It also included representatives from employer groups, private payers, and health policy organizations, such as the Urban Institute. Finally, we included observers from other organizations, including the Medicare Payment Advisory Commission and CMS. We have enclosed a complete list of the task force members for your information.

President
Glen Stream, MD
Spokane, WA

President-elect
Jeffrey J. Cain, MD
Denver, CO

Board Chair
Roland A. Goertz, MD
Waco, TX

Directors
Reid Blackwelder, MD, Kingsport, TN
Conrad L. Flick, MD, Raleigh, NC
Laura Knobel, MD, Walpole, MA
Barbara Doty, MD, Wasilla, AK
Richard Madden, Jr., MD, Salem, NH
Robert Wergin, MD, Milford, NE
Julie K. Wood, MD, Lee's Summit, MO
Wanda D. Filer, MD, York, PA
Daniel R. Spogen, MD, Reno, NV
Robyn Liu, MD, (New Physician Member), Portland, OR
Brent Smith, MD, (Resident Member), Brandon, MS
Jessica Johnson (Student Member), Newington, CT

Speaker
John S. Meigs, Jr., MD
Brent, AL

Vice Speaker
Javette C. Orgain, MD
Chicago, IL

Executive Vice President
Douglas E. Henley, MD
Leawood, KS

11400 Tomahawk Creek Parkway • Leawood, KS 66211-2680 • 800.274.2237 • 913.906.6000 • Fax: 913.906.6075 • fp@aafp.org

Over the last seven months, the task force developed a series of recommendations that would improve payment for primary care services by primary care physicians in the near term and support principles for longer term payment reform developed by the Patient Centered Primary Care Collaborative. The AAFP Board of Directors approved those recommendations last week. Among them were the following recommendations, which we urge CMS to adopt as part of the proposed rule on the 2013 Medicare physician fee schedule:

RECOMMENDATION: That CMS create new codes for evaluation and management (E/M) services provided by primary care physicians with relative values that, at a minimum, would equal or exceed the median survey values from the 2005 survey of E/M codes (done by the primary care and other 'cognitive' specialties at that time). These new codes would be specifically for use only by primary care physicians who meet the definition as defined in the next recommendation.

Given that the bulk of primary care payment is derived from a fee-for-service payment model based on current E/M codes, the AAFP believes that it is important to ensure that the E/M codes used by primary care physicians accurately reflect the work required and be appropriately valued. The current E/M paradigm is based on "problem" identification and management. Primary care today is much more proactive, complex and strategic, including treatment of illness even before symptomatic presentation, extensive screening and prevention, and counseling -- comprehensive, coordinated, and continuous care. Codes for these E/M services provided in primary care today must accurately capture and value the physician work. Additionally, the practice expenses for these codes also need to be revalued to account for the significant infrastructure staffing and material expenses associated with care coordination and the continuity work of primary care. If CMS believes that new vignettes are necessary in further determining the physician work and practice expense values for such new codes, the AAFP would be very interested in working with CMS in this regard.

Additionally, new codes would avoid the difficulty of paying different specialties different amounts for the same codes, which is currently prohibited under the Medicare physician fee schedule. While the creation of new E/M codes for primary care services would ideally occur through the Current Procedural Terminology (CPT) process, the CPT schedule does not permit that in time for the 2013 Medicare physician fee schedule. Instead, we recognize that CMS has the ability to create new Healthcare Common Procedure Coding System codes at its discretion and can do so in time for the 2013 Medicare physician fee schedule.

Regarding the suggestion that CMS use the relative values recommended by the survey data in 2005, the AAFP believes that intensity of primary care work would be more appropriately acknowledged in the 2005 values. The AAFP accepts the notion that complexity and intensity of evaluation and management services provided by primary care physicians differ from similar services done by other specialties and believes the median survey values identified in 2005 best reflect, at a minimum, work values commensurate with new codes which can be created by CMS.

In sum, the AAFP believes that this recommendation has the advantage of appropriately highlighting the complexity of the work of primary care in a manner that may be readily utilized by both CMS and private payers. It should be noted that the recommendation is to use the new codes only for primary care physicians as defined below and that these new codes would replace the current E/M codes and values for such services provided by primary care physicians. Other ways of coding may be important to pursue in the long term, and we encourage CMS to consider this for further development.

In the meantime, these new codes are comprehensive for the acute, preventive, and chronic care provided in family medicine and primary care often in the same visit. Importantly, this is not just about patients with multiple co-morbidities. Further, CMS should make any necessary budget neutrality adjustments through an adjustment to the RVUs of all of the other codes in the Medicare physician fee schedule, rather than an adjustment to the conversion factor. An adjustment to the conversion factor will only serve to dilute the impact of these codes for primary care, whereas an adjustment to the RVUs of all other services will reinforce its impact.

RECOMMENDATION: The AAFP recommends that eligibility for enhanced payment options for primary care physicians be based on the following fundamental precepts. That the eligibility requirements reward demonstration of carrying out three definitional functions of primary care, namely 1) first contact, 2) continuity, and 3) comprehensiveness using claims to characterize every physician and replace the current claims-based process created by the Affordable Care Act (ACA) and revised by CMS.

1) **Additionally, a claims-based measure of coordination of care should be studied and considered for implementation (there currently is not one ready for use).**
2) **As Pediatric data is not available using Medicare data, further study on state Medicaid or other claims based data is needed.**

The definition of primary care in this country varies in different contexts but it consistently encompasses certain core values, including first contact of care, continuity of care, comprehensiveness, and coordination of care. The AAFP believes that to appropriately identify primary care physicians, CMS must use a working definition that reflects the core definitional elements. The following table provides a summary of the measurement of each element. We could not find a claims-based way to measure community/family functions of primary care.

Table 1: Core Definitional Elements of Primary Care

Primary Care Definitional Elements	How to measure and use for payment
first contact care	Family medicine, general internal medicine, general pediatrics and geriatrics (claims-based or NPI)
continuity of care	Patients who see this physician/clinic get the plurality of their care there (claims-based)
comprehensive care	Breadth and depth of ICD-9 codes used by physicians in Medicare claims
coordinated care	Patients who see more than 3 physicians are seen by a PCP or PC practice at least every 6 months
Bridges personal, family, and community	Undetermined

Physician specialty by itself does not necessarily define a primary care physician, as many internal medicine and family physicians work as hospitalists or in emergency rooms or have limited scope of care. The ACA defines primary care physicians by specialty combined with use of certain CPT codes that reflect common primary care services.

The measures above incorporate first contact, comprehensiveness, and continuity using Medicare claims data to identify primary care physicians as an alternative to the definition provided in the ACA. Since pediatric data is not available, the current model would serve as a proxy until other data is available. We have analyzed coordination of care, but this measure was so low using claims that it may not be sufficient to measure this function of primary care at this time. Utilizing key definitional elements of primary care will result in rewarding the appropriate physicians with additional payments for providing primary care.

Applying the filters as described in Appendix A of the enclosed task force report and using Medicare claims data allows identification of physicians who are providing care consistent with core elemental components of primary care with the exclusion of pediatrics. This approach is the first to attempt to define and identify primary care physicians in this way. Moving forward, we believe that it is essential to be able to appropriately identify those physicians providing primary care consistent with its most basic tenets. This approach is as complex as the nuances of the definition of primary care and as simple as recognizing core values we should expect from primary care. It is offered as an alternative to the definition set out in the ACA, and we have demonstrated that it captures a more functional definition of primary care.

We recognize that this definition may appear more complicated than the one that CMS currently uses in conjunction with the Primary Care Incentive Program (PCIP), and we would be happy to work with CMS to help you better understand how this new definition might be implemented. If this new definition is too complicated for CMS to implement immediately, we are open to the agency using the PCIP definition in the interim.

RECOMMENDATION: That CMS pay for the following services under the Medicare physician fee schedule using established relative value units (RVUs) when provided by primary care physicians as an interim strategy until this work is recognized under a care management fee:

- Telephone evaluation and management services (CPT codes 99441-99443)
- Collection and interpretation of physiologic data (CPT code 99091)
- Domiciliary, rest home, or home care plan oversight services (CPT codes 99339-99340)
- Anticoagulant management (CPT codes 99363-99364)
- Medical team conferences (CPT codes 99366-99367)
- Care plan oversight services (CPT codes 99374-99380)

All of the services covered by this recommendation have established RVUs. However, CMS does not pay for them separately under the Medicare physician fee schedule. CMS considers most of them "bundled" with other services paid under the fee schedule. While some of these services and corresponding codes ultimately would be part of a care management fee (as planned for example in the Comprehensive Primary Care Initiative), the AAFP believes that paying for them now on a fee-for-service basis is a sound and interim short-term strategy. All are integral to primary care, and we note that the Relative Value Scale Update Committee (RUC) has made a similar recommendation to CMS.

To be sure, primary care is moving toward a blended system of payment, and these codes ultimately may be covered in a care management fee rather than on a fee-for-service basis. In the meantime, the services described above are not part of face-to-face care and validly fall outside the current bundled payments for E/M services.

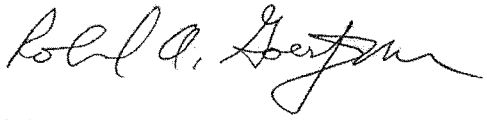
RECOMMENDATION: That CMS value and pay for the online evaluation and management service (i.e., CPT code 99444) provided by primary care physicians.

CPT code 99444 (Online evaluation and management service provided by a physician to an established patient . . .) does not have established RVUs and is not covered under the Medicare physician fee schedule. The RUC attempted to value this code in 2007 and was not successful. The RUC discussed code 99444 and concluded that the definition of work and physician time and complexity involved in this service were unclear, therefore making it difficult to recommend a specific work relative value.

The AAFP believes that the service represented by this code is as integral to primary care as the other non-face-to-face services described in the recommendation above. Since CMS has the ability to value services independent of the RUC, the AAFP recommends that CMS proceed to work directly with AAFP and other organizations that represent primary care physicians to establish a value for this service and implement payment for it under the Medicare physician fee schedule in 2013.

We appreciate your consideration of these recommendations and welcome the opportunity to discuss them with you and your staff. To pursue such conversations, please contact Mr. Robert Bennett, Federal Regulatory Manager at the AAFP at rbennett@aafp.org or at 1-800-274-2237, extension 2522.

Sincerely,



Roland A. Goertz, MD, MBA, FAAFP
Board Chair

Enclosures

RAG:kjm

Statement of

W. Douglas Weaver, MD, MACC

On behalf of the

American College of Cardiology

Presented to the

SENATE FINANCE COMMITTEE

Roundtable on Medicare Physician Payments: Perspectives from Physicians

July 11, 2012

Chairman Baucus and Ranking Member Hatch, I am Dr. Douglas Weaver, Past President of the American College of Cardiology (ACC) and Vice President and Systems Medical Director of Heart and Vascular Services at Henry Ford Health System in Detroit, MI. On behalf of the ACC, I am pleased to participate in the Senate Finance Committee roundtable discussion on reforming the Medicare physician payment system. ACC members, including cardiologists, nurses and other members of the cardiovascular care team, have made a commitment to improving both the quality and value of the care provided in this country.

The ACC is a 40,000-member nonprofit medical society serving the needs of both providers and patients in this country and internationally. The College has been a leader in producing guidelines of care, professional and patient education, and operating national registries for assessing process measures and outcomes of cardiovascular procedures and everyday outpatient care.

Rewarding Quality and Efficiency

The College urges Congress to avert scheduled reimbursement cuts, repeal the sustainable growth rate (SGR) and provide stable payments for several years to allow the development of new delivery and payment models. The current uncertainty in the future stifle both our practices and our hospitals in making real investments aimed at improving integration and reducing the current fragmentation of care and reducing waste. The ACC supports moving the current Medicare physician payment system away from a volume-based system and toward a value-driven system that better aligns compensation with performance of evidence-based medicine and higher value, appropriate healthcare.

The College supports the testing of new payment models of delivering and reimbursing for care through the Center for Medicare and Medicaid Innovation, private payers, and other initiatives. The College believes there is no "one-size-fits-all" replacement and models are needed that work for a variety of settings, including small, independent practices and rural areas as well as large single specialty and multispecialty groups. One size will not fit all and there needs to be the ability to have local solutions.

The ACC has learned that efforts to improve quality and efficiency use the best scientific evidence when available, plus the routine collection of robust clinical data that can then be used to provide feedback on performance. A fundamental challenge of health care in the past was a lack of available and reliable data. The practice of medicine generates a great deal of data but it often goes no further than the instrument on which it was recorded or a paper record in a physician's office. Physicians must believe the data and trust it in order to act on it. In general they are very skeptical of administrative claims data knowing the careless way in which it is often collected and often deficient of clinical nuances that affect both physician choices and patients outcomes.

Through the creation of practice guidelines and appropriate use criteria for the performance of diagnostic tests and therapeutic procedures, and the use of clinical data registries and quality improvement programs, connecting data to practice will both improve care and reduce unnecessary care. If Medicare promotes these activities by incentivizing their use and helping pay for the efforts, we believe the current improvements that we are witnessing will accelerate.

Evidence-Based Guidelines and Performance Measures

The current clinical practice guidelines serve a role in providing a diagnosis and treatment plan for common conditions for the "typical "patient. These will be even more effective as health information technology (HIT) improves and incorporates clinical decision support tools.

The National Cardiovascular Data Registry

Clinical data registries can help medical professionals and participating facilities identify and close gaps in quality of care; reduce wasteful and inefficient care variations; and implement effective, continuous

quality improvement processes. Clinical data registries capture clinical information that is evidence based and derived from clinical guidelines, performance measures and appropriate use criteria in order to accurately measure patient outcomes and clinical practice.

Today, the ACC supports six hospital-based registries and one outpatient physician office-based registry representing over 20 million patient records, operational in over 2500 U.S. hospitals and in over 500 physician offices across the US.

WellPoint, Inc, United Healthcare Services, and Blue Cross Blue Shield of Michigan formally require participation in NCDR® as part of reimbursement or recognition programs. These efforts have galvanized physicians to work together on areas where there is either low or uneven quality. The Blue Cross Blue Shield Association includes NCDR® participation as part of their national Blue Distinction Centers for Cardiac Care Program. Many states, including California, Florida, Maryland, Michigan, Missouri, Washington, and West Virginia, are aligning regional monitoring efforts with NCDR®. Health systems such as Hospital Corporation of America (HCA) and Kaiser Foundation Hospitals (of Kaiser Permanente) leverage NCDR® to support quality improvement efforts within their networks, as does the Veterans Administration.

Decision Support Tools
The ACC has developed appropriate use criteria (AUC) that define when and how often physicians should perform a given procedure or test in the context of scientific evidence, the health care environment, the patient's profile and the physician's judgment. The College has created point of order tools through which physicians can access the AUCs during a patient encounter with minimal workflow disruption.

Blue Cross Blue Shield of Delaware (BCBSD) is requiring the use of our tools that help physicians choose the best imaging test for a patient instead of insurance benefit managers who have at times limited patients' access to appropriate cardiovascular diagnostics. The program provides feedback reports on the patterns of appropriate use to physician practices and health plans. Participants then use the reports to complete action plans and share best practices. We believe that such efforts are the right way to move forward.

The Door to Balloon Initiative
D2B: An Alliance for Quality™ illustrates how data collection and feedback can improve quality and outcomes. The Door to Balloon Initiative, or D2B, challenged cardiovascular specialists to meet the national guidelines developed by the ACC and the AHA that state that hospitals treating heart attack patients with emergency PCI should reliably achieve a door-to-balloon time of 90 minutes or less. "Door-to-balloon time" means the time it takes to diagnose a heart attack and restore blood flow to the heart by placing a stent in a blood vessel. Studies demonstrate strong associations between time to primary PCI and in-hospital mortality risk; however, accomplishing this level of performance was an organizational challenge. In 2006, the ACC partnered with many other organizations to address the challenge by sharing the key evidence-based strategies and supporting tools needed to reduce D2B times nationally. The program was very successful, with widely published studies showing that D2B times dropped to under 90 minutes in over 90 percent of US hospitals, with many now having D2B times under one hour. This initiative significantly improved patient outcomes.

Hospital to Home
The Hospital to Home (H2H) Initiative, led by the ACC and the Institute for Healthcare Improvement, is an important resource for hospitals and cardiovascular care providers to improve transitions from hospital to "home" and, equally important, to avoid any federal penalties associated with high readmissions rates. H2H is an online learning community of individuals and facilities committed to reducing readmissions

and improving patient care. The H2H initiative challenges communities to better understand and tackle readmission problems through the use of simple, targeted, and actionable strategies in three core concept areas: Early Follow-up, Post Discharge Medication Management, and Patient Recognition of Signs and Symptoms.

Alternative Payment Models

SMARTCare
The ACC combined many of its tools into a project to address documented clinical quality, resource use and cost variation in the treatment of stable ischemic heart disease (SIHD) called SMARTCare. In Wisconsin, the project is driven by the ACC State Chapter in collaboration with integrated health care systems, statewide, multi-stakeholder collaborative groups, including business coalitions, measurement and data collaborative groups, and a payment reform partnership. A parallel effort in Florida is led by the ACC State Chapter in collaboration with 6 provider organizations across the state.

The goal is to reduce complications, procedures not meeting current appropriate use standards, and episode cost; achieve high levels of patient engagement; improve quality of life; and increase the number of patients at risk reduction goals. The project seeks to accomplish these changes by improving appropriateness of noninvasive cardiac imaging; treatment decision between medical therapy, stenting, and bypass surgery; and optimizing medication and lifestyle interventions. Combining these tools would provide customized patient benefit and risk information based on evidence and registry data in real time. Information provided in these tools and registries would then be used to assess patterns of care. Feedback about impact on overall clinical care and cost would be made available through an interactive dashboard and analysis tool. Ongoing tracking using longitudinal outpatient registries would allow sites to modify use of their tools over time to better outcomes and increase efficiency. The information is intended to be used to support an episode of care shared savings/bundled payment model and quality incentive payments.

Patient Involvement and Regulatory Relief

Shared Decision Making
Health care decisions are not black and white. ACC believes engaging patients in decision making is crucial to achieving the best outcome for a patient, as determined by the clinical situation and the patient's preferences and values. More emphasis must be placed on shared decision making, the process by which a health care provider communicates to the patient personalized information about the options, outcomes, probabilities, and scientific uncertainties of available treatment options and the patient communicates his or her values and the relative importance he or she places on benefits and harms. Through CardioSmart.org and partnership with the Choosing Wisely Initiative, ACC is providing content and tools to achieve this goal.

Conclusion
Providing physicians and other health care providers with longitudinal data on their performance and tools to improve their performance results in improved quality and efficiency and lower costs. To establish the infrastructure and data necessary, Medicare and private payers should encourage the development and widespread use of clinical data registries that allow the tracking, reporting, and improvement of healthcare quality in concert with payment programs that encourage higher quality. This will form the foundation for meaningful payment reform based on the best clinical evidence.

The pathway to reducing the rate of growth of US health care spending and its alarming contribution to the national deficit will require that we align payment incentives with improved data-driven outcomes---the task requires improving rather than cutting care. Physician leadership, working together with other

clinicians, hospitals, insurers, and Medicare, will be necessary to effect these needed improvements in our health care system. Thank you for the opportunity to speak today about several of the exciting quality improvement collaborations underway in cardiology and what lessons can be applied to improve quality and lower costs across the health care system. The College offers itself as a resource to you as you work with your colleagues to permanently repeal the SGR and transform the Medicare physician payment system.

American Society of Anesthesiologists

1501 M Street, N.W. • Suite 300 • Washington, D.C. 20005 • (202) 289-2222 • Fax: (202) 371-0384 • mail@ASAwash.org

Medicare Physician Payments: Perspectives from Physicians
United States Senate Committee on Finance
Wednesday, July 11, 2012

Statement for the Record by
Jerry A Cohen, M.D., President of the American Society of Anesthesiologists

On behalf of the over 48,000 members of the American Society of Anesthesiologists (ASA), we would like to thank you for holding this important hearing, "Medicare Physician Payments: Perspectives from Physicians." We appreciate the opportunity to submit a statement for the record. ASA has consistently pushed for repeal of the flawed Medicare Sustainable Growth Rate (SGR) formula and replacement with a new mechanism that accurately reflects the increasing costs of providing care to Medicare beneficiaries. Short of repeal, the ASA supports the longest possible "doc-fix" tied to positive payment updates to reduce uncertainty, to ensure that physicians do not have their Medicare payments cut, and to protect access to care for beneficiaries. We look forward to working with the Committee on payment reform and enhancing physician payment based on quality.

The Perioperative Surgical Home™ Model

As you work on payment reform, **we believe the Perioperative Surgical Home™ model for coordinated care deserves the Committee's full consideration.** Currently, there is no coordinated and widely-adopted construct to improve quality of care and outcomes while ensuring patient safety and achieving cost savings across the widest possible range of surgical interventions. Leading institutions, including the Mayo Clinic, have implemented innovative perioperative[1] measures and protocols that simultaneously improve patient outcomes and decrease costs. These models serve as the foundation for the Perioperative Surgical Home™ model. The Perioperative Surgical Home™ model strives to optimize care of patients undergoing surgery by incorporating such novel practices with increased integration of anesthesiologists throughout the perioperative period. This concept now needs to be tested widely.

The goals of the Perioperative Surgical Home™ model are as follows:

- **Improve the safety, effectiveness, timeliness, cost, and efficiency of health care;**

[1] "**Perioperative:** Literally, around (the time of) surgery. More specifically, the period of time extending from when the patient goes into the hospital, clinic, or doctor's office for surgery until the time the patient is discharged home." Webster's New World ™ Medical Dictionary – Online Edition.
http://www.medterms.com/script/main/art.asp?articlekey=22186

- **Increase the ability of beneficiaries to participate in decisions concerning their care;**
- **Provide delivery of care that is consistent with evidence-based guidelines in historically underserved areas; and**
- **Decrease unjustified variation in utilization and expenditures under the Medicare program.**

The Perioperative Surgical Home™ model will test and measure the potential for coordinated management of surgical patients to reduce complications, produce innovative process improvements, and consequently enhance the value of surgical care. Anesthesiologists are the common point of contact for patients undergoing major procedural care, from the neonate to the centenarian, across all surgical disciplines. From this position, anesthesiologists communicate on a daily basis with patients and all members of the surgical team. By empowering and incentivizing anesthesiologists to participate more broadly in patient care, the Perioperative Surgical Home™ model will promote improved communication, teamwork and attention to patient-centered care. Via increased patient engagement and improved care coordination, this model has the potential to improve patient satisfaction along with other outcome measures. Encouraging anesthesiologists to utilize their well-honed skills in efficient patient evaluation and management, as well as their expertise in systems optimization throughout the perioperative period, will benefit quality and efficiency in the health care system.

ASA's Leadership in Patient Safety

As the Committee knows, anesthesiologists have been recognized as the physician leaders in improving patient safety and quality care. The landmark patient safety study by the Institute of Medicine (IOM), *To Err is Human: Building a Safer Health System*[2] found that:

> Few professional societies or groups have demonstrated a visible commitment to reducing errors in health care and improving patient safety. Although it is believed that the commitment exists among their members, there has been little collective action. *The exception most often cited is the work that has been done by anesthesiologists to improve safety and outcomes for patients.*
>
> Anesthesiology has successfully reduced anesthesia mortality rates from two deaths per 10,000 anesthetics administered to one death per 200,000 – 300,000 anesthetics administered.

More recently, the Congressional Research Service (CRS) in its June 2011 report titled *Medical Malpractice: Background and Examination of Issues before Congress* recounted how the ASA has worked to respond to patient safety issues. CRS reported that ASA uses its Closed Claims project to "see what practices were causing liability and then developing new methods to improve the safety of anesthesiology. By 2005, the death rate from anesthesiology had declined to less than 1 in 200,000 cases." We believe that whatever the new physician payment reform is, it must enable anesthesiologists to continue this focus on patient safety and quality care.

---

[2] *To Err is Human: Building a Safer Health System*, Institute of Medicine, 2000.

We believe that **physicians** can encourage beneficiaries to seek appropriate high-value health care services. Some have suggested removing Medicare's anesthesia supervision standard, but substituting nurses for doctors would significantly decrease patient safety and quality of care. Further, such a substitution provides the Medicare program and American taxpayers with no additional cost savings since Medicare pays the same for anesthesia services whether they are furnished by nurse anesthetists or highly-trained anesthesiologists. We must never lose sight of the fact that surgery is dangerous and that anesthesia should only be safely undertaken under the direct administration and/or supervision of a physician who has extensive educational training and experience, preferably in anesthesia. We caution the Committee against removing this important patient safety standard.

Anesthesiology Remains a "Complex, High Risk, Dynamic Patient Care System"

Despite the work of the ASA and the success of its member physicians, much work remains to be done in assuring patient access to safe, high-quality anesthesia care. As the IOM has stated, anesthesiology is a "complex, high risk, dynamic patient care system" that requires an ongoing commitment to quality and safety-enhancing paradigms. Consistent with that requirement, ASA is pleased to share with the Committee our new and ongoing patient safety and quality care centered initiatives throughout this statement. We ask for the Committee's consideration and recognition of these initiatives as it continues its work on health care delivery system and payment reform.

Rewarding Quality and Efficiency

While we have been successful in our efforts to improve quality, anesthesiologists suffer from a significant payment disparity under the Medicare system known as the "33% problem." While modest disparities between Medicare and commercial physician payment rates are longstanding and well-recognized for other medical specialties, the disparity in payments for anesthesia services is unique.

In July 2007, a Government Accountability Office (GAO) report confirmed for the public and the Congress what anesthesiologists have known and struggled with for years: Medicare payments for anesthesia services are drastically low.[3] According to the GAO, Medicare payments for anesthesia services represent only 33% of the prevailing commercial insurance payment rates for the same service. In contrast, the Medicare Payment Advisory Commission (MedPAC) consistently reports Medicare's payments for other physician services represent approximately 80% of commercial rates when averaged across all physician services and geographic areas. Further, the anesthesia payment differential continues and may be expanding. Based on ASA's annual survey data, the 2011 Medicare anesthesia conversion factor was only 31% of even the lowest average commercial conversion factor for anesthesia.[4]

---

[3] U.S. Government Accountability Office. *Medicare and Private Payment Differences for Anesthesia Services*, GAO-07-463, Washington, DC: Government Accountability Office, 2007.

[4] Byrd, Jason R. Loveleen Singh. *ASA Survey Results for Commercial Fees Paid for Anesthesia Services*, 2011. American Society of Anesthesiologists Newsletter. October 2011. Vol. 75. Number 10: 38-41.

We would hope that as the Committee works to address payment disparities under the current system, it will remain mindful of documented payment problems with specialties such as anesthesiology.

We would also like to provide the Committee with information on other ASA initiatives.

The ASA has developed and facilitated the use of quality and outcome measures. In fact, among all provider groups, anesthesiologists ranked third (by percentage) in Physician Quality Reporting System (PQRS) participation in 2010.[5] Currently, there are three traditional anesthesia measures that are included in PQRS: Measure 30 - Timely Administration of Prophylactic Parenteral Antibiotics; Measure 76 - Prevention of Catheter-Related Bloodstream Infections (CRBSI) Central Venous Catheter Insertion Protocol; and Measure 193 - Perioperative Temperature Management. Models involving further integration of anesthesiologists, such as the Perioperative Surgical Home™ model, may be reasonably expected to yield novel quality and outcome measures. In addition, ASA has developed measures that we submitted to the Centers for Medicare & Medicaid Services (CMS) on October 7, 2011 including the new measure - Participation in a Systematic Database for Anesthesia Care. Regretfully, CMS did not include these measures in the recently released Calendar Year (CY) 2013 proposed Medicare Physician Fee Schedule Proposed Rule. ASA is working with CMS to include these key measures in PQRS.

Value Based Payment – We believe that multiple sets of quality measures should exist or be developed to afford flexibility and applicability to the broad range of physician services provided to Medicare and Medicaid beneficiaries every day. Currently, Measures 30 (Timely Administration of Prophylactic Antibiotics) and 193 (Perioperative Temperature Management) have already been adopted by CMS and endorsed by the National Quality Forum (NQF). In a formal comment letter, we recommended that CMS adopt these PQRS measures for use in application of the value based payment modifier to anesthesiologists. CMS did not adopt those anesthesia measures into its value based payment proposal in the CY2013 Medicare Physician Fee Schedule Proposed Rule, and under an expedited timeline CMS will begin to collect data beginning in 2013 to apply the modifier in 2015. ASA is continuing to evaluate the value based payment provisions in the CY2013 Medicare Physician Fee Schedule Proposed Rule.

Electronic Health Records – On May 7, 2012, the ASA submitted a formal comment letter to CMS regarding the Electronic Health Record (EHR) Incentive Program Stage 2 Proposed Rule. ASA has sought modifications to the measures and regulations implementing the EHR Incentive Program so that anesthesiologists can actively participate and demonstrate success. Many anesthesiologists typically rely on hospitals and Ambulatory Surgery Centers (ASCs) to provide the anesthesia electronic health record, much like the facility provides other essential equipment. As a result, Congress intended to exempt anesthesiologists from the program because they were deemed a hospital-based eligible professional. Section 1848(o)(1)(C)(ii) of the law defines the term "hospital-based eligible professional" as "an eligible professional, such as a pathologist, **anesthesiologist**, or emergency physician, who furnishes substantially all of such services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital." However, because the

[5] Centers for Medicare and Medicaid Services. *2010 PQRS and eRx Experience Report*. March 16, 2012.

regulations implemented the definition of "hospital-based eligible professional" at a high threshold of 90% of services performed within the inpatient setting, the overwhelming majority of anesthesiologists are eligible for the program. More troubling is the fact that the overwhelming majority of anesthesiologists are also subject to the eventual payment adjustments, which could amount up to 5% annually. This is because anesthesiologists are subject to penalties based upon criteria never intended for them. For example, although anesthesiologists are never involved in vaccination administration or documentation, the current regulations require them to purchase software used to track patient vaccinations.

Despite being deemed eligible by regulations finalized by CMS, many anesthesiologists have not been able to successfully participate in this incentive program during Stage 1. In fact, according to the data set "CMS Medicare and Medicaid EHR Incentive Program, electronic health record products used for attestation" (accessed via www.data.gov on June 28 2012), only 422 anesthesiologists from across the country have been able to successfully attest.

Initiatives, Guidelines and Registries

While not directly tied to Medicare physician payment, I would like to take the opportunity to highlight a number of initiatives for the Committee to consider. These initiatives could help form the basis for quality measurement as physician payment moves from payment for volume to payment for value.

As briefly mentioned above, ASA operates its **Closed Claims Project** a project to identify major areas of loss in anesthesia, patterns of injury and strategies for prevention.

The ASA Closed Claims Project began in 1985. At the time the project was initiated, professional liability insurance was expensive for anesthesiologists and in some states difficult to obtain. The intention of the Closed Claims Project was to identify root causes of loss thereby improving patient safety while relieving the liability insurance problem. The Closed Claims Project is located at the Department of Anesthesiology and Pain Medicine of the University of Washington in Seattle and is funded by the ASA.

The project consists of an in-depth investigation of 9214 (as of July 2012) closed insurance claims resulting from anesthetic mishaps. Data is gathered in the form of detailed case summaries collected by ASA member anesthesiologists from insurance company claim files. Claims in which the basic sequence of events and/or nature of the injury cannot be reconstructed from the information in the insurance files are excluded. This results in most cases being collected from mishaps resulting in lawsuits, as files in these cases contain the most extensive information. Cases are collected from throughout the United States on a continuous basis.

The database consists of standardized summaries of each case, including patient information (e.g. age, physical status), surgical procedure and positioning, anesthetic evaluation and technique, events leading to the injury or claim, type and severity of injury, outcome of litigation, and physician evaluations of potential for prevention and appropriateness of anesthesia care. The database also includes a brief narrative summary of each claim, describing the

sequence of events and adding any pertinent information not contained in the standardized data collection form.

The ASA Closed Claims Project also conducts studies that focus on specific aspects of professional liability and anesthesia patient safety. In recent years the Project has investigated the reliability of physician judgments of appropriateness of anesthesia care and sources of bias in such judgments. The project is currently collecting data to evaluate the role of the ASA Guidelines for Management of the Difficult Airway in liability. The project is also providing administrative and technical support for the Neurologic Injury after Non-Supine Shoulder Surgery (NINS) Registry and the Postoperative Visual Loss Registry.

Findings are reported in the scientific literature. Findings have also been presented to various audiences, including ASA Annual Meeting Refresher Course lectures since 1990. Abstracts of these lectures are available in the refresher course booklets distributed to the attendees or by request from the project office. Reprints of published articles are also available from the project office.

The ASA has nearly one-hundred standards, guidelines, statements and practice parameters. These instruments provide guidance to improve decision-making and promote beneficial outcomes for the practice of anesthesiology.

- ASA Standards provide rules or minimum requirements for clinical practice. They are regarded as generally accepted principles of patient management. Standards may be modified only under unusual circumstances, e.g., extreme emergencies or unavailability of equipment.
- ASA Guidelines are systematically developed recommendations that assist the practitioner and patient in making health care decisions. These recommendations may be adopted, modified, or rejected according to clinical needs and constraints and are not intended to replace local institutional policies. In addition, practice guidelines are not intended as standards or absolute requirements, and their use cannot guarantee any specific outcome. Practice guidelines are subject to revision as warranted by the evolution of medical knowledge, technology, and practice. They provide basic recommendations that are supported by a synthesis and analysis of the current literature, expert opinion, open forum commentary, and clinical feasibility data.
- ASA Statements represent the opinions, beliefs, and best medical judgments of the ASA House of Delegates. As such, they are not necessarily subjected to the same level of formal scientific review as ASA Standards or Guidelines. Each ASA member, institution or practice should decide individually whether to implement some, none, or all of the principles in ASA statements based on the sound medical judgment of anesthesiologists participating in that institution or practice.
- ASA Practice parameters provide guidance in the form of requirements, recommendations, or other information intended to improve decision-making and promote beneficial outcomes for the practice of anesthesiology. The use of practice parameters cannot guarantee any specific outcome. Practice parameters are subject to periodic revision as warranted by the evolution of medical knowledge, technology and practice. Variance from practice parameters may be acceptable, based upon the judgment

of the responsible anesthesiologist. For more information regarding ASA standards, guidelines, statements and practice parameters, please visit the ASA website at http://www.asahq.org/For-Members/Standards-Guidelines-and-Statements.aspx.

In October 2008, the ASA House of Delegates created the Anesthesia Quality Institute (AQI). The AQI is a separately incorporated organization, with its own Board of Directors. The vision of the AQI is "to become the primary source of information for quality improvement in the clinical practice of anesthesiology." The mission of the AQI is to develop and maintain an ongoing registry of case data that helps anesthesiologists assess and improve patient care. This is achieved by organizing the registry such that anesthesiology practice groups desire to submit their case information and so that individual anesthesiologists, practice groups, researchers, and professional societies find the resulting data useful for improving the quality of care.

The AQI supports four active registries of clinical data:

1) The National Anesthesia Clinical Outcomes Registry (NACOR) has gathered data on millions of cases, thousands of facilities, and thousands of providers. This number is growing every day as new practices submit data and existing practices contribute monthly cases. Registry participants range from practices that record on paper documents to the most wired academic centers in the country. NACOR is collecting the following types of data: Billing/Administrative, Quality/Perioperative Events, Anesthesia Information Management Systems (AIMS) data and Electronic Medical Records.

2) The Anesthesia Incident Reporting System (AIRS) is a national collection of serious adverse events and near misses, collected confidentially. Any anesthesia provider can contribute to AIRS, by accessing the website at www.aqiairs.org. De-identified cases from AIRS provide teaching material for case reports featured in the ASA Newsletter.

3) The Maintenance of Certification in Anesthesiology (MOCA) Practice Performance Assessment and Improvement (PPAI) registry is a joint effort of ASA and the AQI. Participants in MOCA are required to assess the quality of their practice – including clinical data from real patients. ASA modules will provide an easy-to-use format for doing this. The AQI registry will collect and protect the clinical data entered by MOCA participants. For anesthesiologists in practices that participate in NACOR, the AQI will go a step further. We will soon be piloting a voluntary program that helps providers identify the cases they need to collect for their MOCA-PPAI project. In the long run this system will auto-populate much of the required data.

4) The National Pain Registry will help anesthesiologists keep track of long-term pain management outcomes. Working with experts from the American Society for Regional Anesthesia and Pain Management (ASRA) we have developed a template for data and definitions. We will help participants build these measures into existing EHRs so that the data can be periodically transferred to the AQI.

Conclusion

We appreciate your consideration of the Perioperative Surgical Home ™ model and other ASA initiatives as the Committee looks to the physician community and other stakeholders for meaningful ways in which to reform Medicare's current physician payment system.

We look forward to working with the Committee as you continue to address Medicare physician payment reform. If you have any questions, please feel to contact Manuel Bonilla, M.S. (m.bonilla@asawash.org), Director of Congressional and Political Affairs or Grant Couch (g.couch@asawash.org), Federal Affairs Associate at (202) 289-2222.

Statement for the Record
American College of Physicians
25 Massachusetts Ave, NW Washington, DC 20001
Senate Finance Committee Hearing
Medicare Physician Payments: Perspectives from Physicians
July 11, 2012

The American College of Physicians (ACP) applauds Chairman Baucus and Ranking Member Hatch for holding this roundtable discussion and for the committee's bipartisan efforts in trying to develop a solution to Medicare's physician payment system, which has been a burden on physician practices for over a decade. We share your view that "we need physicians to suggest changes to the Medicare physician payment system that will spur high quality, high value care." In that spirit, ACP's statement will focus primarily on how Congress could build upon physician-led initiatives to transition to a new value-based payment and delivery system. We will discuss delivery and payment reform models that we view as the most promising in any post-Sustainable Growth Rate (SGR) environment, as well as noting the kinds of structural and reporting capabilities, payment incentives, and measurement systems needed for them to work.

Our testimony offers the following for the Subcommittee's consideration:

1. Discussion of why fundamental payment and delivery system reform is imperative
2. Principals for transitioning to value based payment initiative
3. Analysis of specific payment and delivery system reform models, in both the private and public sectors, which could be the basis for transitioning to fundamental reform.
4. Developing Payment Policies to Support Physician-led Programs to Promote High Value Care
5. Improving Medicare fee-for-service to support care coordination
6. Leveraging and Improving Existing Quality Improvement/Value Based Payment Programs
7. Suggestions on a legislative framework to transition to better payment models.

WHY FUNDAMENTAL PAYMENT AND DELIVERY SYSTEM REFORM IS IMPERATIVE

Fundamental reform of the Medicare payment system is long overdue, including repeal of the SGR. For more than a decade, the SGR has caused annual scheduled cuts in payments to physicians, endangering access to care, destabilizing the program, and creating barriers for physicians to develop the practice capabilities to improve clinical quality and effectiveness. Although Congress usually over-rides the scheduled cut with a freeze of current payment rates or a small positive update, such short-term "patches" have not offered the stability needed to ensure stability and access, nor have they provided a roadmap to transitioning to better payment models—while adding hundreds of billions of dollars to the cost of full SGR repeal.

Further, the current Medicare payment system contributes to fragmentation of care and higher costs by undervaluing critically-important primary, preventive and care coordination services, by creating payment "silos" between physicians and hospitals and among physicians themselves, and by aligning payments with the volume of services provided rather than the value of those services to patients.

Repeal of the SGR is essential, and we are hopeful that it can be achieved this year. But repeal of the SGR alone will not move Medicare to better ways to organize, deliver and pay for care provided to Medicare enrollees.

Accordingly, our testimony will focus on how to get from here to there, from a fundamentally broken physician payment system to one that is based on the value of services to patients, including immediate and longer-term steps that build upon successful physician-led initiatives in the private and public sectors.

PRINCIPLES TO CREATE A TRANSITIONAL VALUE-BASED PAYMENT INITIATIVE

ACP believes that steps can be taken over the next 1-5 years, while providing physicians and patients with a necessary period of stable payments, to start more physicians on the road to better payment models, and reward "early adapters" who already have taken the leadership and risk of participating in new value-based payment and delivery models. During such a transitional period, we propose that physicians receive higher updates for demonstrating that they have successfully participated in an approved transitional quality improvement (QI) or value-based payment program (VBP). We begin by offering the following principles for developing a transitional QI/VBP program, and then we provide an assessment of specific physician-led models that could be incorporated into such a transitional QI/VBP program:

1. ACP supports in concept the idea of providing an opportunity for performance based updates based on successful participation in an approved Transitional QI/VBP initiative that meets standards relating to the effectiveness of each program, building on successful models in the public and private sectors.

2. Transitional performance based update programs should be incorporated into a broader legislative framework to stabilize payments and transition to new models. This is important so that physician and the Medicare program have a clear "destination" and pathway to achieving it, even as physicians begin the journey through the transitional QI/VBP initiative.

3. The transitional QI/VBP program should include models for which extensive data and experience already exist, and that can more readily be scaled up for broader adoption by Medicare. Specifically, participation in the Patient Centered Medical Home (PCMH) and Patient-Centered Medical Home Neighborhood (PCMH-N) models, as determined by practices meeting designated standards through a deemed accreditation body and/or standards to be developed by the Secretary with input from the medical profession. Participation in other established models that have demonstrated the potential to improve care coordination, such as Accountable Care Organizations (ACOs), bundled payments, and global primary care payments should also be considered for inclusion in a transitional QI/VBP program. In addition, physicians who agree to incorporate programs, like ACP's High Value, Cost-Conscious Care Initiative, into their clinical practice through shared decision-making with patients, might also qualify for a transitional QI/VBP payment. We discuss these initiatives in more detail later in our testimony.

4. Existing QI/VBP payment models—the Medicare PQRS, e-RX, and meaningful use programs—if included in a transitional performance-based payment update program, should be improved to harmonize measures and reporting to the extent possible and to establish a consistent incentive program across all-elements. Efforts should also be made to align them with specialty boards' maintenance of certification programs. Later in our testimony, we provide specific recommendations on leveraging and improving such programs.

5. Transitional performance based updates could be tiered so that programs that provide coordinated, integrated and patient-centered care get a higher performance update than less robust programs build on the current, silo-ed fee-for-service system.

6. Performance-based payment updates should be in addition to a higher "floor" on payments for undervalued primary care/preventive/and coordinated care services, not limited by physician specialty, so that any physician who principally provides such undervalued services could qualify for the higher update. This is important to address the continued under-valuation of these critically important services, even as payments also begin to reflect physician participation in the transitional QI/VBP initiative.

7. For a transitional QI/VBP program to be effective, in improving quality, CMS will need to improve its ability to provide "real time" data to participating physicians and practices. A method will need to be created to map practice-level participation in a transitional QI/VBP initiative to the individual physician updates under the Medicare Physician Fee Schedule.

ACP welcomes the opportunity to work with the Committee and other physician organizations to develop the details of a transitional QI/VBP initiative that builds upon the successful physician-run models, including PCMHs and PCMH-Ns, as discussed later in this testimony.

SPECIFIC PAYMENT AND DELIVERY REFORMS THAT CAN SERVE AS THE BASIS FOR TRANSITIONING TO FUNDAMENTAL REFORM

1. Patient-Centered Medical Home (PCMH)

ACP has joined with other physician organizations in advancing new models of payment and delivery that are centered on patients' needs, including working with the Centers for Medicare and Medicaid Services (CMS), private payers, business, and consumer groups to broadly test the PCMH model, which already is showing success in improving outcomes and reducing costs.

PCMH in the Public and Private Sector

A series of PCMH initiatives are being implemented throughout the public and private sector. In its first year the CMS Innovation Center (CMMI), established by the Affordable Care Act (ACA), has introduced 16 initiatives, involving over 50,000 health care clinicians. CMMI's initial efforts have focused on improving patient safety, promoting care coordination, investing in primary care transformation, creating bundled payment models, and addressing the needs of dual-eligibles. One critical program of the CMMI is the Comprehensive Primary Care Initiative (CPCi), which is collaboration between private and public payers and primary care practices to support patient centered primary care. In this initiative, primary care practices will receive new, public and private funding for primary care functions not included in the fee-for-service payments and will have the opportunity to share net savings generated through the program. Forty-four commercial and State insurers are joining with Medicare to support comprehensive primary care, provided that selected practices demonstrate capabilities aligned with the PCMH model. If successful, CMS has the authority to expand the program throughout Medicare, potentially leading to a sustainable new payment and delivery model for primary care.

In addition to these pilot programs, a number of large insurers have announced their intent to roll the PCMH model out more widely. For instance, in January 2012, Wellpoint, a private insurer covering 34 million Americans with a network of 100,000 primary care doctors, publicly announced its decision to invest in the medical home model across its entire network. Aetna, another large private health plan insuring more than 18 million Americans with a network of 55,000 primary care doctors, also recently announced a PCMH program roll-out in Connecticut and New Jersey, with expectations to expand the program nationally in 2012. And, building on a large medical home pilot project already underway, UnitedHealthcare, insuring 34 million Americans, announced in February 2012 an expansion of its value-based payment model, affecting between 50 percent and 70 percent of its customers. Numerous Blue Cross Blue Shield (BCBS) plans across the U.S. have been leaders in their respective marketplace, with over 4 million BCBS members in 39 states currently participating in some version of a PCMH initiative. For example, Care First, the BCBS affiliate in the Maryland/DC area, has implemented the PCMH model within over 75 percent of its participating primary care practices.

These private insurers have made the decision to roll the PCMH model out based on their experience to date with pilot programs, as well as the substantial evidence that health systems with a strong primary care foundation

deliver higher-quality, lower-cost care overall and greater equity in health outcomes.[1] Taking this a step further, research also shows that patient-centered primary care is best delivered in a medical home.[2] Although peer-reviewed academic studies evaluating the medical home model in its full implementation are still limited[3,4,5] there is much to be learned from the numerous PCMH evaluations that have considered individual components of the PCMH model in specific settings, including a recent Institute of Medicine report that evaluated methods of care for those who are chronically ill.[6] One compelling indication of the value of PCMHs in improving outcomes and lowering costs is the simple fact that so many large, private sector payers have embraced the PCMH model, scaling it up to make PCMHs widely available to their subscribers, with many of them are reporting substantial costs savings as a result.

Scaling Up the PCMH Model

ACP believes that the PCMH model has advanced enough that it could be scaled up for widespread implementation throughout Medicare in the immediate future. The growing amount of experience in both the public and private sectors on how to organize care around PCMHs, the thousands of physician practices that already achieved certification or accreditation as a PCMH, and the growing amount of data on its effectiveness in improving care and lowering costs, makes it a logical model to scale up to the broader Medicare program. **This could be done, for instance, by providing higher Medicare payments to physician practices that have achieved recognition by a deemed private sector accreditation body.** At a subsequent stage, PCMH performance metric could be added and incorporated into Medicare payment policies.

At the same time, ACP recognizes that there are challenges to the PCMH model. Some of these include:

- The need for care coordination across settings and the continuum of patient care. ACP has taken a leadership role in helping to address this challenge through our work on the development of the PCMH-Neighborhood model, which is discussed below.
- Related to the issue of care coordination is the lack of real- or near-time data being provided to practices on their patients, which makes it extremely challenging for them to provide proactive, patient-centered care. This is exacerbated by the lack of effective data and information sharing across sites of care. ACP has been deeply involved in the national policy issues surrounding the use of health information technology to facilitate effective clinical data sharing—including the EHR Incentive Program as initiated with the HITECH act. In our most recent comments on the notice of proposed rulemaking from both CMS[7] and ONC[8] on Stage 2 Meaningful Use, we highlighted our support of the government's vision to use EHRs and health IT to improve care, but believe that more needs to be done to align the measures across all of the initiatives currently underway including CMS PQRS and e-prescribing programs. While CMS has made strides in aligning the measures, at a high level the technical requirements in each of the programs are different enough that dual processes must be undertaken. We are also concerned about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, e-Prescribing Incentive Program, and Physician Quality Reporting System (PQRS) by requiring that the

---

[1] Johns Hopkins Bloomberg School of Public Health. Publications of the bureau of primary health care and primary care policy center. (2012). Available at: http://www.jhsph.edu/pcpc/publications.html.
[2] Commonwealth Fund (2012, March 12). Patient-Centered Coordinated Care. Program Description. http://www.commonwealthfund.org/~/media/Files/Programs/2012/Program%20PDFs/2011_PatientCentered_Coord_Care_with_caption.pdf.
[3] Peikes, D., Genevro, J., Scholle, S. H., Torda, P. (2011, Feb). The patient-centered medical home: Strategies to put patients at the center of primary care. Agency for Healthcare Research and Quality. AHRQ No. 11-0029. Rockville, MD. Retrieved from http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_tools__resources_patient-centered_v2.
[4] Jaén C. R., Ferrer R. L.,, Miller W. L., Palmer R. F., Wood R, Davila M, et al. (2010, May 1). Patient outcomes at 26 months in the patient-centered medical home national demonstration project. Ann Fam Med, 8(1 Suppl):S57–S67; S92.
[5] Reid, R. J., Coleman, K., Johnson, E. A, Fishman, P. A., Hsu, C., Soman, M. P., Trescott, C. E., et al. (2010, Mar) The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. *Health Affairs*, 29(5):835–43.
[6] Institute of Medicine. (2012). *Living well with chronic illness: A public health call to action.* Washington, DC: National Academy Press.
[7] These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf.
[8] These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf.

activity to avoid the penalty must be completed in the prior year or even two years in advance of the legislated deadline. As a result, CMS has effectively moved up the legislated deadline beyond what the market can bear. More about ACP's effort to facilitate the adoption of health IT will be addressed below.

- Practices that are trying to transform and that are actively engaging in or pursuing PCMH recognition/accreditation, meaningful use for their electronic health records, e-prescribing, etc. also struggle when they do not receive timely payments from their payers for these activities.
- Finally, in many cases practices are transforming to provide services to their patients in line with the PCMH model, but are only paid to do so for a subset of their patient population (e.g., Wellpoint and Aetna are paying them a per member per month payment for their beneficiaries, but they are not receiving payment from CMS for their Medicare patients). This issue is being addressed in some areas of the country, particularly those that were selected to participate in the CPCi, discussed above, but many other practices across the country are not being "made whole" in terms of payment for the work they are doing.

The Role of the PCMH in a Post-SGR Environment

Given all of the federal, state, and private sector activity described above, as well as ongoing efforts to address the challenges that have been discussed, it is reasonable to expect that the PCMH model will be ready to be a part of a new, value-based health care payment and delivery system. Under this model, practices that provide comprehensive primary care to their patients will be:

- Paid differently, including:
  - A periodic (e.g., monthly, quarterly) care management fee to allow them to strengthen their capacity to provide comprehensive, patient-centered care. This fee could go toward additional staffing, infrastructure, health information technology, and/or otherwise uncompensated physician and staff time.
  - A potentially revised, improved, and/or expanded set of fee-for-service evaluation and management codes that better incorporate physician and staff non-face-to-face time when providing care management and care coordination services.
  - Shared savings based upon improved quality of care and better patient outcomes.
- Organized differently, in order to:
  - Deliver proactive, timely preventive care to their patients.
  - Provide 24/7 access to their patients through online interactive tools, data, and information.
  - Actively engage patients, their families, and their caregivers in their health care.
  - Provide comprehensive care management services to their patients, particularly those with high health care needs (e.g., multiple chronic conditions).
  - Coordinate care across their patients' medical neighborhoods by acting as the first point of contact and working collaboratively with the team of clinicians involved in their patients' care.
- Measured differently, via measures that are focused on:
  - Delivery of patient-centered care, which could be determined by recognition from a national "patient-centered medical home" program such as the Accreditation Association for Ambulatory Health (AAAH), the Joint Commission, NCQA, URAC, or a state-based accreditation program; and/or by criteria developed by the Secretary of HHS that may pull from the national programs, current CMS Innovation Center Initiatives (e.g., the Comprehensive Primary Care Initiative), or other sources.
  - Delivery of high quality and efficient care – potentially looking to the core measures recommended by the PCMH Evaluators' Collaborative established by the Commonwealth Fund[9], which includes measures in the following domains: clinical quality (process and outcome), utilization, cost and patient experience of care.

---

[9] Rosenthal MB. Abrams MK. Biton A. et. al. Recommended core measures for evaluating the patient-centered medical home: Cost, utilization and clinical quality. Commonwealth Fund. May 2012. http://www.commonwealthfund.org/~/media/Files/Publications/Data%20Brief/2012/1601_Rosenthal_recommended_core_measures_PCMH_v2.pdf

- Delivery of coordinated care, which could be determined, in part, by recognition of non-primary care practices through the Specialty Practice Recognition program currently being developed by NCQA for release in spring, 2013. This program will assess a specialty/subspecialty practice's ability to integrate/coordinate with primary care practices, and engage in processes to deliver patient centered care, improved patient access, improve care quality and implementation of "meaningful" health information technology.
    - In addition, the Agency for Healthcare Research and Quality (AHRQ) has available an atlas of care coordination measures; [10] and
    - The National Quality Forum (NQF) has established a platform for the development of care coordination measures consisting of a set of domains, principles and preferred practices. [11]

Measures and measure strategies should be thoughtfully aligned with – and where possible leverage – the regular practice assessment, reporting and quality improvement activities that individual physicians already are required to undertake as part of their specialty board Maintenance of Certification (MOC). For example, the American Board of Internal Medicine (ABIM), which is the largest of the certifying boards, includes in its MOC program a suite of quality measurements, reporting and improvement tools specifically focused on patient-centered primary care/specialist communication, and will soon introduce a care coordination module developed by several of the experts who also helped shape the Medical Neighbor concept, described below. Aligning PCMH/N practice accreditation standards with professional MOC assessment and improvement activities will send a powerful signal to physicians about the significance of the PCMH model, reduce redundant reporting requirements and facilitate participation by smaller practices.

2. ***Patient-Centered Medical Home – Neighborhood***

The importance of involvement of the "medical neighborhood" to the ultimate success of the PCMH model to fully achieve its quality and efficiency goals has been highlighted by recent policy papers by ACP [12] and the Agency for Healthcare Quality and Research (AHRQ).[13] Specialty and subspecialty practices, hospitals, and other health care professionals and entities that provide treatment to the patient need to be recognized and provided with incentives—both non-financial and financial—for engaging in patient-centered practices that complement and support the efforts of the PCMH to provide high quality, efficient, coordinated care. The above cited College policy paper outlines a model using care coordination agreements to promote a functioning PCMH-Neighborhood. Reciprocal recognition of professional MOC standards and activities that focus on these same skills and systems, including implementation of such agreements, is a potent lever.

The NCQA, acknowledging the importance of the involvement of the "medical neighborhood" in support of PCMH (primary) care, is in the process of developing a "medical neighbor" recognition process that identifies specialty and subspecialty practices that engage in activities supportive of the PCMH model—with particular emphasis on care coordination and integration. This decision was made following the conclusion of a comprehensive feasibility study in which this concept was strongly supported by multiple health care stakeholders—including physician groups, employers, health plans, state and federal payers, and patient advocates. In addition, the American Board of Internal Medicine and the NCQA are, collaborating to align aspects of Maintenance of Certification and the new "medical neighbor" recognition process.

---

[10] Agency for Healthcare Research and Quality. Care Coordination and Measures Atlas. Accessed at http://www.ahrq.gov/qual/careatlas/

[11] NQF. Preferred practices and performance measures for measuring and reporting care coordination. 2010. Accessed at http://www.qualityforum.org/Publications/2010/10/Preferred_Practices_and_Performance_Measures_for_Measuring_and_Reporting_Care_Coordination.aspx

[12] American College of Physicians. The patient centered medical home neighbor: The interface of the patient centered medical home with specialty/subspecialty practice. 2010. Accessed at http://www.acponline.org/advocacy/where_we_stand/policy/.

[13] Agency for Healthcare Research and Quality (AHRQ). Coordinating care in the medical neighborhood: Critical components and available mechanisms. 2011. Available at http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/what_is_pcmh.

Efforts to promote processes to coordinate care between primary care practices and the other physicians and health care professionals providing treatment to the patient have been an integral part of both private and public integrated care systems (e.g. Kaiser, Department of Veterans Affairs) and are an important component of the developing Accountable Care Organization (ACO) models. This new NCQA program, and similar efforts, can serve to encourage specialty/subspecialty practices and other "neighborhood" health care entities currently not involved within an integrated system—settings in which most care is currently being delivered—to implement these important processes. This is already happening in several areas of the country. For example:

- The Vermont Blueprint for Health program is implementing a program in which medical home and related, anchored subspecialty practices engaging in efficient, integrative processes will be sharing a monthly care coordination fee for the treatment of COPD, CHF, diabetes, and asthma.
- The Texas Medical Home Initiative will require participating primary care practices to establish care coordination agreements with their most frequently referred to specialist and hospital settings.
- Programs in both the Denver and Grand Junction areas of Colorado are in the process of implementing "medical neighborhood" programs that promote increased integration among primary and specialty care practices.

INCORPORATING HIGH VALUE CARE INTO PAYMENT POLICIES

Medical specialty societies, including ACP, are taking a leading role in developing and implementing programs to improve the value of care provided to patients. These programs could also be considered for incorporation into a value-based payment model.

ACP's High Value, Cost-Conscious Care Initiative (HVCCC), which includes clinical, public policy, and educational components, [14] was designed to help physicians and patients understand the benefits, harms, and costs of an intervention and whether it provides good value, as well as to slow the unsustainable rate of health care cost increases while preserving high-value, high-quality care.

For the clinical component of the HVCCC Initiative, ACP has released materials focused on three areas: low back pain, oral pharmacologic treatment of type 2 diabetes, and colorectal cancer. Furthermore, as part of this initiative, ACP convened a workgroup of physicians that identified, using a consensus-based process, 37 common clinical situations in which screening and diagnostic tests are used in ways that do not reflect high-value care.[15] Furthermore, on July 10, ACP and the Alliance for Academic Internal Medicine (AAIM) unveiled a high-value, cost-conscious care curriculum to help train internal medicine residents about how to avoid overuse and misuse of tests and treatments that do not improve outcomes and may cause harm. The free curriculum, available at www.highvaluecarecurriculum.org, is designed to engage internal medicine residents and faculty in small group activities organized around actual patient cases that require careful analysis of the benefits, harms, costs, and use of evidence-based, shared decision making. The flexible curriculum consists of ten, one hour interactive sessions that can be incorporated into the existing conference structure of a program.

ACP has also joined other leading professional medical organizations in the Choosing Wisely campaign,[16] which complements our HVCCC Initiative. An initiative of the ABIM Foundation, the goal of the Choosing Wisely campaign is to promote thoughtful discussions among physicians, patients, and other stakeholders about how to use health care resources to improve quality of care. In April 2012, ACP unveiled our list of "Five Things"[17] internists and patients should question in internal medicine.

---

[14] Additional information can be found at: http://www.acponline.org/clinical_information/resources/hvccc.htm.

[15] Qaseem A, Alguire P. et al. Appropriate Use of Screening and Diagnostic Tests to Foster High-Value, Cost-Conscious Care. *Ann Intern Med.* 2012;156:147-149. Accessible at http://www.annals.org/content/156/2/147.full.pdf+html?sid=10a2df33-7fa3-45c1-a01d-dc7ecd1b9f6c

[16] More information on this initiative can be found at: http://choosingwisely.org/.

[17] This document can be found at: http://choosingwisely.org/wp-content/uploads/2012/04/5things_12_factsheet_Amer_College_Phys.pdf.

On April 19, ACP and Consumer Reports announced a new collaborative effort to create a series of *High Value Care* resources to help patients understand the benefits, harms, and costs of tests and treatments for common clinical issues. The resources will be derived from ACP's evidence-based clinical practice recommendations published in *Annals of Internal Medicine*. The initial pieces of the *High Value Care* series will be two patient brochures about diagnostic imaging for low back pain and oral medications for type 2 diabetes. The *High Value Care* resources will be available on the websites of ACP (ACPonline.org), Consumer Reports (ConsumerReports.org), and *Annals of Internal Medicine* (Annals.org).[18]

Programs like ACP's HVCCC initiative could be supported by Medicare payment policies by: (1) reimbursing physicians appropriately for spending time with patients to engage them in shared decision-making based on the recommendations from those programs and similar efforts by other specialty societies and (2) developing a way to recognize, with higher payment updates, physicians who can demonstrate that that they are incorporating such programs into their practices and engagement with their patients. For instance, under a transitional VBP program, physicians might qualify for higher updates if they can demonstrate that they have a plan to use evidence-based guidelines on high value care, developed by their own professional societies, to inform, educate and engage patients in shared decision-making on clinical treatment options. The goal would be to provide ongoing structural payment support to such physicians and patients in shared decision-making based on the guidelines, not to link payment for any specific test or procedure to the clinical guidelines.

IMPROVING MEDICARE FEE-FOR-SERVICE TO SUPPORT CARE COORDINATION

Even as new models of payment are being evaluated, and some like the PCMH scaled up more broadly through the program in the near-term, Medicare fee-for-service (FFS) will continue to be the principal way that most doctors will be reimbursed for at least the next several years. In addition, FFS is an element of other payment and delivery models, including PCMHs and ACOs. Consequently, it is important to make FFS improvements to recognize and support the value of coordinated care.

Specifically, ACP support the development and recognition under Medicare fee-for-service payment of two new CPT codes—(1) for chronic, complex care and (2) transition care following a facility-based discharge. These new codes have been developed by a CPT Panel workgroup and approved by the CPT Editorial Panel during their May 2012 CPT Meeting. These codes are currently undergoing a survey process in order to be assigned recommended values by the Relative Value Update Committee (RUC), and then receive a final valuation by the Centers for Medicare and Medicaid Services (CMS). These codes are designed to allow physicians to report their non-face-to-face time, and the clinical staff (team) time spent on patient cases—an important element of the overall Patient Centered Medical Home (PCMH) model, which was discussed above The College is also encouraged by the inclusion of a similar new transition of care code applicable to post-hospital discharge situations in the recently released Medicare 2013 Physician Fee Schedule proposed rule.

LEVERAGING EXISTING QUALITY IMPROVEMENT/VALUE BASED PAYMENT MODELS

Physicians with a demonstrated commitment to quality and efficiency, who are not able to participate in the more comprehensive models during the transitional period and possibly in the longer term, could be offered the ability to receive incentives for their participation in existing programs, such as meaningful use (MU), the physician quality reporting system (PQRS), and e-prescribing (eRX), and by harmonizing such programs with specialty boards' practice improvement programs.

Major improvements in the MU, eRx, and MU programs are needed, though, if they are to be part of a transitional VBP program. Currently, there is no true alignment among these programs in their measures, reporting requirements and payment incentives. CMS has been unable to provide timely feedback to physicians regarding whether they are successfully satisfying program requirements, leading to frustration and distrust. ACP has been deeply involved in the national policy issues surrounding the use of health information technology to facilitate

[18] More information on this effort can be found at: http://www.acponline.org/pressroom/high_value_care_ed_materials.htm.

effective clinical data sharing—including the EHR Incentive Program as initiated with the HITECH act. In our most recent comments on the notice of proposed rulemaking from both CMS[19] and ONC[20] on Stage 2 Meaningful Use, we highlighted our support of the government's vision to use EHRs and health IT to improve care, but believe that more needs to be done to align the measures across all of the initiatives currently underway including CMS PQRS and e-prescribing programs. While CMS has made strides in aligning the measures, at a high level the technical requirements in each of the programs are different enough that dual processes must be undertaken. We are also concerned about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, e-Prescribing Incentive Program, and Physician Quality Reporting System (PQRS) by requiring that the activity to avoid the penalty must be completed in the prior year or even two years in advance of the legislated deadline. As a result, CMS has effectively moved up the legislated deadline beyond what the market can bear.

In addition, ACP recommends that measures and measure strategies be thoughtfully aligned with – and where possible leverage – the regular practice assessment, reporting and quality improvement activities that individual physicians already are required to undertake as part of their specialty board Maintenance of Certification (MOC).

SUGGESTIONS ON A LEGISLATIVE FRAMEWORK TO TRANSITION TO BETTER PAYMENT MODELS

This statement provides sufficient evidence that enough progress is being made to develop, implement, and evaluate new payment and delivery models to serve as the basis for replacing the SGR. **Getting from here to there, though, will require that Congress enact a legislative framework to eliminate the SGR, stabilize payments during a transition phase, evaluate and implement new models, and specify a pathway and timetable to such models.**

Specifically, ACP envisions two phases in the SGR reform process. During the first stage, Medicare would stabilize and improve payments under the current Medicare fee schedule for at least the next five years by eliminating the SGR as a factor in establishing annual updates and by ensuring higher payments and protection from budget neutrality cuts for undervalued primary care, preventive and care coordination services.

During stage two, physicians would be given a set timetable to transition their practices to the models that Congress and the Department of Health & Human Services (HHS) have determined to be most effective based on experience with the payment/delivery system models evaluated during stage one, leading to permanent replacements to the existing Medicare payment system. ACP supports full testing of models including the patient-centered medical home and the patient-centered medical home neighborhood, Accountable Care Organizations, and other models that meet suggested criteria for value to patients. We recommend the development of different payment initiatives for different specialties and types of practice, rather than a "one-size-fits-all" model for all physicians.

The Physician Payment Innovation Act of 2012, H.R. 5707: Reps. Allyson Schwartz (D-PA) and Joe Heck (R-NV) recently introduced legislation, consistent with ACP's core principles above, outlines the pathway to full SGR repeal and implementation of new value-based models of care that focus on quality of care, as opposed to volume of care, as occurs under the current payment system.

H.R 5707 achieves five key policy goals: it repeals the Sustainable Growth Rate (SGR), it eliminates a nearly 30 percent cut on January 1, 2013, it stabilizes payments through 2018 with no cuts for the next six years and positive updates to all physicians during 2014 -2017 and then extend 2017 rates through 2018, it provides higher updates for undervalued primary, preventive, and coordinated care services, whether delivered by primary care physicians or by other specialists, accelerates development, evaluation, and transition to new payment and delivery models, developed with input by the medical profession and external validation.

---

[19] These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf.
[20] These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf.

ACP recognizes that there may be variations on the framework proposed by H.R. 5707 that could achieve the same goals of eliminating the SGR, stabilizing payments, recognizing the importance of improving payments for undervalued primary, preventive and coordinated care services, and establishing a clear pathway to patient-centered, value-based models. We are open to discussion of how best to achieve a transition consistent with the above goals, while recognizing that H.R. 5707 is the first and only bipartisan bill that we are aware of that translates the above critical policy goals into a practical legislative framework.

SUMMARY AND CONCLUSION

Based upon our above responses, the College specifically recommends that:

1. Congress and the Medicare program should work ACP and other physician organizations to develop a transitional QI/VBP initiative, which would provide higher updates to physicians who successfully participate in a transitional QI/VBP initiative, consistent with the principles discussed above.

2. Congress should look to the PCMH as being one of the most promising models for improving outcomes and lowering costs; learning from the extensive and growing experience in the private sector and through the CMS Innovation Center, as well as from private sector recognition and accreditation programs. We are confident that the PCMH model, and the related PCMH-Neighborhood, can be scaled up in the more immediate future, as part of a transition to better payment and delivery systems to replace the SGR and pure fee-for-service.

3. Congress and CMS should work with the medical profession on reducing barriers to the PCMH model, including facilitating the coordination of care among physicians and across settings; facilitating the use of health IT in meaningful ways; aligning the multiple federal initiatives with the goal of health care transformation, including timely payment to those physicians that meet the requirements of these initiatives; recognizing existing professional quality reporting and improvement activities where applicable, and facilitating participation in these initiatives by all payers.

4. Medicare should adopt payment policies that support the efforts by ACP and other physician membership organizations to provide guidance to physicians on high-value, cost-conscious care, including payment policies to support shared decision-making strategies to engage patients in making decisions with their physician on their care, informed by evidence on value and effectiveness.

5. Medicare should make improvements in the existing Medicare physician fee schedule to create incentives for care coordination.

6. Congress could provide incentives to physicians, who are not able to participate in comprehensive models as they transition to new payment delivery systems, which participate in existing programs such as meaningful use, PQRS, and e-prescribing (eRX), and by harmonizing such programs with specialty boards' practice improvement programs.

7. The Senate Finance Committee should report legislation to repeal the SGR, provide stability in payments for all physicians, higher updates for undervalued care coordination, preventive, and primary care services, and transition to new payments and delivery models, working from the bipartisan Medicare physician Payment Innovation Act, H.R. 5707.

The College appreciates the opportunity to share our observations, experiences and recommendations on how Congress can work with ACP and others in the medical profession to advance comprehensive, patient-centered, and value-based payment and delivery system reforms that build upon successful physician-led quality improvement initiatives in the private and public sectors.