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THE NEED TO MOVE BEYOND THE SGR

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

MAY 5, 2011

Serial No. 112–46

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THE NEED TO MOVE BEYOND THE SGR

THURSDAY, MAY 5, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:04 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Murphy, Gingrey, Lance, Cassidy, Guthrie, Barton, Upton (ex officio), Pallone, Dingell, Capps, Baldwin, and Waxman (ex officio).

Also present: Representatives Harris and Christensen.

Staff present: Allison Busbee, Legislative Clerk; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Debbee Keller, Press Secretary; Ryan Long, Chief Counsel, Health; John O'Shea, Professional Staff Member, Health; Heidi Stirrup, Health Policy Coordinator; Stephen Cha, Democratic Senior Professional Staff Member; Alli Corr, Democratic Policy Analyst; Tim Gronniger, Democratic Senior Professional Staff Member; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; Karen Nelson, Democratic Deputy Committee Staff Director for Health, and Mitch Smiley, Democratic Assistant Clerk.

Mr. PITTS. The subcommittee will come to order. The chair recognizes himself for 5 minutes for an opening statement.

OPENING STATEMENT OF JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

The system that is currently used to pay physicians for providing services to beneficiaries in the Medicare System is broken and has been for some time. The dilemma that currently threatens doctors and Medicare beneficiaries alike is all too familiar.

According to the most recent Congressional Budget Office estimate if nothing is done physicians will see reimbursement for services provided to Medicare patients cut by 29.4 percent on January 1, 2012. This will have a disastrous effect on access to care for Medicare beneficiaries. According to surveys by the American Medical Association faced with cuts of this magnitude as many as 82 percent of physicians say that they will need to make significant changes in their practices that will affect access to care.

We have been here before. In fact, we have been in this situation for almost a decade. Since 2002, Congress has acted repeatedly to avert scheduled fee cuts. In 2010 alone Congress passed one—two

1-month overrides, two 2-month overrides, one 6-month override, and most recently for 2011, Congress passed a 1-year override. All this was done without resolving the underlying problem.

Meanwhile, the cost of fixing the problem continues to grow. In March the Congressional Budget Office estimated that the price just to wipe out the accumulated debt and return to the baseline would be $298 billion. This staggering price tag is just one side of the physician payment reform problem. The current payment system is fundamentally flawed, and keeping the current system or making minor adjustments is no longer a viable option. Even maintaining the current system with 0 percent updates through 2020, would cost $275.8 billion.

Too often the discussion around physician payment reform has focused on the deficiencies of the current system and the urgent need to move away from the sustainable growth rate formula without a clear vision of the kind of system we want to replace it with.

Essentially, all of us agree on the need for a new payment system, and there are a lot of good ideas about what an ideal payment system should look like. The witnesses that are participating in today's hearing bring a wealth of knowledge on this issue, and some of them have personal experience in design and administration of innovative systems.

I want to thank the distinguished panel of experts that have taken the time to testify today. I am encouraged that this hearing will go beyond merely describing the deficiencies of the current SGR System and will lead to a productive discussion of how we move to a system that reduces the growth in healthcare spending, preserves access to care for Medicare beneficiaries, and pays providers fairly based on the value, not the volume of their services.

[The prepared statement of Mr. Pitts follows:]

Rep. Joseph R. Pitts
Opening Statement
Energy and Commerce Subcommittee on Health
Hearing on "The Need to Move Beyond the SGR"
May 5, 2011

The system that is currently used to pay physicians for providing services to beneficiaries in the Medicare system is broken, and has been for some time. The dilemma that currently threatens doctors and Medicare beneficiaries alike is all too familiar.

According to the most recent Congressional Budget Office estimate, if nothing is done, physicians will see reimbursement for services provided to Medicare patients cut by 29.4% on January 1, 2012. This will have a disastrous effect on access to care for Medicare beneficiaries.

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Even maintaining the current system with zero percent updates through 2020 would cost $275.8 billion dollars.

Too often, the discussion around physician payment reform has focused on the deficiencies of the current system and the urgent need to move away from the Sustainable Growth Rate formula without a clear vision of the kind of system we want to replace it with.

Essentially all of us agree on the need for a new payment system and there are a lot of good ideas about what an ideal payment system should look like. The witnesses that are participating in today's hearing bring a wealth of knowledge on this issue and some of them have personal experience in the design and administration of innovative systems.

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Mr. PITTS. And I yield the remaining time to the vice chair, Dr. Burgess.

OPENING STATEMENT OF MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Well, thank you, Mr. Chairman, and actually I really mean this. Thank you for holding this hearing. It has been way too long. As I was telling one of our witnesses I was 20 pounds lighter and a lot less gray the last time we held a hearing on Medicare physician payment.

I am also so relieved that we have five doctors on the panel. It seems like every time we have done this in the past all we have are economists and lawyers, so doctors, welcome, and we know it is past time for action. I want to do my part to ensure that Medicare beneficiaries can continue to see their doctor, but it is just not going to happen if we don't fix this problem.

Repeal is expensive, so stipulated, but it is also critical to the future for America's patients. Let us all accept the premise that it has—the SGR has to go, and this morning we are here to hear our witnesses focus on their solutions.

I have always thought you start with a relatively simple question, what does it cost to—for a doctor to provide the service, and then you build in a reasonable profit for participation and coordination. But today we send all the wrong messages to our doctors. We say work harder and faster, deal with weekly expansions of services and regulations of the CMS, none-physician bureaucrats will tell you how to practice and will do more so, in fact, under the President's new healthcare law, we are going to hold your checks, but we need you to take more patients. Practice costs are rising but don't expect us to help you meet your costs, and oh, by the way, a 30 percent pay cut in December.

Is it any wonder that the country's physicians are fed up? We do need a true path forward. There may be three congressional committees who have a say on this issue, but it is this committee, the Committee on Energy And Commerce and the Subcommittee of Health, where the solution needs to come to life.

I am a fee-for-service doctor. I always practiced that way. I will admit it has its problems but so does linking payment rates to definitions of quality set by non-physicians. You need only look at the ACO regulations that recently came out of CMS. We have been testing models for years, and we have had multiple demonstration projects, but, look. Here is the bottom line. If we get to December, and we are doing an extension, that is a failure on our part. We need a permanent solution that is predictable, updatable, and reasonable for this year, and nothing else will do.

Thank you, Mr. Chairman. Before I yield back my time can I ask unanimous consent that Dr. Harris, who is not a committee member, be allowed to sit at the——

Mr. PITTS. Without objection.

Mr. BURGESS. Thank you.

Mr. PITTS. So ordered. The chair thanks the gentleman and recognizes the distinguished ranking Member of the subcommittee, Mr. Pallone, for 5 minutes.

OPENING STATEMENT OF FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman. I am pleased we are having a hearing in the Health Subcommittee on something other than repealing the Affordable Care Act, so I commend you for that initially. I would also like to thank you for your willingness to approach today's critical issue in a bipartisan manner, and it is my hope that we move forward in a bipartisan manner in the future on this issue.

Today's hearing is appropriate because we really must move beyond the sustainable growth rate in Medicare's payment policy. It is unstable, unreliable, and unfair, and we really must move beyond legislating SGR policy in month-long intervals. You know, I know last December when we passed the 1-year fix it was the twelfth time we had passed a patchwork bill in the last decade and the sixth time in 1 year alone.

So I am not saying whose fault that is, but the fact of the matter is we need to stop kicking the can down the road. It is not fair to our Nation's seniors, and it is not fair to our Nation's doctors. It is a game of chicken that I think drives physicians out of Medicare and makes it harder for seniors to see a doctor.

So the question remains how do we fix it. The Democrats made an attempt when the House of Representatives considered and passed H.R. 3961, the only bill intended to permanently eliminate the large cuts required under the SGR that was ever passed by either body of Congress since the creation of the SGR in 1997. That bill would have reset the spending targets of the SGR and eliminated the accumulated deficit that generates the large annual cuts. It also would have set more realistic growth targets and promoted coordinated care by incentivizing accountable care organizations to control costs, a concept that was also embraced in the Affordable Care Act.

Now, I am not saying that that bill was the perfect approach because nothing is perfect, but it certainly was a solution. Unfortunately, we couldn't get it passed into law, signed by the President. So I don't have a perfect answer, but I know that getting a Medicare program with security and reliability for our seniors is a high hurdle.

In that regard I would like to commend all the provider groups for their thoughtful responses to the committee's requests for comments. If this going to get done, we all need to be engaged, committed, and open-minded, and I look forward to today's hearing and finally tackling this problem, as I said, on a bipartisan basis once and for all.

I would yield now the remainder of my time to the gentleman from Michigan, our ranking Member emeritus, Mr. Dingell.

OPENING STATEMENT OF JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Mr. Chairman, I thank the gentleman, and I commend you for holding today's hearing. We address an intolerable situation that is only going to get worse as time passes.

Each year since 2002, Congress has had to come in and at the eleventh hour prevent cuts to provider services and fees under Medicare. Due to our failure to fix this fatally-flawed payment system, doctors and all other providers have been unable to plan for the future, and the price tag has grown each year, and it is going to continue to do so.

It is very clear to anyone who looks at it that we can no longer kick the can down the road. Last Congress the House passed legislation I introduced, H.R. 3961, which would have repealed the SGR formula, ending the cycle of short-term patches and permanently improving the way Medicare pays its physicians and other providers. While I happen to think that my bill that passed the House last year was a good piece of legislation, I think we should explore all possible proposals, but we should keep in mind we have to get this miserable situation fixed.

I am committed to working with my colleagues on both sides of the aisle, and I look forward to passing a solution to this problem again this Congress. I hope that this time it will become law, because the situation has become intolerable, and we are going to lose both the advantages and the benefits of Medicare as well as the cooperation, the goodwill, and the services of the different providers who are adversely affected by this miserable current situation.

And I yield back to the gentleman from New Jersey the 49 seconds I have.

Mr. PALLONE. Thank you, Mr. Chairman. I don't know if any of my other colleagues would want the time.

If not, I will yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the full committee chairman, Mr. Upton, for 5 minutes.

OPENING STATEMENT OF FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Well, thank you, Mr. Chairman. The opening paragraph of the original 65 Medicare legislation promised that the Federal Government would not interfere in the practice of medicine. This promise extended to government control over the administration of and compensation for medical services.

Today we know the Federal Government through Medicare sets irrational spending targets and administers the prices for more than 7,000 physician services. That is a long way from the original promise.

In spite of the government interference and micro-management, spending in Medicare has continued to grow at a rate that threatens to make the program financially insolvent. In '09, fee-for-service Medicare spent about $64 billion on physician and other health professional services, accounting for 13 percent of total Medicare spending and 20 percent of Medicare's fee-for-service spending.

Clearly something has got to change. Although we cannot afford the current rate of spending on physician services, we also know that if the pending 29.4 percent fee cuts are allowed to go into effect, a large good number of doctors will be forced out of Medicare, and a large number of Medicare beneficiaries will lose their access to care. We are all well aware of the inadequacies of the sustain-

able growth formula as a payment policy, and we are also aware of the budgetary burden that is failing to fix the problem it has caused.

Unfortunately, given the opportunity the President decided that this issue, arguably the greatest threat facing Medicare, if not the entire healthcare system, would be left out of his health reform legislation. Today we begin the chance to correct the omission.

I thank our witnesses for taking time out of their busy schedule. We look forward to your testimony, and I yield my time to Mr. Barton.

[The prepared statement of Mr. Upton follows:]

Opening Statement
Chairman Fred Upton
Subcommittee on Health
Hearing on Medicare Physician Payment
Thursday, May 5, 2011

The opening paragraph of the original 1965 Medicare legislation promised that the federal government would not interfere in the practice of medicine. This promise extended to government control over the administration of and compensation for medical services.

Today, the federal government, through the Medicare program, sets irrational spending targets and administers the prices for more than 7,000 physician services. This is a long way from that original promise.

In spite of this government interference and micromanagement, spending in Medicare has continued to grow at a rate that threatens to make the program financially insolvent. In 2009, fee-for-service (FFS) Medicare spent about $64 billion dollars on physician and other health

professional services, accounting for 13 percent of total Medicare spending and 20 percent of Medicare's FFS spending.

Clearly, something has to change. Although we cannot afford the current rate of spending on physician services, we also know that, if the pending 29.4 percent fee cuts are allowed to go into effect, a large number of doctors will be forced out of Medicare and a large number of Medicare beneficiaries will lose access to care.

We are all well aware of the inadequacies of the Sustainable Growth Rate formula as a payment policy, and we are also aware of the budgetary burden that failing to fix the problem has caused. Unfortunately, given the opportunity, the president decided that this issue—arguably the greatest threat facing the Medicare program, if not the entire health care system—would be left out of his health reform legislation.

Today we have a chance to begin to correct that omission. I thank the witnesses for taking time out of their busy schedules to help us understand how to get to a physician payment system that will not only control spending, but will make sure that what we pay for is of the highest value to the Medicare beneficiary.

Thank you and I yield the balance of my time to ____.

Mr. BARTON. Thank you, Chairman Upton, and we welcome Congressman Harris to the committee. He looks good here and maybe one day he will be here permanently.

OPENING STATEMENT OF JOE BARTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you, Chairman Pitts and Ranking Member Pallone for holding this hearing today. I remember very well back in 2006, when I had—we had lost the majority on the Republican side, but we were in a lame duck session, and Congressman Dingell and Senator Baucus came to me as the chairman at that time and said, let us work right now in the lame duck to fix the SGR. And knowing how difficult it was to do, I said no to that because I wanted them to have the fun of having to fix it.

In retrospect, I should have taken them up on their offer and gone to then-Speaker Hastert and said "Let's get this done while we can," because the problem has only grown worse in the intervening 4–1/2 years. The current system is broke, and you cannot fix it no matter how much we tinker with it.

As Chairman Upton just pointed out, we are going to see a decrease in reimbursement of over 29 percent by next year if we do nothing. The deficit now in the SGR is at approximately $300 billion. That is a big number, even in Washington where we have $3.5 trillion budgets and $1.5 trillion annual deficits. But it is a fixable problem if we really mean it when Mr. Dingell and Mr. Pallone and Mr. Waxman say the same general things as Mr. Upton and Mr. Pitts and people like myself.

So, Mr. Chairman, it is good that you are having this hearing. The last time we had a hearing of this sort I was chairman of the full committee. The problem was big then. It is bigger now, but if we work together, we can fix it, and I hope that in this Congress on a bipartisan basis we can do that.

With that I want to yield the balance of my time to Dr. Gingrey. He has some comments he would like to make.

Mr. GINGREY. Mr. Chairman, I thank the former chairman of the committee for yielding to me.

OPENING STATEMENT OF PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

On the first day of 2012, physicians face a 30 percent cut if we don't fix the current Medicare Physician Payment System. This is a problem that Congress created, and this is a problem that I expect Congress, not Republicans, not Democrats, but Congress to fix.

Dr. McClellan, in the past you have been gracious enough to offer your insight on this issue to the GOP Doctors' Caucus. Several of us on this panel are members. Dr. Murphy is and I am, and we co-chair this caucus. We want to thank you for those efforts.

As you know, the GOP Doctors' Caucus has been discussing potential SGR reform since the last Congress. We continue to explore ideas that might help solve the problem, including private contracting, allowing more flexibility in physician payment models, and encouraging greater quality measurements so that we might lead to a greater outcome for patients.

We look forward to continuing that work and working relationship with you and all of our witnesses today.

I also want to thank personally my good friend, Dr. Todd Williamson from the great State of Georgia, in fact, former president of the Medical Association of Georgia. Todd, it is great to see you as a witness before the committee again today, and with that, Mr. Chairman, I yield back.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the ranking member of the full committee, Mr. Waxman, for 5 minutes.

OPENING STATEMENT OF HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman. I would like to start by acknowledging and welcoming the bipartisan interest in addressing the ongoing problem Medicare has in providing stability to support patient access to doctors. Too often we have been forced to the edge of the brink only to scramble at the last minute to avoid drastic cuts that would jeopardize access for Medicare beneficiaries and the military families under TRICARE. This is unacceptable to our physicians, to their patients, and to Medicare, and we have to find a better way.

Whatever virtues the SGR had when it was created 14 years ago, and even then I didn't see much in it, I voted against it, it is clear that they have vanished. Six times in the last 2 years the Congress has had to pass legislation blocking fee cuts of up to 21 percent or more, and cuts of that magnitude go to the very core of the program and would threaten the ability of seniors and persons with disabilities to see their doctors.

Democrats in the last Congress, in the House, passed the only bill ever by either body that would permanently solve the SGR problem. It did not become law. That is why we repeatedly worked to pass short-term patches to block the SGR. But that is not the way to solve the problem. It is essential that we find another way to get this done.

But it is not enough to fill in the budgetary gap created by the SGR. We must work towards a new way of paying for care for physicians and all providers that encourages integrated care. We want patients to trust that their physicians are talking to each other, they are talking to their pharmacy, hospitals, and other providers about how to take care of the problems that exist and to prevent problems before they even arise.

We want to achieve all three of the goals Dr. Berwick talks about; improving care for individuals, improving care for populations, and reducing costs. Right now the way we pay for care doesn't always support these goals.

The Affordable Care Act makes major strides to improve the way Medicare deals with physicians and other providers. New care models are supported by the ACA, including accountable care organizations and medical homes. Value-based purchasing is pursued across the continuing providers in Medicare, and because we don't know what the payment system of the future will look like, the ACA opens an arena to innovative experimentation and cooperation with the private sector to identify the best path forward.

Many of the physicians associations responded to our request for comments, noted that the Affordable Care Act's opportunities for innovation and expressed a desire to pursue those opportunities in our effort to move beyond Medicare's current fee-for-service system. And I would like to thank them as did Ranking Member Pallone in suggesting different alternatives for us to look at.

I hope that this hearing will not focus narrowly on options that would shift our problems paying for the SGR onto beneficiaries. I know that we do not have any beneficiaries on this panel. I don't know if we have any lawyers. I am pleased we have some doctors, but the beneficiaries have some concerns as well, and I would like to ask unanimous consent to submit for the record a letter from the AARP and the Medicare Rights Center commending the committee's work on the SGR but opposing proposals that would increase cost sharing under the guise of "private contracting."

I hope this hearing will be the beginning of a process that will lead to a permanent solution to provide both stability and better care for Medicare beneficiaries. I earnestly hope we can work together on a bipartisan basis to solve this issue this year.

And, Mr. Chairman, I thank you for this opportunity to make this statement, and I would like that that unanimous consent to put those letters in the record.

Mr. PITTS. Let me see the letters. Do you have a copy of the letters? Let's just take a look at them. The chair thanks the gentleman and would like to thank the witnesses for agreeing to appear before the committee this morning. Your willingness to take time out of your busy schedules underscores just how important this is to all of you as it is to all of us.

On March 28, 2011, the Energy and Commerce Committee sent a bipartisan letter to 51 physician organizations asking for input on reforming the Medicare Physician Payment System. The chair will introduce the responses from the following organizations as part of the permanent record: The American Association of Clinical Endocrinologists, The American Academy of Dermatology Association, the Association of American Medical Colleges, the American Academy of Otolaryngology, AARP, the American College of Obstetricians and Gynecologists, the American College of Rheumatology, the Alliance for Integrity in Medicine, the American Medical Association, the American Academy of Ophthalmology, the American Geriatrics Society, the American Physical Therapy Association, the American Society of Clinical Oncology, the American Society for Clinical Pathology, the American Society of Cataract and Refractive Surgery, the American Society of Gastrointestinal Endoscopy, the American Society of Hematology, the American Society of Plastic Surgeons, the American Urologic Association, the American Academy of Neurology, the American College of Surgeons, the Medical Group Management Association, the American College of Cardiology, the Society of Hospital Medicine, the Society of Nuclear Medicine, and the Society of Thoracic Surgery.

Now, we received a lot of letters the last couple of days. As they are received they will be entered into the record. Have you finished looking at that?

[The information appears at the conclusion of the hearing.]

Without objection your two letters will also be entered into the record.

[The information follows:]

May 4, 2011

The Honorable Fred Upton
Chairman
House Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20510

The Honorable Henry Waxman
Ranking Member
House Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20510

The Honorable Pitts
Chair, Health Subcommittee
House Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20510

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20510

Dear Representatives Upton, Waxman, Pitts, and Pallone:

I am writing to you on behalf of AARP's millions of members and the millions of older Americans and their families who depend upon the Medicare program. We applaud the House Energy and Commerce Committee for addressing the Sustainable Growth Rate (SGR) problem and for seeking solutions to the problem from stakeholders within the health care industry.

As you know, the SGR formula by which Medicare updates its physicians' fees is widely viewed as broken. Yet for more than a decade, Congress has failed to change the system, and the problem continues to grow worse. It has become increasingly more expensive to fix, and the anticipated cuts to doctors continue to grow larger. Unless Congress acts by the end of this year, doctors will see a nearly 30 percent cut in their payments from Medicare. Facing this constant uncertainty and dramatic cuts to their payments, more and more physicians are choosing to no longer take Medicare patients. Our members are concerned they could lose access to doctors if their pay is cut.

Protecting seniors' access to their Medicare doctors is one of AARP's top priorities. We have surveyed our members, and whether they are Democrats, Republicans or Independents, they believe Congress should find a bipartisan, bicameral, fiscally responsible solution that will keep doctors in the Medicare program. They are concerned that they will lose access to their doctors and future retirees won't be able to get the care they need.

Long-Term Versus Short-Term Solution

Rather than address the SGR problem in the long term, Congress has consistently chosen instead to pass short-term band-aid approaches. In 2010, Congress passed five such short-term fixes and, unfortunately in many cases failed to act in a timely manner before enacting legislation to retroactively address the issue. The longer we wait to address the long-term solution to the problem, the more physicians we can expect to leave – or threaten to leave – the Medicare program.

We understand that many provider groups have suggested that Congress enact yet another short-term solution to give lawmakers time to develop a long-term solution to the physician payment problem. We agree that simply enacting short-term solutions with no movement toward a lasting solution is not helpful.

AARP encourages Congress to enact the longest possible resolution to the SGR problem. We believe any solution should aim to emphasize value over volume, and take steps to promote better quality care. Our members believe Congress has a responsibility to keep doctors in Medicare so today's seniors and future retirees can keep seeing the doctors they trust. Seniors deserve the peace of mind that they can find a doctor when they need one.

Private Contracting and/or Balanced Billing

Some Members of Congress and provider organizations have recently suggested relaxing "private contracting" and/or "balanced billing" rules as a potential solution to the physician payment problem. Under current rules, a physician may enter into a private contracting arrangement with a beneficiary and, in such arrangement, the beneficiary agrees to pay 100 percent of the physician's charges for services (under this arrangement, physician charges are typically higher than the Medicare-approved charge for the same service). Some physicians who have private contracting arrangements also charge an additional monthly or annual fee for their services (e.g., concierge medicine). Although such arrangements are possible, Medicare does not cover services provided by physicians who have entered into a private contracting arrangement with Medicare beneficiaries. Physicians who engage in these practices are barred from participating in Medicare for two years; and those who enter into private contracts must do so for all of their Medicare patients (e.g., they are forbidden from picking and choosing patients and/or services they may bill Medicare).

Under current law, Medicare allows for "balance billing" by non-participating providers; however, the program places a limit on how much non-participating physicians may "balance bill" beneficiaries: no more than 15 percent of Medicare's allowed charges. So, for example, nonparticipating physicians are permitted to charge $115 for services for which Medicare would allow physicians to charge only $100.

AARP strongly opposes relaxing the current Medicare rules related to balanced billing and/or private contracting because they would do nothing more than shift costs onto Medicare beneficiaries. Some have estimated that it would cost roughly $330 billion over ten years to "fix" the SGR system. Proponents of these private payment arrangements believe this would give the government fiscal certainty. AARP strongly opposes the idea of allowing physicians to charge beneficiaries whatever they want, which would essentially pass much of the $330 billion cost directly on to Medicare beneficiaries. While this may provide more fiscal certainty to the federal government, it would produce tremendous financial insecurity among those on Medicare, who would have no limits on what their doctors could charge them.

Some balanced billing proposals would allow Medicare beneficiaries to contract with physicians outside Medicare at rates established between the physician and beneficiary. Such proposals blatantly favor the physician and amount to nothing more than physicians dictating payment rates and forcing beneficiaries to accept those rates or seek services elsewhere. This is particularly troubling for those beneficiaries who currently experience problems finding a physician who will treat them.

Both private contracting and balanced billing threaten access to care for beneficiaries who cannot afford to pay the charges physicians impose. Before Medicare was created in 1965, more than half of older Americans were uninsured and they were the population most likely to be living in poverty. Today, about 50 percent of Medicare beneficiaries have incomes below $22,000. The average older person already spends about one third of his/her income on health care. These individuals cannot afford to pay more out-of-pocket for physicians' services. As a result, we believe these types of approaches would be attractive primarily to those beneficiaries with the highest incomes. Moreover, encouraging these physicians to charge patients different amounts based on their patients' incomes undermines Medicare as a universal insurance program.

In addition, beneficiaries do not have access to pricing or physician performance information that would allow them to compare costs and choose lower-cost, higher value physicians. Even if such information were available, beneficiaries often lack the ability to use the information wisely, especially when in need of urgent medical services.

Private contracting and balanced billing also <u>increase</u> health care costs by raising prices. Seventy-five percent of all health care costs in our country are spent on the treatment of chronic diseases, many of which could be easily prevented with early interventions. Research has shown that when out-of-pocket costs increase, consumers will visit doctors less. These arrangements would only deter beneficiaries from seeking preventive and other care until their illness worsens. Discouraging preventive care will increase the need for costly treatment and intervention of these chronic diseases, shifting costs to other parts of the Medicare program.

Finally, not only do private contracting and balanced billing shift costs onto beneficiaries, but neither does anything to improve the quality of care delivered. In fact, under both approaches, physicians will continue to be rewarded by the quantity of care provided, rather than on the quality of that care. As Congress grapples with how to address the SGR problem, it should focus on rewarding quality providers, not on the quantity of services provided.

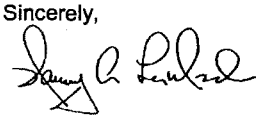
Conclusion

Over 47 million older and disabled Americans depend on Medicare today. As you know, the recently enacted Affordable Care Act (ACA) included many delivery system reforms—such as Accountable Care Organizations (ACOs), patient-centered medical homes, value-based purchasing, quality-based payments, and patient safety initiatives. We have been working closely with hospitals, physicians, and health plans to help ensure that these delivery system reforms can be implemented so that current and future beneficiaries can realize a Medicare program that is both higher quality and more efficient.

However, we believe these types of major delivery system reforms take time, planning, and commitment from Congress and the President to achieve a new way of delivering care with new incentives based on achieving quality -- not quantity -- of care. In addition, we believe our nation's leaders must help educate seniors about how they want to reform our system. Asking seniors simply to pay more to see the doctor of their choice can't be the answer.

Our members believe that giving seniors the peace of mind that they can keep seeing their doctors isn't a Republican or Democratic issue. And older Americans agree it's time to work together to find a solution both sides can support that will keep doctors in Medicare. AARP is committed to working with both sides of the aisle to ensure Congress reaches a financially responsible solution that will help prevent seniors from losing their doctors.

Sincerely,



Nancy LeaMond
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May 4, 2011

The Honorable Fred Upton
Chairman
House Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20510

The Honorable Henry Waxman
Ranking Member
House Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20510

The Honorable Pitts
Chair, Health Subcommittee
House Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20510

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20510

Dear Representatives Upton, Waxman, Pitts, and Pallone,

The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through our counseling and advocacy services, educational programs and public policy initiatives. Through our direct work with Medicare patients, we have specific insights into the impact of payment policies on people with Medicare.

There is no doubt that changes to the Sustainable Growth Rate (SGR) must be made in order to ensure that people with Medicare continue to have adequate access to physicians. While there is not currently a general physician shortage in the Medicare program, according to the Medicare Payment Advisory Commission (MedPAC), we must have a stable and predictable physician payment mechanism to maintain access to physicians for Medicare patients. Because of the uncertainty surrounding SGR, some doctors are telling people with Medicare that they will no longer be able to see Medicare patients due to these putative cuts. This uncertainty in the past few years over payment rates—Congress acted five times in 2010 to prevent cuts—only serves to increase anxiety. For that reason, it is imperative that policymakers begin to seriously examine a longer-term fix.

However, we have grave concerns about proposals that would allow physicians to enter into private contracts with Medicare patients or "balance bill" patients for cost-sharing over the Medicare-allowed

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amount. Our concerns about the SGR stem from our concerns about Medicare patients' access to providers. Proposals that would increase costs for Medicare consumers do not address this issue; rather, such proposals create an access issue of a greater and different sort.

Currently, half of all people with Medicare have household incomes below $20,000 per year, and half of the next generation of people with Medicare will have annual incomes below $27,000. Furthermore, out-of-pocket spending for Medicare patients is already burdensome and increased from 11.8 percent in 1998 to 16.2 percent in 2006. People with Medicare are not in a position to bear increased health care costs. Through our casework, we have seen time and time again Medicare patients putting their financial stability at risk to pay for needed care or forgoing medically necessary care altogether.

There are existing rules that allow physicians to charge more than the Medicare-allowed amount. Although these rules are designed to preserve participation by physicians in the Medicare program, in our experience even these rules are flawed and often result in access problems or financial harm to Medicare patients. Under the current rules, doctors can enter into private contracts with Medicare patients, but if they do so they are not allowed to participate in the Medicare program for two years. Providers may also charge fees for certain costs that are not covered by Medicare. As demonstrated by the case examples below, expanding the allowance of private contracting and balance billing will only exacerbate the problems patients already face and will do nothing to protect patients' access to providers.

> Ms. H went to a doctor who had opted out of Medicare. Because the doctor was no longer participating in the Medicare program, in order to see the doctor, Ms. H had to enter into a private contract with the doctor and pay an agreed-upon fee. Due to the cost, Ms. H was forced to find an alternative doctor who participated in Medicare and limited patient charges to the Medicare-allowed amount.
>
> Mr. B called the Medicare Rights Center because he was no longer able to afford the extra costs being charged by his cardiologist. Although the doctor accepted Medicare, he wanted to charge an administrative fee to all Medicare patients for record-keeping, administrative and other costs "not covered by Medicare." Mr. B was unable to pay this fee because he lives on a limited income. Therefore, he has not seen his cardiologist and must now find a new doctor.

Through its casework, the Medicare Rights Center knows the risks associated with the policies described above. Approaches that would strengthen private contracting authority or the right to balance bill on an individual basis would create a tiered patient system in which doctors would be able to arbitrarily determine rates and decide to whom those rates would apply.

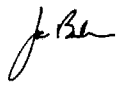
Furthermore, private-contracting and balance-billing proposals set harmful precedents. Although current proposals under consideration may pertain only to doctors, there is no guarantee that such private contracting rights will not begin to be applied to other providers, such as hospitals, and in other health care settings as well. These proposals serve to fundamentally undermine the purpose of the Medicare program by unraveling the protections against high costs that prevent people from accessing the care they require.

Finally, these payment mechanisms do not help to improve the quality of care people with Medicare receive. They would undermine the incentives and payment reforms that serve as the foundation for the Affordable Care Act (ACA), and that achieve savings in the Medicare program by paying for quality of care rather than for the quantity of services provided. If providers are allowed to balance bill individuals for care, than as we move towards a pay-for-performance model, providers can simply

make up payment differences through private contracts without taking measures to improve the quality of care patients receive. In short, private contracting and balance billing, like certain recent deficit-reduction proposals concerning Medicare, simply shift costs to Medicare patients and do nothing to address the underlying source of rising Medicare costs, which is rising costs in the health care sector overall.

While we appreciate that Congress takes seriously its obligation to find a long-term solution to the SGR problem, passing costs to consumers is not an appropriate answer and will only lead to the same result as the SGR, if it is ever implemented: decreased access to physicians.

Sincerely,



Joe Baker
President

Mr. PITTS. Let me introduce our panel at this time. The first witness is Dr. Mark McClellan. Dr. McClellan is former Administrator for CMS, currently the Director of the Engelberg Center for Health Policy Studies at the Brookings Institution in Washington, DC. The next witness is Dr. Cecil Wilson. Dr. Wilson is the current President of the American Medical Association. Next, Dr. David Hoyt is the Executive Director of the American College of Surgeons. Harold Miller is the Executive Director for the Center for Healthcare Quality and Payment Reform in Pittsburgh, Pennsylvania. Professor Michael Chernew is a Professor of Health Policy at Harvard Medical School, Dr. Todd Williamson is a practicing neurologist and representative of the Coalition of State Medical and National Specialty Societies, and our final witness is Dr. Roland Goertz. He is the current President of the American Academy of Family Physicians.

Your testimony will be entered, written testimony will be entered into the record. We ask that you summarize your statements in 5 minutes, and Dr. McClellan, you may begin.

STATEMENTS OF MARK B. MCCLELLAN, M.D., PH.D., DIRECTOR, ENGELBERG CENTER, BROOKINGS INSTITUTION SENIOR FELLOW; CECIL B. WILSON, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION; DAVID B. HOYT, M.D., EXECUTIVE DIRECTOR, AMERICAN COLLEGE OF SURGEONS; HAROLD D. MILLER, EXECUTIVE DIRECTOR, CENTER FOR HEALTHCARE QUALITY AND PAYMENT REFORM; MICHAEL E. CHERNEW, PH.D., PROFESSOR OF HEALTH POLICY, HARVARD MEDICAL SCHOOL; M. TODD WILLIAMSON, M.D., COALITION OF STATE MEDICAL AND NATIONAL SPECIALTY SOCIETIES; AND ROLAND A. GOERTZ, M.D., MBA, PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

STATEMENT OF MARK B. MCCLELLAN

Mr. MCCLELLAN. Thank you, Chairman Pitts, Representative Pallone, and distinguished members of the subcommittee. I very much appreciate this opportunity to speak with you on the critical issue of Medicare physician payment. Physicians and the health professionals who work with them are the linchpin of our healthcare system.

Unfortunately——

Mr. PITTS. Is your microphone on?

Mr. MCCLELLAN. It is on. Maybe I am not speaking quite——

Mr. PITTS. Pull it a little closer.

Mr. MCCLELLAN. Is that better?

Mr. PITTS. Yes. That is better.

Mr. MCCLELLAN. I will get right up to it.

Unfortunately, finding a better way to both pay physicians adequately and address Medicare's worsening financial outlook has been very difficult. Frequent fixes to the sustainable growth rate formula for physician payment have meant that theoretical savings have not materialized and that physicians can't reliably plan ahead or fully cover their rising practice cost, let alone make needed investments in better ways to provide care that could also save money.

The result is a frustrating gap for physicians between the care they are able to deliver while making ends meet in their practice and the care that should be possible in a more-effective payment system. This is not a new problem. I testified before many of you on this distinguished subcommittee 5 years ago about the same issues, but it has become a more ordinate problem, as many of you noted, from the standpoint of both quality of care for beneficiaries and the physical challenges facing Medicare.

As Congress considers how to address this problem, I urge the subcommittee to look beyond approaches that remain tied to the existing formula simply by delaying it again or by resetting baselines to higher spending levels. This is an opportunity to provide better support for physicians who lead in improving care, and the best starting point for doing so are the many practical ideas to improve quality and lower costs already being developed and implemented by physicians and other health professionals around the country, often in spite of Medicare payment rules.

Payment reforms in the Medicare Modernization Act and the Affordable Care Act provide a foundation for this as do many payment reforms being implemented now in States and in the private sector. But success in Medicare will require more than good ideas about payment reform. It will require real physician leadership. No one knows better where the best opportunities are to improve care and avoid unnecessary costs for their Medicare patients, and no one else will be trusted by Medicare beneficiaries.

For example, oncologists have noted how much Medicare payments are tied to the volume and intensity of chemotherapy they provide. As Medicare reimbursement rates have been squeezed, the margin between what it costs to obtain chemotherapy drugs and what Medicare pays to administer them has become more important in covering their practice costs. At the same time, oncology practices get relatively little support for time spent working out a treatment plan that meets these individual patients' needs, for managing patients' symptoms, for coordinating care with other providers.

Some oncologists have partnered with private insurance to change this so they can get more support for the care that reflects the needs of their patients. They still get paid for cost-related chemotherapy, but instead of having to support their practice off chemotherapy margins, they receive a bundled payment that is no longer tied to giving more intensive chemotherapy. Instead the bundled payment provides support for the treatment protocols that the physicians determine are most appropriate.

In this example the physicians were willing to take on more accountability for the quality of their care and for avoiding preventable complications and costs since it would allow them to focus more on what they are trained and professionally determined to do to get their patients the care they most need.

There are many other examples of this, including in surgery and primary care and in many other areas of the delivery of care to Medicare beneficiaries. They all have some things in common that should be part of any payment reform legislation. They require a foundation of better data and meaningful, valid quality and cost

measures. Most important is providing timely information on Medicare beneficiaries to providers.

It is also important to take more steps to align Medicare's existing incentive programs with these clinical improvement efforts, like Medicare's Meaningful Use Payments for Health Information Technology and Medicare's Quality Reporting Payments, as well as reforms affecting hospitals and crosscutting reforms like Accountable Care Organization payments. If they are aligned, these payments could add up to much more support for the investments of money and time needed to improve care.

Medicare should also support promising payment reforms already being implemented successfully by private plans and States. In all of these efforts more physician leadership is critical. These reforms will succeed not because we got the actuarial analysis right or we came up with the right names for all these complicated payment reforms but because Medicare beneficiaries are seeing that their healthcare providers are getting more support to provide them with better care at a lower cost.

Thank you, again, Mr. Chairman, for the opportunity to testify today, and I look forward to assisting the subcommittee in addressing the difficult but critically-important challenges of reforming Medicare physician payment.

[The prepared statement of Mr. McClellan follows:]

Prepared Testimony for the House Energy & Commerce Committee

The Need to Move Beyond SGR

May 5, 2011

Mark McClellan, MD, PhD

Chairman Pitts, Representative Pallone and distinguished members of the Subcommittee, thank you for inviting me to speak to you today on the critical issue of Medicare physician payment. Physicians and the health professionals who work with them are the linchpin of our health care system. The support they receive influences everything – how and how well they are able to meet patients' needs, the quality of care, and its costs. How Medicare pays physicians has an important impact on the care that Medicare beneficiaries receive and the fiscal outlook of the Medicare program.

Unfortunately, finding a better way to both pay physicians adequately and address Medicare's worsening fiscal outlook has been very difficult. The legislation creating the "Sustainable Growth Rate" (SGR) hasn't solved that problem. Every year since 2002, Congress has had to provide temporary fixes to the formula. In reality, these "fixes" have meant the theoretical savings from the SGR don't materialize, and physicians can't reliably plan ahead or fully cover their rising practice costs, let alone make needed investments in innovative ways of delivering care that could also save money. The result is frustrating pressure on physicians to do more for patients with less, and growing difficulty for physicians in bearing the cost of all the things Medicare pays for poorly, if at all – coordinating care across the different providers who see beneficiaries, educating patients about how they can stay well or manage their health problems, delivering care in less costly settings, even spending extra time with them when they need it.

At the same time, the fiscal challenges facing the Medicare program have gotten far worse. Medicare spending already accounts for roughly3.5 percent of GDP. If scheduled physician payment reductions continue to be overridden,and provider payments continue to growat current rates, then Medicare expenditures could surpass 5% of GDP by 2030.Not only would this require substantial additional tax revenues; if the past is any guide, it also means that other key Federal priorities will be squeezed down.

This is not a new challenge. I had the privilege of discussing this topic with the Subcommittee five years ago, when I was CMS Administrator. At that time, I said: "If we are able to design a payment system that aligns reimbursement with quality and efficiency, we can better encourage physicians to provide the type of care that is best suited for our beneficiaries: care focused on prevention and treating complications; care focused on the most effective, proven treatments available." This solution, I testified, would be far preferable to the current physician payment system.Since then, the need for a better approach to physician payment and the ideas for implementing it has become more pressing. We are past the time when short-term "Band-aid" solutions to the SGR are adequate. We can't afford any further delay in significant steps toward a better physician payment system in Medicare.

As Congressconsiders how to address the SGR problem this time around, I urge the Subcommittee to look beyond approaches that remain tied to the existing formula simply by delaying it again, orby resetting baselines to higher spending levels. Rather, this is an opportunity to provide better support to physicians who lead in improving care.

The best starting point for supporting physician leadership isn't yet another arbitrary payment formula, but the many practical ideas already being developed and implemented by physicians

and other health professionals around the country – often in spite of Medicare payment rules – to improve quality and lower cost. What we pay physicians is a relatively small part of overall health care spending. Yet physician payment can have a big impact on total health care spending. The real problem is not how much we are spending on physician payment, but whether we can support their best ideas for improving care and avoiding unnecessary complications and costs, instead of just supporting more volume and intensity.

Not only is this more urgent than ever before; we are in a better position to do it than ever before. Legislation including theMedicare Modernization Act and the Affordable Care Act has created or enhanced initiatives that help lay the foundation for needed payment reforms in Medicare, as have reforms in states and the private sector. They include paying more when physicians use health IT to actually improve care, and when physicians report on and achieve better quality of care. The ACA also provides the opportunity to strengthen accountable care organizations and related reforms that are being implemented successfully in private health plans and states, which can also support better care. As CMS Administrator, I advocated for or piloted many of these reforms, which have had considerable bipartisan support.

None of these reforms will solve Medicare's payment problems alone, and all have had significant challenges in their implementation. But this is why physician payment reform needs to consider better ways to pull individual payment changestogether in support of better care. Implementing a number of piecemeal additions and patches to Medicare's existing fee-for-service payment system runs the risk of pulling physicians in even more directions, and distracting them further from the key goal of improving care and reducing costs. For payment reform to have the greatest impact, leadership from physicians and other health care professionals in doing more than just heading off the latest SGR cut is essential.

No one knows better than physicians how to answer the key questions: where are the best opportunities to improve care and avoid unnecessary costs for their Medicare patients, and how can we implement practical payment reforms that support these improvements in care? Every day, physicians and health care professionals see opportunities to improve the value of care, but are frustrated by a Medicare payment system that often works against them. Their experience, in aggregate, could add up to meaningful system-wide savings to help offset the costs of fixing the SGR.

This experience is accumulating in physician practices around the country. For example, many oncologists have noted the degree to which Medicare payments are tied to the volume and intensity of chemotherapy they provide. Especially as Medicare reimbursement rates are squeezed, covering a large part of practice costs depends on the margin between what it costs them to obtain chemotherapy drugs and what Medicare pays to administer them. At the same time, oncology practices get little support for doing many of the things that their patients need, things like spending time working out a treatment plan that meets each patient's individual needs; managing patient symptoms; coordinating care with other providers.

To get a better match between payments and what the oncologists think is most important for their patients, oncologists at the Kansas CityCancerCenter, in Kansas City, Missouri, have partnered with United Healthcare to provide more resources for these other activities. They still get paid for costs related to the chemotherapy they administer. But instead of having to support their practice off the chemotherapy margins, they receive a bundled payment that is no longer tied to giving more intensive chemotherapy; instead, the bundled paymentprovides support for the treatment protocols that the physicians determine are most appropriate.The oncologists at Kansas City Cancer Center were willing to take on more accountability for the quality of their

care and for avoiding unnecessary complications and costs if it would allow them to focus more on what they are trained and professionally determined to do – get their patients the care they most need.

Another example of provider-led innovation comes from opportunities identified by health care providers to coordinate care among the physicians, nurses, and other health professionals involved in performing major surgical procedures, such as joint replacements. Based on extensive experience and published evidence, surgeons have identified the most effective ways to carry out key components of the procedures. Supporting well-organized teams including physicians, medical staff, and others involved in the surgical episode to implement these steps can reduce complications and hospital and post-acute costs. However, coordinating these activities takes time and resources, for example to get consensus on the best steps to implement to improve safety and quality, and to implement information systems that help track these steps. But Medicare doesn't pay for these steps to coordinate care, even when they reduce costs.Underway in several cities right now, Medicare's Acute Care Episode (ACE) demonstration pays hospitals and physicians a prospectively fixed amount for a bundle of services that includes both Medicare part A and part B, for selected inpatient orthopedic and cardiac procedures In this setting, doctors and hospitals now have more financial support towork together to reduce the overall cost of care for patients undergoing these procedures. Formal evaluation of the ACE project is not yet complete, but sitesare observing significant reductions in episode costs while maintaining or improving quality. In this bundled payment program, everyone has benefitted: hospitals and physicians have seen margins increase, because they have more flexibility to direct resources to where they really matter for improving quality

and reducing costs, and Medicare costs per episode are lower as well. In this demonstration, some of the savings have even been returned to beneficiaries.

These are just specific examples, and there are many more – in care coordination through medical or health homes, in community-level collaborations to identify key gaps in quality of care for chronic diseases then tracking improvements in them, and in other areas. They don't always work. But that doesn't mean that the best strategy for Medicare continues to be trying out individual reform pilots and attaching a variety of increasingly complex additions to the Medicare fee-for-service payment formulas. Instead, any SGR payment fix should be accompanied by more support for improvements in care that also results in cost savings.

Payment reforms that support greater quality and efficiency need a foundation of better data and meaningful, valid quality and cost measures. Most important is providing timely information on Medicare beneficiaries to providers, to help them improve care for their patients. As I have described in a recent article, one way to make sure that quality measures are relevant and do not create unnecessary reporting burdens or other problems is to make sure that the measures come directly from data systems used by physicians to support their delivery of care.

More effective support for quality and efficiency also meansmore efforts to align Medicare's payment reforms. One of the big challenges for physicians, especially those in small practices, is getting adequate support to make the investments needed to implement care improvements. This is especially difficult if they are facing a range of different payment reforms, all of which seem to require different kinds of efforts. Further steps to align Medicare's other payments affecting physicians – to minimize the burden of participating in payment opportunities like "meaningful use" payments for health information technology and quality reporting, as well asnewer

initiatives including medical homes and accountable care organizations – could enable the next physician payment reforms to have more impact. This can be done through steps like using consistent performance measures derived from physicians' own efforts to improve care in their practices. Medicare payments should also be better aligned with state and private planpayment reforms. Such multi-payer reforms would provide greater support for physicians' efforts to improve care than public or private reforms alone.

Achieving greater alignmentin support of better care and lower costs will require more leadership from physicians. All of these payment reforms involve steps toward physicians getting more flexibility in how they provide care to meet the needs of individual beneficiaries than Medicare has traditionally provided, and simultaneously steps towardaccountabilityensuring care gets better while avoiding unnecessary costs. By identifying the most promising ways to achieve these goals within medical practices and in how physicians collaborate to deliver care, physician groups, specialty societies, and the health professionals who work with them can accelerate and shape progress toward a more sustainable Medicare payment system.

Thank you again for this opportunity to testify today, and I look forward to assisting this Subcommittee in addressing the difficult but critically important challenges of reforming Medicare physician payment.

Mr. PITTS. Thank you, Dr. McClellan.

Dr. Wilson, you are recognized for 5 minutes.

STATEMENT OF CECIL B. WILSON

Mr. WILSON. Thank you, Mr. Chairman. My name is Cecil Wilson. I am the President of the American Medical Association and an internist in Winter Park, Florida. The AMA thanks the members of the subcommittee for your leadership in addressing the needs to move beyond the SGR, and we look forward to collaborating with the subcommittee and Congress to develop Medicare physician payment reforms that strengthen Medicare.

The SGR is a failed formula. The longer we wait to cast it aside the deeper the hole we dig. It is past time to replace the SGR with a policy that preserves access, promotes quality, and increases efficiency.

The AMA recommends a three-pronged approach to reforming the Physician Payment System. First, repeal the SGR. Second, implement a 5-year period of stable Medicare physician payments, and third, during this 5-year period test an array of new payment models designed to enhance care coordination, quality, and appropriateness and reduce cost.

In addition, Congress should enact H.R. 1700, the Medicare Patient Empowerment Act. This bill 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.

The first prong of the AMA's approach repealing the SGR is critical. Since 2002, and you have alluded to this, Congress has had to intervene on 12 separate occasions to prevent steep cuts. But more than repeal is needed. Because of the uncertainty wreaked by the SGR over the past decade, a time of fiscal stability is imperative. So the AMA recommends 5 years of positive payment updates from 2012, through 2016, and I want to be clear. This would not be a 5-year temporary delay of SGR cuts but 5 years of statutory updates should be in conjunction with repeal of the SGR.

This would allow time to carry out demonstration and pilot projects that would form the basis of a new Medicare Physician Payment System, and a replacement for the SGR should not be a one-size-fits-all formula. Instead, a new system should allow physicians to choose from a menu of new payment models including shared savings, gain sharing, payment bundling programs across providers, and episodes of care.

Additional models are needed to embrace a wide spectrum of physician practices, including models focusing on conditions for specific capitation, warranties for inpatient care, and mentoring programs. While these models are being tested we also need evidence on how to properly structure and implement models which show the most promise while addressing complex issues such as effective risk adjustment and attribution.

To assist with this process the AMA is working with specialty and State medical societies to form a new physician payment and delivery reform leadership group. This group will include physicians who are participating in payment and delivery innovations and by sharing expertise and resources physicians can then assess

the models that will improve patient care, and they can be implemented across specialties and practice settings. They can also learn how to get the programs off the ground, address challenges, and assess the impact of these reforms on patient care and practice economics. And the lessons learned can be widely disseminated to physician practices across the country as we move toward reform.

The AMA recognizes that reforming the Medicare Physician Payment System is a daunting task. We are eager, however, to work with the subcommittee and all members of Congress to lay the groundwork for reform so that we can achieve the mutual and fundamental goal of strengthening the Medicare program for this generation and many generations to come.

So thank you for the opportunity to be here today, and I look forward to your questions.

[The prepared statement of Mr. Wilson follows:]

Statement

of the

American Medical Association

before the

House Energy and Commerce Committee
Subcommittee on Health

RE: The Need to Move Beyond the SGR

Presented by: Cecil B. Wilson, MD

May 5, 2011

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Summary of the Statement of the

American Medical Association

before the

House Energy and Commerce Committee
Subcommittee on Health

RE: The Need to Move Beyond the SGR

May 5, 2011

The American Medical Association (AMA) is pleased to have the opportunity to provide the House Energy and Commerce Subcommittee on Health with our recommendations for developing a pathway toward reforming the Medicare physician payment system. The following bullets summarize key points discussed in our written statement:

- The AMA recommends a three-prong approach to reforming the physician payment system:

  (1) Repeal the SGR;
  (2) Implement a five-year period of stable Medicare physician payments that keep pace with the growth in medical practice costs; and
  (3) Transition to an array of new payment models designed to enhance care coordination, quality, appropriateness and costs.

- The five-year period of stable statutory updates should be in conjunction with repeal of the SGR. This will allow time to develop and test demonstration and pilot projects that would form the basis for a new Medicare physician payment system.

- A replacement for the SGR should not be another one-size-fits-all formula.

- New payment models that reward physicians and hospitals for keeping patients healthy and managing chronic conditions should be tested during the five year transition period. These should include, for example, shared savings, gainsharing, and payment bundling programs across providers and episodes of care.

- Since the vast majority of physician practices are small businesses that do not have access to the significant upfront investments required to participate in these new models, other models should be tested as well, including models focusing on partial capitation, condition-specific capitation, hospital inpatient warranties, and mentoring programs.

- The AMA is working with specialty and state medical societies to form a new "Innovator Committee," including physicians and other experts. This will facilitate sharing expertise and resources, assess models that can be implemented across specialties and practice settings, and widely disseminate lessons learned.

The AMA is thankful for this opportunity to work with the Subcommittee and Congress to replace the SGR with a sustainable Medicare physician payment system.

Statement

of the

American Medical Association

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House Energy and Commerce Committee
Subcommittee on Health

RE: The Need to Move Beyond the SGR

Presented by: Cecil B. Wilson, MD

May 5, 2011

The American Medical Association (AMA) is pleased to have the opportunity to provide the House Energy and Commerce Subcommittee on Health with our recommendations for developing a pathway toward reforming the Medicare physician payment system. We applaud Chairman Pitts, Ranking Minority Member Pallone, and all the Subcommittee Members for your leadership and continued efforts to address this problem, and appreciate the full Committee's bipartisan effort last December to prevent the 25 percent cut under the current sustainable growth rate (SGR) formula from taking effect for one year, thereby allowing the necessary time to work on this complex issue. We laud the Subcommittee's continued commitment, under both Republican and Democratic leadership, to develop a permanent, sustainable solution, and welcome the opportunity to provide the Subcommittee with our ideas.

Overall, the AMA recommends a three-prong approach to reforming the physician payment system:

(1) Repeal the SGR;

(2) Implement a five-year period of stable Medicare physician payments; and

(3) Transition to an array of new payment models designed to enhance care coordination, quality, appropriateness and costs.

Repealing the SGR and implementing a period of stable payments, while testing new models that would lay the pathway for a new payment system, must be enacted concurrently to ensure an optimal reform approach. We recognize that reforming the Medicare physician payment system is a daunting task. The AMA is eager, however, to continue to work with members of the House and the Senate on both sides of the aisle to lay the ground work for reform. Over the course of the next weeks and months, we look forward to continuing our dialogue and providing all Members with additional data, information, and policy ideas.

REPEAL THE SUSTAINABLE GROWTH RATE

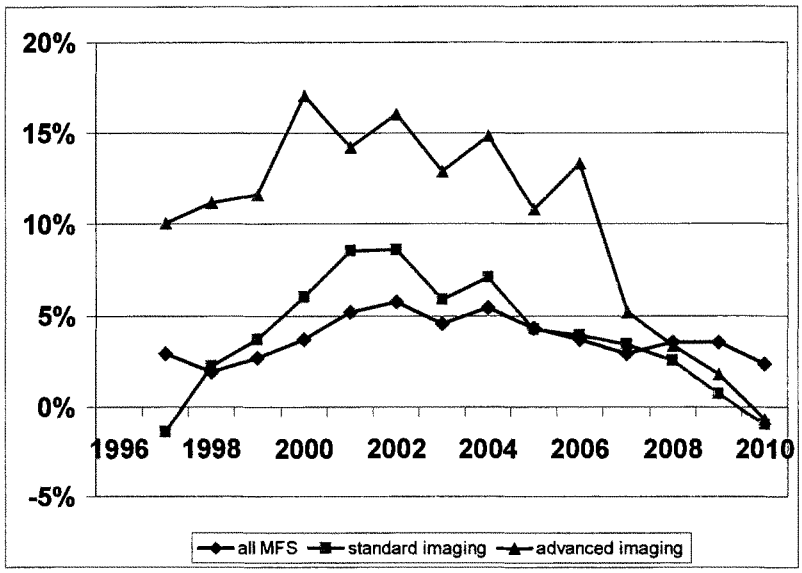
The SGR is a Fatally Flawed Formula

The SGR was enacted in 1997 to determine physician payment updates under Medicare Part B. It was intended to reduce Medicare physician payment updates to offset the growth in utilization of physician services that exceeds gross domestic product (GDP) growth. Specifically, actual growth in spending on physician services is compared to a cumulative target growth rate linked to GDP, using 1996 as the base year. When actual growth exceeds the cumulative target, payment updates are reduced and will be less than practice cost growth. Despite numerous efforts to "fix" the SGR, dating as far back as the Balanced Budget Act of 1999, the formula remains fundamentally flawed. The growth in the cost of caring for Medicare beneficiaries has historically grown faster than the GDP due to technological advances in care, an aging population, expansion of Medicare benefits, and other factors. Yet, these factors are not included in calculations of the target growth rate, and thus the SGR targets do not appropriately account for actual growth in the utilization of physicians services or address actual need for medical services by our senior and disabled patients enrolled in Medicare.

Additionally, the concept of a global target affecting the actions of individual physicians is flawed in that there is no individual incentive to reduce spending. Since the inception of the SGR, trends in volume growth have been unpredictable. Nevertheless, despite Congressional interventions to set

aside steep SGR-mandated physician payment cuts, utilization growth in recent years has been relatively low. For example, the chart below shows that in the late 1990s, at the SGR's inception, annual volume/intensity growth in Medicare physician fee schedule (MFS) services ranged from 1.9 percent to 2.9 percent. MFS volume/intensity growth accelerated in 2000 and 2001, reaching a plateau during 2001 to 2004 with annual growth ranging between 4.6 percent and 5.8 percent. Volume growth, however, began to decelerate in 2005, was in the 3 percent to 3.7 percent range from 2006 to 2009, and dipped to 2.4 percent in 2010.

Trends in Volume Growth since SGR Inception



Congressional Intervention to Avert Medicare Crisis and Steep Medicare Physician Payment Cuts

Since 2002, the SGR formula has annually called for reductions in Medicare reimbursements. Payments were cut by 5 percent for 2002, and Congress has intervened on 12 separate occasions since

then to prevent additional cuts from being imposed. Five separate bills were passed to stop a 22 percent cut in 2010 alone. On all 12 occasions, Congress has never provided the funding necessary to reform the flawed SGR formula, resulting in steeper cuts in subsequent years. Therefore, the current Congress is now challenged by the prospect of even steeper cuts than previous Congresses. The 10-year cost of a long-term solution has grown from about $48 billion in 2005 to nearly $300 billion today, and physician payments are scheduled to be cut by 29.5 percent on January 1, 2012, with cuts potentially continuing in future years.

The only way to start on a path to permanently reform the physician payment system is to repeal the SGR. This would also provide stability to patients covered by other payers that tie their rates to Medicare including military members, their families, and retirees in TRICARE, retired Federal employees in FEHBP, and those enrolled in state Medicaid programs.

PERIOD OF STABLE PAYMENTS

Due to the fundamentally flawed nature of the SGR and budget baseline effects from congressional interventions to halt scheduled SGR cuts, physician practices have faced fiscal uncertainty over the last decade. The AMA recommends for the period 2012-2016, that physicians be provided with positive Medicare physician payment updates that keep pace with the growth in medical practice costs. During this time, policymakers, stakeholders, and experts would work to develop and transition to a new Medicare physician payment system. Providing statutory updates for five years will provide predictability and fiscal stability for physician practices at a time in which they will also be making significant investments in health information technology and quality improvement initiatives. This should not be interpreted as another temporary delay in SGR-driven cuts. Statutory updates should be provided in conjunction with repealing the SGR.

As the Medicare Payment Advisory Commission (MedPAC) asserted in its March 2011 report, "a potentially more pressing Medicare cost to consider is the mounting frustration of physicians, other health professionals, and their patients if substantial Medicare fee cuts continue to loom large in future years." Stability is sorely needed. According to the AMA Physician Practice Information Survey, 78 percent of office-based physicians in the United States are in practices of nine physicians and under, with the majority of those physicians being in either solo practice or in practices of between 2 and 4 physicians. The vast majority of physician practices are small businesses and the constant insecurity that the SGR produces, with temporary Medicare payment holds and ever-steeper cuts threatened, is taking a heavy toll on them.

Replacing the SGR, however, should not be another one-size-fits-all formula. Rather, a new system should involve transitioning to a new generation of payment models that reward physicians and hospitals for keeping patients healthy, managing chronic conditions in a way that avoids hospitalizations, and, when acute care episodes occur, delivering high quality care with efficient use of resources. We envision physicians choosing from a menu of payment models, selecting ones that best address their patients' needs, specialty, practice type, capabilities and community. We believe that statutory payment updates for five years will allow time for demonstrations and pilots of new Medicare and private sector payment models to take place. During this time, evidence should be available on how to properly structure and implement those models with the most promise, while addressing issues such as risk adjustment and attribution. We believe this process should be dynamic, enabling physicians to transition into those models as they become available.

Further, we believe this period will provide Congress the opportunity to act on additional legislation to create a new Medicare physician payment system that incorporates these models by September 30, 2015. The bill establishing five years of statutory updates could include provisions requiring congressional action by such date and provide for congressional "fast-track" procedures to ensure

consideration of such legislation. The Centers for Medicare and Medicaid Services (CMS) would begin implementation of the new payment system, adopted by Congress, through the proposed and final 2016 Medicare Physician Payment Rule, which would become effective on January 1, 2017.

NEW PAYMENT MODEL OPTIONS

Since Medicare's creation in 1965, previous administrations and congresses have enacted changes to the Medicare physician payment system about every decade or so to address evolving Medicare fiscal constraints. For numerous years since the SGR was implemented, Congress, stakeholders, and policy experts such as MedPAC have grappled with ideas on how to replace the SGR. In the attachment to this testimony, we outline several payment models that are being, or will be, demonstrated or piloted in Medicare and the private sector, including models focused on Medicare shared savings, gainsharing, payment bundling across providers and episodes of care, and care provided through a medical home. As the demonstration and pilot process continues to be fluid, so should our discussion about a new system and model ideas.

PHYSICIAN INNOVATOR COMMITTEE

The AMA is also working with the specialty and state medical societies to form a new "Physician Innovator Committee." This Committee will include physicians who are currently participating in payment and delivery innovations, and by sharing expertise and resources, will provide an opportunity for the medical community to learn from their experiences. There is an urgent need for data to truly assess which delivery and payment models will improve patient care and which are feasible for implementation across specialties and practice settings. The underlying premise is that, in order for physicians to effectively lead the development and diffusion of new payment and health care delivery models, we must learn from the early innovators the steps involved in getting their programs off the ground, the challenges they faced and how they overcame them, and what impact these reforms have had on patient care and practice economics. The Leadership Group can allow the physician

community to begin immediately to develop the knowledge base on the next generation of physician payment models and not have to solely rely on formal evaluation studies whenever they are issued by the government.

PROPOSED TRANSITIONAL MODELS

Many of the Medicare demonstration projects outlined in the attachment to this testimony hold great promise for identifying winning payment reform pathways that can simultaneously improve patient care quality and coordination, improve physician operating margins, and reduce the rate of growth in Medicare spending. Yet, some of these projects are limited in that they solely rely on shared savings as a means to accomplish their reform objectives. The existing Physician Group Practice (PGP) demonstration has made it clear that there are significant upfront investments required for participation in these new models, but demonstration designs limit the incentive payments to distributions of shared savings and do not assist practices with these upfront costs or provide any assurance that they will ever recover them. Shared savings distributions, if they are achieved at all, are not paid until long after these initial investments are required.

In addition to having access to financial reserves, participation in any of the new payment and delivery models requires physician practices to have certain capabilities, including: (1) the ability to obtain and analyze large amounts of data on patient utilization and costs for their own services as well as services provided by others; (2) skills to improve quality and cost performance and report performance measures; (3) ability to identify inappropriate utilization and reduce it; (4) knowledge of evidence-based practices that achieve good outcomes; (5) ability to share information with other physicians and providers at the point of care; and (6) ability to manage patient care in a coordinated way and experience managing risk. In the past, these skills have not been taught in medical school or residency training. Physicians need to acquire these skills through their experience in practice. With the vast majority of medical practices qualifying as small businesses and involving a small number of

physicians, it is important to put in place transitional models that will help small and solo practices to develop these capabilities.

To address both of these limitations, the AMA recommends that several transitional models be tested by Medicare, in addition to the demonstrations we have already discussed. A more detailed discussion of these and other transitional approaches is available in "Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care," a paper by Harold D. Miller of the Center for Healthcare Quality & Payment Reform available at www.paymentreform.org.

Partial Capitation

Section 3022 of the Affordable Care Act (ACA) authorized, but did not require, CMS to include partial capitation models in the Medicare Shared Savings Program, *i.e.*, ACO program. In its recent ACO proposed rule, CMS indicates that it is not proposing any partial capitation models at this time, although they may be addressed separately by the Center for Medicare and Medicaid Innovation. Under this payment model, an ACO would agree to accept a pre-defined monthly per-patient payment during a multi-year period that would be used to cover all of the costs of care for a defined group of patients. The payment would be risk-adjusted and would be lower than what CMS would project paying for those patients under the regular Part A and B payment schedules. This model would enable physician practices with experience in successfully managing capitation contracts under Medicare Advantage and commercial insurance, such as North Texas Specialty Physicians and the Mount Auburn Cambridge Independent Practice Association (IPA), to deliver better care to Medicare fee-for-service beneficiaries as well as guarantee savings to the Medicare program. Additionally, it would provide a means for practices to recoup their upfront investments, reward physicians for achieving savings through a particular treatment delivery, and permit them to gain experience managing risk.

Virtual Partial Capitation

A variant of the model above would define a per-patient budget for a defined group of patients instead of making an upfront payment. Individual physicians who volunteer to participate would bill for individual services as they will do in Medicare Shared Savings Program. The total billings would then be compared to the budget, and the payments to the physicians and other providers in the ACO would be adjusted up or down to keep total payments within the budget. This approach gives physicians the flexibility to use alternative treatment approaches, as in capitation, without requiring them to have the capability to pay claims to other providers.

Condition-Specific Capitation

This model would involve making a prospective payment covering all of the services related to a particular condition or combination of conditions for a population of patients, rather than the full range of conditions as in the partial capitation model described earlier. Under condition-specific capitation, a specialty physician practice, multi-specialty group, or IPA would be paid a pre-defined amount to cover the costs of all of the care needed to address a particular condition, whether that care is provided by physicians in the organization receiving the payment or other physicians. For example, a multi-specialty group or IPA could be paid a fixed amount to cover the costs of all services associated with care related to its patients' congestive heart failure, including all physician services, hospital care, rehabilitation, etc. (This payment model could also be structured as a "virtual" payment or budget, as described above for virtual partial capitation.) This would enable primary care and specialty physician practices to work together to take accountability for the subset of patients and patient care they felt they could most effectively manage; over time, they could expand to additional types of patients in order to accept a broader partial capitation payment.

Accountable Medical Home

In contrast with the shared savings approach to medical homes, the accountable medical home model would give a primary care practice, multi-specialty group, or IPA the upfront resources needed to restructure the way primary care is delivered to its patients in return for a commitment to reduce the rate at which those patients use emergency rooms for non-urgent visits, are admitted and readmitted to the hospital for ambulatory care sensitive conditions, and order diagnostic tests or other ancillary services that may be inappropriate. Accountable medical homes could improve patient care and achieve savings for the Medicare program in several key areas without being penalized for the costs of specialized services they are not in a position to control. In the State of Washington, the Puget Sound Health Alliance and the Washington State Health Care Authority are currently putting this model in place for commercial payers and Medicaid plans. CMS could use the approach they have developed in the Medicare program.

Warranties for Inpatient Care

Adoption of a model like Geisinger Health System's ProvenCare could be a beneficial transitional model for Medicare payment reform. Physicians and hospitals providing treatment for specified conditions would determine a Medicare payment rate that would allow them to offer a warranty for the inpatient treatment and not charge more for addressing infections, complications or other defined adverse events that may occur during the course of the patient's care. Offering such a warranty provides an economic incentive for improving quality and preventing complications from occurring. As quality improves over time and rates of warrantied complications diminish, physicians and hospitals will be able to reduce the bundled payment rate to save money for Medicare while still obtaining higher margins on their own operating costs. At least initially, the price of the warrantied services is likely to be higher than what Medicare pays for a service with no complications because of the need to cover the costs of treating complications that will arise in a certain number of cases. Since Medicare would no longer be paying separately for the complications covered by the warranty, this

method would save money in total. In contrast to the current payment system, this would reward physicians and hospitals for preventing complications and delivering better quality care rather than paying more when complications arise. Most consumer products that are sold with a warranty do cost more than those without a warranty. Consumers purchase warrantied products not only as a protection against costly repairs but also because they know that the manufacturer must offer a high-quality product in order to manage its own financial risks. The warranty model is also a good transitional model because, as Geisinger did, physicians could begin with one service, like cardiac surgery, and then expand it to other areas as they gain experience with the approach.

Mentoring Programs

Perhaps the simplest way for small and solo practices to develop capabilities like analyzing patient utilization, quality and cost data, sharing information with others to prevent duplicate tests, adopting evidence-based measures and improving quality and cost performance is to learn from those who have done it. Another transitional model, therefore, would be for Medicare to provide financial and technical support to small physician practices that are working with Regional Health Improvement Collaboratives[1] or partnering with high performing groups in order to learn from them. The Mayo Clinic Affiliated Practice Network, Henry Ford Physician Network, Pittsburgh Regional Health Initiative, and Oregon Health Care Quality Corporation are several examples of this type of mentoring approach.

Medicare Payment Option Allowing Patients to Freely Contract With Physicians Without Penalty

In addition to pursuing SGR repeal and Medicare payment reforms, as discussed above, the AMA supports enactment of legislation establishing an additional payment option in Medicare fee-for-service that allows patients and physicians to freely contract, without penalty to either party, for a fee

[1] For more information see "Regional Health Improvement Collaboratives: Essential Elements for Successful Healthcare Reform," Network for Regional Healthcare Improvement, www.nrhi.org.

that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient. Under this option, Medicare beneficiaries could use their Medicare benefits and physicians could bill the patient for all amounts not covered by Medicare. Physicians could also continue to elect Medicare participating (PAR) or non-participating (non-PAR) status for other beneficiaries they treat, and would not have to opt out of the Medicare program for two years for all their patients, as is required under existing law. The approach would: (i) provide patients with more choice of physicians; (ii) increase the number of physicians who will continue to accept Medicare patients; and (iii) help preserve our Medicare program, along with patient-centered care, for our elderly and disabled patients. Therefore, the AMA strongly supports the "Medicare Patient Empowerment Act," a bill that was recently introduced by Representative Price to achieve these goals, and we urge the Subcommittee's support of this legislation as well. This legislation should be pursued as an addendum to the three-pronged approached discussed above, and not in lieu of replacing the SGR.

While replacing the SGR is critical, it must be done correctly. We believe the proposed framework and timeline described above are critical to developing the evidence-base necessary to ensure a reformed Medicare physician payment system meets our mutual goal of improving the Medicare program while ensuring beneficiaries' continued access to care. We look forward to continuing to work with the Subcommittee to repeal the SGR and transition to a system that incorporates new payment models designed to enhance care coordination, quality, appropriateness and cost.

The AMA is thankful for this opportunity to work with the Subcommittee and Congress to replace the SGR with a sustainable Medicare physician payment system.

ATTACHMENT

Demonstration and Pilot Models

An array of approaches to physician payment and delivery reform are being tested in Medicare and the private sector. Approaches include pay-for-performance, bundled payments, medical homes and accountable care organizations, as well as approaches that blend elements of multiple models. This diversity is important because there is no one-size-fits-all payment model that will achieve physicians' and policymakers' objectives for improved care and affordability. These pilot projects are an important means for policymakers and physicians to learn how new models work, how best to structure them, their savings potential, the capabilities practices need to be able to implement these changes, and which models work best for different specialties, communities and practice types before more widespread application. Additionally, it is important to test transitional approaches to reform that will give physicians sufficient time and resources to develop the infrastructure and care management capabilities that will be needed to succeed under a different payment system.

Acute Care Episode (ACE) Demonstration (P.L. 108-173, Sec. 646)

- A tested shared savings model for combined hospital and physician payments.
- Rewards efficiencies while improving quality.

Section 646 of the Medicare Modernization Act of 2003 (MMA) authorized demonstrations to test incentives for delivering improved quality of care and efficient allocation of resources. The ongoing three-year 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. For example, a report indicates that within 18 months of starting the demonstration, 150 orthopaedic surgeons at Baptist Health System in San Antonio, saved $4 million by negotiating discounted prices on supplies and implantable knee and hip joints and shared gains of $558,000. In the absence of the demonstration authority, this so-called "gainsharing" between hospitals and physicians would be prohibited by law. The design also requires each site to have a physician-hospital organization so that there is joint governance and oversight of the project. The first ACE site began its program in May 2009.

National Pilot Program on Payment Bundling (P.L. 111-143, Sec. 3023)

- Next step in the evolution of the ACE demonstration.
- Expands model beyond cardiovascular and orthopaedic services; also to include outpatient care.

By January 1, 2013, the U.S. Department of Health and Human Services (HHS) secretary is required to establish a Medicare pilot program for integrated care. This pilot will include episodes of care involving a hospitalization, broader than the ACE demonstration, to improve the coordination, quality and efficiency of health care services, such as: (1) physician services delivered inside and outside of an acute care hospital setting; (2) other acute care inpatient

services; (3) outpatient hospital services, including emergency department services; (4) post-acute care services, including home health, skilled nursing, inpatient rehabilitation, and inpatient services furnished by long-term care hospitals; and (5) other services the secretary determines are appropriate. The secretary will also establish a payment methodology, including bundled payments or bids for episodes of care. Payment will be made to the entity that is participating in the pilot program.

Extension of Gainsharing Demonstration (P.L. 109-171, Sec. 5007; P.L. 111-148, Sec. 3027)

- Expands on the ACE demonstration project for inpatient services.

Section 5007 of the Deficit Reduction Act of 2005 (DRA) authorized a gainsharing demonstration program to test and evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care. Similar to the ACE demonstration described above, the project allows hospitals to provide gainsharing payments to physicians that represent a share of the savings incurred through their collaborative efforts. This project began October 1, 2008, and was extended for two years by the ACA. The project consists of two sites: Beth Israel Medical Center, New York City and Charleston Area Medical Center, West Virginia.

Physician Group Practice (PGP) Demonstration (P.L. 106-554, Sec. 412)

- A tested ambulatory care model with increased savings potential over time.

Section 412 of the Benefits Improvement and Protection Act of 2000 (BIPA) mandated the five-year PGP demonstration to test incentives for encouraging better care coordination, improving quality and lowering Medicare expenditures. Ten group practices were competitively selected to participate and many of the lessons learned from the first few years of experience with the PGP demonstration are being applied in developing the new Medicare Shared Savings program. For example, the Regulatory Impact Statement in the recently released proposed rule details the PGP sites' start-up and operating costs as a way of estimating costs to participate in the Shared Savings program (i.e., based on the PGP demonstration, CMS estimates average start-up and first year operating expenses of $1,755,251). 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 have been able to meet quality benchmarks. CMS expects a number of the PGP groups to transition to accountable care organizations within the Shared Savings Program.

Patient-Centered Medical Home (P.L. 109-432, Sec. 204)

- Primary care model for improved care management and coordination.

Section 204 of the Tax Relief and Health Care Act of 2006 (TRHCA) mandated a three-year Medicare demonstration of the patient-centered medical home in up to eight states to provide targeted, accessible, continuous and coordinated care to patients with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment. Although CMS obtained demonstration design options from Mathematica Policy Research which it shared with the AMA and primary care specialty societies and secured recommended relative value units for the care management payment from the AMA/Specialty Society Relative Value Scale Update Committee, CMS recently announced that they would not pursue this project. It is possible that the shared savings nature of the program has presented an implementation barrier, as the law is structured such that the care management payments to primary care physicians will be offset by the savings that the Medicare medical homes generate. Instead of the Medicare medical home, CMS decided

to first put in place a Multi-payer Advanced Primary Care Initiative. This demonstration is also in eight states and involves providing monthly care management payments to physicians who serve as a patient's medical home. The eight states are Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. In addition to Medicare, the program involves private payers and Medicaid. The project is expected to be operational by the middle of 2011 and will last for three years.

Medicare Shared Savings Program (P.L. 111-148, Sec. 3022)

- ACO model built around primary care but potentially encompassing specialty and facility services, scheduled to begin in 2012.

Section 3022 of the Patient Protection and Affordable Care Act (ACA) requires the HHS secretary to establish the Medicare Shared Savings Program by January 1, 2012. The law allows accountable care organizations (ACOs) comprised of groups of physicians, networks of individual practices, joint ventures between hospitals and physicians, hospitals employing physicians, and others to participate in the Medicare Shared Savings Program. To qualify, an ACO must agree to be accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries for which it is assigned. An ACO must have physicians who provide primary care to at least 5,000 Medicare patients and have in place: (1) a formal legal structure that would allow the organization to receive and distribute payments for any shared savings; (2) a leadership and management structure that includes clinical and administrative systems; (3) defined processes to promote evidence-based medicine; and (4) processes to report on quality and cost measures. Payments for services provided by physicians and other ACO participants will be made by Medicare according to the usual hospital and physician payment schedules. Additionally, ACOs will be able to share among their participants a portion of Medicare savings achieved in excess of a benchmark. ACOs must agree to participate in the program for at least three years. On April 7, 2011, CMS published in the *Federal Register* a Notice of Proposed Rulemaking on the ACO program with a 60-day comment period. In addition to the proposed rule, the government is also seeking comments on proposed waivers and safe harbors from self-referral, anti-kickback, gainsharing civil monetary penalties, and antitrust laws that would otherwise prohibit the type of coordinated activities and monetary distributions that successful ACOs will require.

Independence-at-Home Demonstration Program (P.L. 111-143, Sec. 3024)

- Designed to avoid costly institutional care.

By January 1, 2012, the HHS secretary is required to establish an independence-at-home demonstration program to bring primary care services to the homes of high-cost Medicare beneficiaries with multiple chronic conditions. Health teams could be eligible for shared savings if they achieve high-quality outcomes, patient satisfaction and cost savings. The HHS secretary will estimate an annual per capita spending target for the estimated amount that would have been spent under Parts A and B in the absence of the demonstration, with the target adjusted for certain risks. A medical home practice could receive an incentive payment based on actual savings achieved in comparison to the target. This demonstration project is still under development.

Community Health Team Support for Patient-Centered Medical Homes (P.L. 111-148, Sec. 3502)

- Expanded model to support primary care across disciplines.

The HHS secretary is required to provide grants or enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional "health teams" to support primary care practices (including obstetrics and gynecology practices) within their local hospital service areas, and to provide capitated payments to primary care providers according to criteria established by the secretary. The health teams could, for example, collaborate with patient-centered medical homes in coordinating prevention and chronic disease management services, or develop and implement care plans that integrate preventive and health promotion services.

Mr. PITTS. The chair thanks the gentleman.

Just a quick announcement. We are in our first series of votes for the day. We will take one more witness and then briefly recess at that time, reconvene immediately following those two votes.

Dr. Hoyt, you are recognized for 5 minutes.

STATEMENT OF DAVID B. HOYT

Mr. HOYT. Chairman Pitts, Ranking Member Pallone, and Members of the subcommittee, I am David Hoyt, a trauma surgeon and the Executive Director of the American College of Surgeons. On behalf of the more than 75,000 members of the College, I want to thank you for inviting the American College of Surgeons to testify today.

The College recognizes that developing a long-term solution to the failing Sustainable Growth Rate formula for Medicare payment is an enormous undertaking, particularly in light of the need to limit the growth in healthcare spending.

The College understands that the current fee-for-service model is unsustainable and maintains that any new payment should be part of an evolutionary process that achieves the ultimate goals of increasing the quality of patient care, reducing the growth of healthcare spending. We assert that these two are directly related objectives.

The first to reforming, the step toward reforming Medicare payment formula is to immediately eliminate the SGR and set a realistic budget baseline for future Medicare payment updates. The new baseline should fairly reflect the costs of providing quality healthcare, preserve the patient-physician relationship, and ensure that patients have continued access to the physician of their choice. Following the elimination of the SGR, we believe it is essential to provide a transition period of up to 5 years to allow for testing, development, and future implementation of a wide range of alternative payment models aimed at improving quality and increasing the integration of care.

To that end the College is currently analyzing the role of creating bundled payments around surgical episodes of care. The primary goal of the bundled payment model is to improve the quality and coordination of patient care through the alignment of financial incentives for surgeons and hospitals. One approach to bundled payments combines payments to surgeons and hospitals for an episode of inpatient surgery into a single fee.

The ideal surgical procedures to bundle include elective, high volume, and/or high expenditure operations that can be risk-adjusted and for which relevant evidence-based or appropriateness criteria exists. In order for a bundled payment to be successful, certain safeguards must be included, such as ensuring quality patient care and physician-led decision-making about how and whom—to whom the bundled payments are distributed.

With the right approaches we can improve both quality of patient care and at the same time reduce healthcare costs. The American College of Surgeons has been able to significantly improve surgical quality for more than 100 years in the specific fields of trauma, bariatric surgery, cancer, and surgery as a whole. These initiatives

reduce complications and save lives, which translates into lower costs, better outcomes, and greater access.

Based on the results of our own quality programs such as the National Surgical Quality Improvement Program or ACS NSQIP, we have learned that four key principles are required to measurably improve the quality of care and increase value. They are setting the appropriate standards, building the right infrastructure, using the right data to measure performance, and verifying the processes with external peer review.

The first, the core process that must be followed in any quality improvement program is to establish, follow, and continually reassess and improve best practice. Standards must be set based on scientific evidence so that surgeons and other healthcare 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.

Secondly, 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 that hospitals have to have proper staff, equipment such as CT scanners, and infection prevention measures. If the appropriate structures are not in place, patients' risks increases.

Third, we all want to improve the quality of care we provide for our patients, but hospitals cannot improve quality if they cannot measure quality, and they cannot measure quality without valid, robust data which allow them to compare their results to other similar hospitals or amongst similar patients. It is critical that quality programs collect risk-adjusted information about patients before, during, and after their hospital visit. Patient clinical charts, not insurance or Medicare claims are the best sources of this type of data.

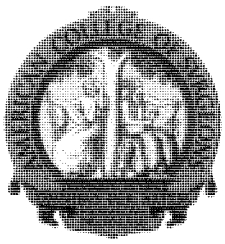
And then finally the final principle is to verify quality. Hospitals and providers must allow an external authority to periodically verify that the right processes and facilities are in place, that outcomes are being measured and benchmarked, and that the hospitals and providers are doing something to address the problems they identify. The best quality programs have long required that processes, structures, and outcomes of care be verified by an outside body. Emphasis on external audits will accompany efforts to tie payment to performance and rank the quality of care provided.

The Patient Protection and Affordable Care Act is intensifying the focus on quality. We believe that complications and costs can be reduced and care and outcomes improved on a continuous basis using these principles that I have outlined and should be the basis for payment reform.

The College welcomes the heightened focus on quality. The evidence is strong. We can improve quality, prevent complications, and reduce costs. Most of all this is good news for patients.

Again, thank you, Mr. Chairman, for the opportunity to share our College comments.

[The prepared statement of Mr. Hoyt follows:]



Statement of the
American College of Surgeons

Presented by

David Hoyt, MD, FACS

before the
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

RE: "The Need to Move Beyond the SGR"

May 5, 2011

Executive Summary

The American College of Surgeons (the College) recognizes that developing a long-term solution to the failing sustainable growth rate (SGR) formula for Medicare physician payment is an enormous undertaking. The College maintains 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, which we assert are directly related objectives. To move beyond the SGR, repeal must be followed by a period of stability in which bundled payments and other models can be tested and implemented, all the while keeping the focus on quality to improve value and lower cost.

The College has a century of experience in creating programs to improve surgical quality and patient safety. Based on the results of these programs, such as the National Surgical Quality Improvement Program, we have learned that four key principles are required to measurably improve the quality of care. They are:

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

Quality initiatives based on these principles have the potential to reduce complications and save lives, which translates into lower costs, better outcomes, and greater access. That's good for providers and payers, government officials and taxpayers. Most of all, that's good for patients.

Chairman Pitts, Ranking Member Pallone and Members of the Subcommittee, I am David Hoyt, a trauma surgeon and the Executive Director of the American College of Surgeons. On behalf of the more than 75,000 members of the College, I wish to thank you for inviting the College to testify today. We appreciate the Subcommittee's recognition that the sustainable growth rate (SGR) is a failed system for calculating Medicare reimbursement for physician services and strongly support the effort to replace the SGR with more innovative models of physician payment.

The College recognizes that developing a long-term solution to the Medicare physician payment system is an enormous undertaking, especially given the need to limit the growth in health related spending. In addition to the SGR, 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 strongly believes 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, which would endanger seniors' access to high quality care in the Medicare program. The College understands that the current fee-for-service model is unsustainable and maintains that any new payment system should be part of an evolutionary process that achieves the ultimate goals of increasing quality and safety for the patient and reducing growth in health care spending, which we assert are directly related objectives. We therefore feel that to move beyond the SGR, repeal must be followed by a period of stability in which bundled payments and other models can be

tested and implemented, all the while keeping the focus on quality to improve value and lower cost.

Stable Transition Period

The first step toward reforming the Medicare payment formula is to immediately eliminate the SGR and set a realistic budget baseline for future Medicare payment updates. This baseline should allow for updates that fairly reflect the costs of providing quality health care and are sufficient to preserve the patient-physician relationship and ensure patients have continued access to the physician of their choice. Following the elimination of the SGR, we believe it is essential to provide a transition period of up to five years that would allow for the testing, development and future implementation of a wide range of alternative payment models aimed at improving quality and increasing the integration of care.

During the transition period, we propose that Congress replace the SGR with a system of separate service category growth rates (SCGR) that recognizes the unique nature of the various types of services that physicians provide to their patients, while allowing for increased payments for areas experiencing workforce shortages such as primary care. Unlike the SGR, which bases reimbursement on the overall spending on all physician services, the SCGR would establish a system that determines reimbursement based on the spending and volume growth among like services. The College believes that the SCGR would have distinct advantages as a transition model to more innovative reforms. First of all, it recognizes that all

physician services are not alike, and lower growth services, such as primary care and surgery, would no longer simply be subject to the blunt cuts of the SGR. Second, under the SCGR, efforts to promote specific services would be greatly simplified. Under the proposal for example, payments for primary care could be increased without requiring corresponding Medicare cuts for other services. Most importantly, the SCGR would support efforts to promote improved quality and safety leading to better value by recognizing that these goals will look different and will be achieved in different ways for different services. Also, as Medicare studies various payment models, the SCGR could enable Congress and CMS to study and better understand how these physician quality improvement efforts affect spending for hospitals, skilled nursing, home health and other service areas in the Medicare program. In addition, the SCGR could also provide a mechanism to study alternative payment mechanisms.

Testing and Implementation of New Models

The College strongly believes that a new delivery system must focus on promoting safe, high quality care and improving patient access while reducing cost. A partnership among patients, physicians, hospitals, and payers is essential to developing a successful delivery system. The testing, development, and future implementation of a wide-range of alternative payment models such as accountable care organizations (ACOs) and the bundling of payments for care received from various providers for a particular condition over a set period of time is critical to

reaching these goals. We believe that in order for any alternative payment model to be successful it must:

- Ensure that quality and safety are the highest priorities for patient care
- Require that specific quality metrics are achieved before any savings can be shared among payers or providers
- Structure payment models to work in concert with and align incentives with proven quality improvement programs
- Appropriately adjust for risk factors and variability that may impact cost of care or treatment, including age, health status, and other factors
- Maintain primacy of physician-leadership within a highly qualified team of health care professionals to work with patients in determining evidence-based courses of clinical care
- Acknowledge that surgical care is delivered in a variety of geographical locations and facilities and that innovative responses may be required to address patient needs in urgent or unique situations
- Preserve the ability of a surgeon to recommend the surgical treatment plan that best meets the patient's needs as guided by best practices and evidence-based medicine
- Ensure clearly-defined mechanisms for appropriate distribution of shared risk and savings among patients, physicians, and health care team members

One area that the College is currently analyzing is the role of surgery in bundled payments. The primary goal of a bundled payment model is to improve the

quality and coordination of patient care through the alignment of financial incentives of surgeons and hospitals. One approach to bundled payment combines the payments of surgeons and hospitals for a defined episode of inpatient surgery into one single fee. Instead of being paid for each visit or service, surgeons and hospitals would be paid for all services provided to a patient related to a particular procedure or condition, depending on how the episode is structured.

The College believes that a bundled payment model could foster greater coordination and improvement in quality of care, which could lead to greater efficiency and a reduction in cost. Accordingly, we are studying the process and the feasibility for creating bundles around surgical episodes of care. The criteria for choosing ideal surgical procedures to bundle include, but are not limited to, procedures that are elective, high volume, and/or high expenditure, and that can be risk-adjusted, and for which relevant evidence-based or appropriateness criteria exist. In order to maximize the opportunity for a bundle to improve quality and reduce cost, the bundle would likely combine both the payment to the hospital and the payment to all physicians who provide care to the patient for the chosen bundled procedure. Although the National Pilot Program on Payment Bundling, as set forth in the *Patient Protection and Affordable Care Act*, defines an episode as beginning three days prior to and ending 30 days post-discharge, it is unclear whether this timeframe would be appropriate for all potential surgical bundles. In addition, for a bundled payment model to be successful, certain safeguards must be included, such as ensuring quality patient care and physician-led decision making about how and to who bundled payments are distributed.

The College is examining these and other issues related to the creation of surgical bundles of care. We support efforts to coordinate patient care, improve quality, reduce adverse events, and thereby reduce costs, and we view bundled payment as a potential opportunity to further this goal.

Continuous Quality Improvement

Finally and most importantly, 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. 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 strong data to measure and improve surgical quality, increase the value of health care services and reduce costs. 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 the right 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 in order 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 COT 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[i].

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 need data strong enough 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. Patients' clinical charts – not insurance or Medicare claims – are the best source for this type of data.

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 doing something in response to what they find out. 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 CoC, 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.[ii] 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 NSQIP program, which has its history in the Veterans Health Administration, is now in more than 400 private sector hospitals around the country. NSQIP uses a trained clinical staff member to collect clinical, 30-day outcomes data for randomly selected cases. Data is 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 is fed back to participating sites through a variety of reports, and 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.[iii] 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, and save thousands of lives and 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.

Thank you once again, Mr. Chairman, for the opportunity to offer the College's comments and views. It is the College's position that controlling health care costs in Medicare should be achieved not through methods that would endanger patients' access to care, but through improving quality and value. I would be pleased to answer any questions.

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[i] The National Study on Costs and Outcomes of Trauma, published in the Journal of Trauma; Injury, Infection and Critical Care, by Ellen Mackenzie, et al. December 2007

[ii] Sachdeva AK, Blair PG. Educating surgery resident in patient safety. Surgical Clinics of North America 84 (2004) 1669-1698.

[iii] Hall BL, et al. "Does Surgical Quality Improve in the American College of Surgeons National Surgical Quality Improvement Program." Ann Surg. 2009; 250:363-376.

Mr. PITTS. The chair thanks you, Dr. Hoyt, for your recommendations, testimony.

The committee will stand in recess until 10 minutes after the second vote.

[Recess.]

Mr. PITTS. The recess having expired we will reconvene with the testimony, and we are up to Mr. Miller. You are recognized for 5 minutes.

STATEMENT OF HAROLD D. MILLER

Mr. MILLER. Thank you, Mr. Chairman and Members of the committee. It is nice to be here with you today.

I think the fundamental challenge that you as a committee and Congress are facing is the issue of how to control healthcare costs, and there is three fundamental ways that you can do that.

One is you can cut benefits or increase costs for the beneficiaries, which obviously you don't want to do. Second is to cut fees for physicians and hospitals, which is obviously inappropriate and hasn't worked, and the third way is to change the way care is delivered, and that is really what I think we need to be focusing on is how to change care in a way that will reduce costs without rationing, and there is three basic ways that you can do that.

One is by helping to keep people well so that they don't have healthcare costs at all. Second is that if they do have something like a chronic disease, to help them manage that in a way that avoids them having to be hospitalized, and if they do have to be hospitalized, to make sure that they don't get infections, complications, and readmissions. And all of those things save money, but they also are improvements for patients, and I think the patients would find desirable.

The problem that we have today and the reason why we are talking about payment reform is that the current payment system goes in exactly the opposite direction. Doctors and hospitals lose money whenever they prevent infections. We don't pay for many of the things that will help patients stay out of the hospital, and in healthcare nobody gets paid at all when the patients stay well. So the incentives go in exactly the opposite direction.

So there are ways to fix that. You don't fix it by changing the fee levels, you don't change it by adding more and more regulations. You do it by putting in fundamentally different payment models, and the two fundamental changes that are needed is, first of all, to be able to pay for care on an episode basis rather than on a service-by-service basis, having a single price for all the care associated with an episode of a patient's treatment, and also including a warranty against not charging more for when infections or complications occur. This is the same way that every other industry in America charges for its products and services, a single price with a warranty, and it would be appropriate for healthcare, too.

The other approach is to have what I like to call comprehensive care payment, which is to have a single payment for a physician practice for all of the care that a patient needs to manage their—the particular conditions that they have. Paying in that way provides the flexibility for physicians to decide exactly what the right

way is for care to be delivered to that patient as well as the accountability for overall costs, and where these programs have been tried they have worked.

Now, the myth that has developed is that only large integrated health systems can do this, and because of the visibility of a number of large systems that have tried these things, I think that is where the myth has come from, but the truth is that there are small physician practices around the country that are also operating under these kinds of programs very successfully, and I think like, again, like in every other industry where small business have been the innovators, I think that there is also a very important opportunity here for small physician practices to be the innovators in this if we provide the right kind of support.

Now, I have talked to physicians all over the country, and whenever they have the time to be able to understand them, I have found that they actually embrace these models. But they need the time to be able to transition, and they need support to be able to get there, and there is really four kinds of support that they need.

First of all, they need data and analysis of that data. Physicians today generally don't even know whether their patients are being hospitalized, whether they are going to the ER, or how many duplicate tests they are getting. So in order to manage that they have to have that kind of support.

Second, they need training and coaching to be able to change the way they deliver care. That kind of reengineering is not taught in medical school, and it is very challenging to do it while you are still trying to deliver care.

Third, physicians need transitional payment reforms so that they can start taking accountability for the things that they can take accountability for without risking bankruptcy in the short run as they evolve towards these broader payment models.

And forth, physicians need to have all payers, Medicare, Medicaid, and commercial payers, paying them the same way. Otherwise they are spending more time trying to administer different payment systems.

Now, the best way to organize this, I don't think, is through a one-size-fits-all federal program. I think it needs to be done at the community level because care is structured and delivered differently in every community. And in a growing number of communities around the country there are now entities called Regional Health Improvement Collaboratives. These are non-profit, multistakeholder entities. They don't deliver care, they don't pay for care, but they help to provide the kind of data and analysis and technical assistance to physician practices to be able to evolve in this direction.

And I think that Congress can help these regional collaberatives in three key ways. One is by providing them data. Today it is impossible to get data from Medicare to know how you are doing for Medicare patients if you want to change that. Second, you can give them some modest federal funding to support what they are doing, and when I say modest, I am talking millions, not billions, and third, you can encourage or require Medicare to participate in the cases where they have developed multi-payer payment reforms already at the local level. The big thing that they are missing is hav-

ing Medicare at the table, and I think that is going to be a very important strategy to support that.

So I appreciate the opportunity to be here today, and I would be happy to answer any questions or provide any help.

[The prepared statement of Mr. Miller follows:]

Testimony of Harold D. Miller
Executive Director, Center for Healthcare Quality and Payment Reform
and
President & CEO, Network for Regional Healthcare Improvement
to the
Subcommittee on Health, Committee on Energy and Commerce
U.S. House of Representatives
May 5, 2011

Mr. Chairman and Members of the Committee:

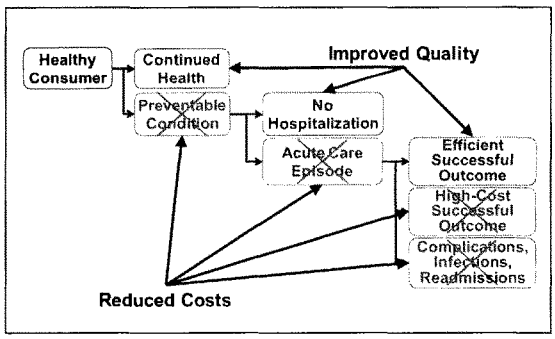
I commend you for working to address the important issues associated with physician payment reform and I appreciate the opportunity to provide input to your deliberations. The following are the major points that I would like to make to you today:

- Healthcare costs can be reduced without rationing, but a major barrier is current payment systems, which financially penalize physicians and hospitals for reducing costs.
- There are two principal ways healthcare payment should be reformed. The first is Episode-of-Care Payment, where physicians and hospitals are jointly paid a single price for all of the services associated with a hospitalization or procedure, including a warranty stating that they will treat any related infections and complications at no extra charge. The second is Comprehensive Care payment, where a physician practice receives a single payment to cover all of the care a patient needs for their chronic diseases or other conditions. These payment systems have been shown to improve quality and lower costs.
- Small, independent physician practices as well as large integrated systems can participate in these payment systems. However, small physician practices need a reasonable transition period and the following kinds of assistance to do so successfully:
  - Access to data and analysis on current utilization patterns and costs;
  - Training and coaching on restructuring of care processes;
  - Transitional payment reforms, such as accountable medical home payments, bundled payments, and condition-specific comprehensive care payments; and
  - Participation by all payers, including Medicare, Medicaid, and commercial plans.
- Because of the wide variation in the structure of healthcare delivery systems across the country, the best way to organize this help is through community-based, non-profit, multi-stakeholder organizations called Regional Health Improvement Collaboratives. Congress can help these Collaboratives support successful payment reforms for physicians by:
  - providing access to Medicare data so they can help physicians identify the best opportunities to improve quality and reduce costs.
  - providing some modest federal funding so that Collaboratives can provide the hands-on help that physician practices need to improve quality and reduce costs.
  - encouraging or requiring Medicare to participate in the multi-payer payment and delivery reforms communities design.

Healthcare Costs Can Be Reduced Without Rationing

The challenge that the Committee and Congress have faced for many years has been how to control costs in the Medicare and Medicaid programs without denying care that patients need or limiting their access to high-quality physicians and hospitals. Although many people seem to believe that costs can't be reduced without rationing, there are three major ways to do so:

- **Preventing health problems from occurring in the first place.** Many illnesses can be prevented through interventions such as immunizations, weight management, and improved diet, and the severity of other illnesses can be reduced through regular screenings (e.g., for cancer or heart disease) that lead to early diagnosis and prompt treatment.
- **Helping patients manage chronic diseases and other conditions so they don't have to be hospitalized as often.** Studies have shown that rates of emergency room visits and hospitalizations for many patients with chronic disease and other ambulatory-sensitive conditions can be reduced by 20-40% or more through improved patient education, self-management support, and access to primary care.[1]
- **Reducing the high rate of infections, complications, and readmissions that occur today when patients do have to be hospitalized.** For example, work pioneered by the Pittsburgh Regional Health Initiative and replicated in other parts of the country proves that such events can be dramatically reduced or even eliminated through low-cost techniques.[2].



All of those things not only can save money for Medicare, Medicaid, and commercial health plans, but they improve outcomes for patients, too.

Current Payment Systems Are a Major Barrier to Higher Value Health Care

The problem today is that current payment systems drive the healthcare system in exactly the opposite direction. For example:

- **Many valuable preventive care and care coordination services are not paid for adequately or at all** (e.g., primary care practices are typically paid only when a physician sees a patient in person, not when the physician speaks to the patient on the phone). Similarly, specialists are only paid for seeing patients in person, not for advising primary care physicians on care management or for time spent coordinating services with the primary care physician. A primary care physician or specialist who hires a nurse to assist with patient education typically cannot be reimbursed for the time the nurse spends with the patient. All of these things can limit the ability of physicians to flexibly design services to best meet a patient's needs, resulting in unnecessary illnesses and treatments.
- **Physicians and hospitals can be financially penalized for providing better quality services.** For example, reducing errors and complications during hospital stays can not only reduce both physicians' and hospitals' revenues, but also reduce hospital profits and their ability to remain financially viable.[3]
- Perhaps most fundamentally, under current payment systems, **physicians don't get paid at all when their patients stay well.**

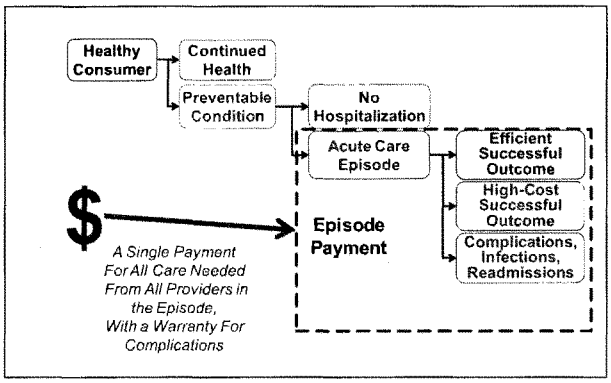
You can't fix those things by increasing or decreasing fee levels or by adding more and more regulations. The SGR obviously can't do it, either. The payment system itself is broken and has to be fundamentally changed.

There Are Better Ways to Pay For Health Care

There are two major kinds of payment reforms that would correct these problems and provide both the flexibility and accountability that physician practices, hospitals, and other providers need to both improve the quality and reduce the costs of healthcare.

Episode-of-Care Payments

One is to use Episode-of-Care Payments to pay for hospitalizations and major acute procedures. Instead of paying physicians and hospitals separately for each service associated with the hospitalization or procedure, they would jointly be paid a single amount for the entire episode. For example, once a patient has a heart attack, a single payment would be made to the hospital and physicians for all of the care needed by that patient for the heart attack. The amount of the payment would be severity-adjusted, e.g., the hospital and physicians would be paid more for caring for a heart attack patient with other health conditions such as diabetes or emphysema.



Moreover, the Episode-of-Care Payment would be designed to cover the costs of treating any related infections and complications that the patient experiences. In effect, the hospital and physicians would be providing a limited warranty on their care, i.e., if the patient experienced a problem such as an infection or preventable complication, the hospital and doctors would treat that problem at no extra charge.

The advantages of Episode-of-Care Payment include the flexibility it provides for hospitals and physicians to decide which services should be provided within the episode (rather than being restricted by the services specifically authorized under a fee-for-service system), the incentive it creates to eliminate any unnecessary services within the episode, the incentive for the hospital and physicians to better coordinate their services, and the incentive for everyone to prevent infections and complications.

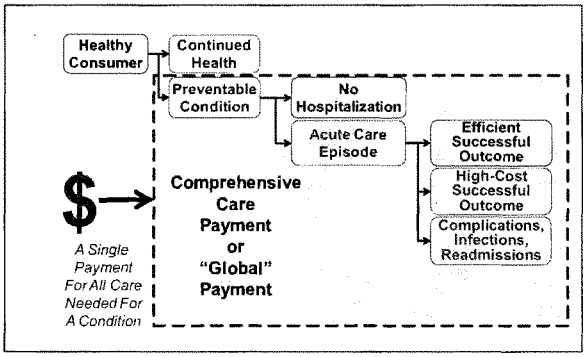
This approach – a single payment for a complete product or service, with a warranty to correct defects at no charge – is how most other industries are paid for their products and services, and it makes sense to use it in healthcare, too.

For example, the Geisinger Health System in Pennsylvania, through its ProvenCare[SM] system, provides a "warranty" that covers any follow-up care needed for avoidable complications within 90 days at no additional charge. The system was started for coronary artery bypass graft surgery, and has been expanded to hip replacement, cataract surgery, angioplasty, bariatrics, low back pain, perinatal care, and other areas.[4] Offering the warranty led to significant changes in the processes used to deliver care, and Geisinger has reported dramatic improvements on quality measures and outcomes.[5]

Comprehensive Care Payments

The major weakness of Episode-of-Care Payment is that it does nothing to reduce the number of episodes of care. If a physician practice is managing the care for patients with chronic disease, we want the practice to find ways to reduce the frequency that those patients are hospitalized, not simply ensure higher quality and lower costs every time they *are* hospitalized. We also want to find ways to reduce the frequency of certain kinds of procedures when there is evidence of overuse that is harmful to patients.

A second payment reform that achieves these goals is Comprehensive Care Payment[6], or what is often referred to as "global payment." Under this model, a physician practice or health system would accept a single payment to cover all of the healthcare services their patients need for their health conditions during a specific period of time (e.g., a year). The amount of this payment would be adjusted based on the health of the patients (i.e., how many conditions they have) and other characteristics that affect the level of services needed. For example, a physician practice would receive a higher payment if it has more patients with severe heart disease rather than mild heart disease, but the payment would not depend on what kinds of treatment the patients



receive. As a result, a physician practice gets paid more for taking care of sicker patients, but not for providing more services to the same patients.

For example, the Alternative Quality Contract implemented by Blue Cross Blue Shield of Massachusetts in 2009 defines a single payment to a physician practice or health system for a group of patients to cover all care services delivered to those patients (including hospital care, physician services, pharmacy costs, etc.), with the payment amount adjusted by the health status of the patients. The physician practice or health system can earn up to a 10% bonus payment for achieving high performance on clinical process, outcome, and patient experience measures. The amount of the payment is based on historical costs for caring for a similar population of patients and is increased annually based on inflation. Outlier payments are made for patients with unusually high needs and expenses, and limits are placed on the total amount of financial risk the providers accept.[7] An evaluation of the first year results showed that participating healthcare providers achieved better quality, better patient outcomes, lower readmission rates, and lower utilization of emergency rooms.[8]

Separating Performance Risk from Insurance Risk

An important feature of both Episode-of-Care Payment and Comprehensive Care Payment is that they give physicians and health systems responsibility for *performance risk* – their ability to manage their patients' conditions in a high-quality and efficient manner –but not *insurance risk* – whether a patient has an illness or other condition requiring care. In contrast, traditional (non-condition-adjusted) capitation systems transferred *all* cost risk to the provider. Insurance risk is really what insurance is designed to address, and under both Episode-of-Care and Comprehensive Care Payments, insurance risk remains with Medicare or a health insurance plan.[9]

Small Physician Practices Can Deliver High-Value Care

Because of the visibility of the outstanding work that the Geisinger Health System, Intermountain Healthcare, Thedacare, and other large systems have done, a myth has developed that only large, integrated delivery systems can manage such payments and deliver higher-value care. But experience has shown that small, independent physician practices can also use better

payment models to deliver higher-quality, lower-cost care. For example, the earliest known example of someone offering a warranty in healthcare was not a large health system, but a single physician. In 1987, an orthopedic surgeon in Lansing, Michigan collaborated with his hospital to offer a fixed total price for surgical services for shoulder and knee problems, including a warranty for any subsequent services needed for a 2-year period, including repeat visits, imaging, rehospitalization, and additional surgery. A study found that the payer paid less and the surgeon received more revenue by reducing unnecessary services such as radiography and physical therapy and reducing complications and readmissions.[10]

Small physician practices will likely need to join together through Independent Practice Associations (IPAs) or other structures to achieve the necessary economies of scale to manage Comprehensive Care Payments. However, physicians do not need to be employed by hospitals or join large group practices in order to do so. There are many examples of how physician practices, including very small practices, are successfully managing these new payment models.[11]

Just like in every other industry, where small businesses are often the innovators, small healthcare providers can be more efficient and innovative than large systems, if we give them the opportunity to do so without imposing unnecessary and expensive regulatory requirements.

Helping Physician Practices Succeed

I've talked to physicians all over the country about these payment reform concepts, and what I've found is that once they understand them, they are willing to embrace them. But they need assistance to implement them successfully, and they need a reasonable transition period.

What kind of help do physicians need?

Access to Data and Analysis on Cost and Quality

Physicians today typically don't know how often their patients are being hospitalized, going to the ER, being readmitted, or getting duplicate tests. Although many people seem to believe that all information problems will be solved by electronic health records, a physician's EHR typically only includes information on the services that he or she provided, not on the

services delivered by other providers. Medicare and health plans have the only comprehensive data on the services patients receive, and physicians typically do not have access to this information, particularly in a timely fashion.[12]

Timely access to such data is critical if a physician is going to be held accountable for costs and quality, particularly if this includes services delivered by hospitals or other providers. However, it is not enough simply to have access to data or even to traditional quality measures that are produced by Medicare and commercial health plans; physicians need useful *analysis* of those data to identify where opportunities exist for quality improvement and cost reduction.

Training and Coaching in Process Improvement

Data can show where opportunities exist to reduce utilization and costs, but physicians also need training and coaching in how to restructure their practices in ways that can take advantage of these opportunities. Not only is this re-engineering not taught in medical school, it is hard for physicians to do it and still keep up with the demands of ongoing patient care.

Transitional Payment Reforms

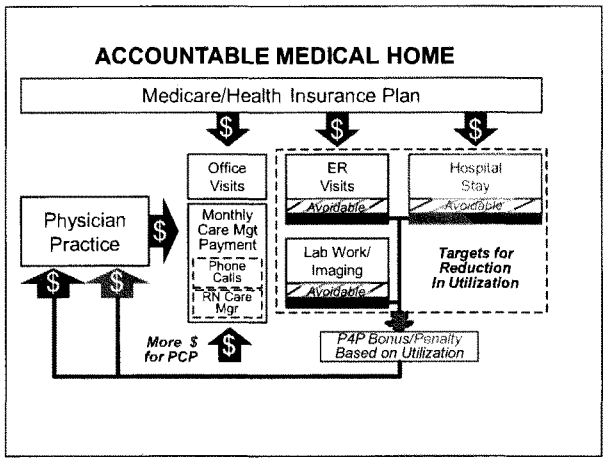
It will be challenging for physicians and other healthcare providers who have been operating under the fee-for-service payment system for many years to suddenly switch to operating under systems such as Episode-of-Care Payment and Comprehensive Care Payment that require greater accountability for cost and quality. As described above, physicians will need new resources and capabilities in order to manage successfully under dramatically different payment models, and it will take time for them to develop these.

However, physicians cannot change the way they deliver care unless payment systems are implemented that support those changes. The solution to this "chicken and egg" problem – better payment systems require better delivery systems, but better delivery systems require better payment systems – is to develop and implement *transitional* payment reforms, i.e., payment changes which will give physicians more flexibility and accountability for costs and quality than they have today under fee-for-service, but less than they would have under the ultimate payment system that would be used, so that the physicians have time to transition their processes and

organizational structures to enable them to develop the capabilities to move to even higher levels of flexibility and accountability.[13]

Examples of the kinds of transitional payment reforms that would be helpful include:

- **Accountable Medical Homes.** This would involve paying primary care practices with three new components:
  - A Care Management Payment would be paid to the primary care practice for each patient (in addition to current fees for individual services) to support better patient education and self-management support, access to physicians by telephone, etc.;
  - Specific targets for reducing utilization of healthcare services outside of the practice (e.g., non-urgent emergency room visits, ambulatory care sensitive hospitalizations, or high-tech diagnostic imaging) would be established that would result in savings greater than the cost of the Care Management Payment; and
  - Bonuses/penalties would be paid to the practice based on its performance against the targets.



- **Medical Neighborhood Payments to Specialists.** Similar to the payment model above for primary care practices, specialists would be paid more to better manage and coordinate patient care, but with specific targets for reducing utilization of expensive services such as hospital care.

- **Bundling Hospital and Physician Payments for Major Acute Episodes**, i.e., making a single payment for both hospital and physician services instead of separate payments, and allowing the hospital and physicians to allocate the payment among themselves to recognize efforts to improve quality and reduce costs.
- **Warranties for Inpatient Care**, i.e., allowing hospitals and/or physicians to set a new price for procedures that would enable them not to charge more for services to correct errors, infections, and other hospital-acquired complications.
- **Condition-Specific Partial Comprehensive Care Payments.** A physician practice or group of providers would be paid a single amount for some or all of the services that a patient will need from some or all providers for one or more of their health conditions over a fixed period of time (e.g., a year). This would replace separate fees currently paid for the individual services that the patient needs for those specific health conditions.

These transitional payment reforms can be designed in ways that save Medicare and other payers money and improve quality for patients. (More detail on these and other transitional payment reforms can be found in *Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care*, Center for Healthcare Quality and Payment Reform, January 2011.) Sections 3021 and 3022 of the Affordable Care Act provide CMS with the authority to implement such models, but it has not yet done so.

Consistent Payment Reforms Across All Payers

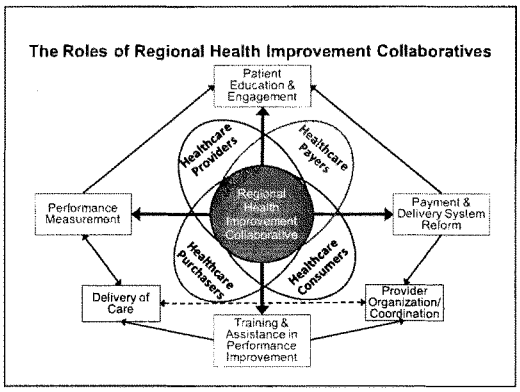
Fourth, physicians need to have *all* payers – Medicare, Medicaid, and commercial health plans – make these payment changes and do so in similar ways. Even if one payer is willing to implement desirable payment reforms, it is difficult and may even be inappropriate for a provider to change the way it delivers care for only that payer's patients.

There are a growing number of communities that have developed multi-payer payment reforms involving all or most of the commercial insurance plans in the community and Medicaid programs. The biggest problem they have faced is that Medicare does not participate, meaning that 30-40% or more of a physician practice or hospital's patients are not included in the payment reforms.

Supporting Community-Driven Solutions

No one-size-fits-all national program can address these needs, since the supports and changes need to be designed and implemented in ways that are feasible for the unique provider and payer structures in each community and in ways that complement, rather than conflict with, the quality improvement activities that are already underway in each individual community. Moreover, since all of the healthcare stakeholders in the community – consumers, physicians, hospitals, health plans, businesses, government, etc. – will be affected in significant ways, they all need to be involved in planning and implementing changes; however, since in many communities there is considerable distrust between different stakeholder groups, a neutral facilitator is needed to help design "win-win" solutions.

A growing number of communities are recognizing that *Regional Health Improvement Collaboratives* are an ideal mechanism for developing coordinated, multi-stakeholder solutions to their healthcare cost and quality problems. A Regional Health Improvement Collaborative (RHIC) does not deliver healthcare services directly or pay for such services; rather, it provides a neutral, trusted mechanism through which the community can plan, facilitate, and coordinate the many different activities required for successful transformation of its healthcare system.



Regional Health Improvement Collaboratives have three key characteristics:

- They are **non-profit organizations** based in a specific geographic region of the country (i.e., a metropolitan region or state);
- They are **governed by a multi-stakeholder board** composed of healthcare providers (both physicians and hospitals), payers (health insurance plans and government health

coverage programs), purchasers of health care (employers, unions, retirement funds, and government), and consumers; and

- They help the stakeholders in their community **identify opportunities for improving healthcare quality and value, and facilitate planning and implementation of strategies for addressing those opportunities**.

There are currently over 40 Regional Health Improvement Collaboratives in the country. Most were formed relatively recently, but some have been in existence for ten to fifteen years or longer. There has been dramatic growth in the number of Regional Health Improvement Collaboratives in recent years, partly due to the rapidly growing concern about healthcare costs and quality across the country, and partly due to proactive efforts by the Robert Wood Johnson Foundation (through the Aligning Forces for Quality program) and the U.S. Department of Health and Human Services (through the Chartered Value Exchange program) to foster the creation of such entities. The leading Collaboratives are members of the Network for Regional Healthcare Improvement, which is the national association of Regional Health Improvement Collaboratives.[14]

Regional Health Improvement Collaboratives in the Network for Regional Healthcare Improvement

Albuquerque Coalition for Healthcare Quality
Aligning Forces for Quality – South Central PA
Alliance for Health (West Michigan)
Better Health Greater Cleveland
California Cooperative Healthcare Reporting Initiative
California Quality Collaborative
Finger Lakes Health Systems Agency
Greater Detroit Area Health Council
Health Improvement Collaborative of Greater Cincinnati
Healthy Memphis Common Table
Institute for Clinical Systems Improvement (Minnesota)
Integrated Healthcare Association (California)
Iowa Healthcare Collaborative
Kansas City Quality Improvement Consortium
Louisiana Health Care Quality Forum
Maine Health Management Coalition
Massachusetts Health Quality Partners
Midwest Health Initiative (St. Louis)
Minnesota Community Measurement
Minnesota Healthcare Value Exchange
Nevada Partnership for Value-Driven Healthcare (HealthInsight)
New York Quality Alliance
Oregon Health Care Quality Corporation
P2 Collaborative of Western New York
Pittsburgh Regional Health Initiative
Puget Sound Health Alliance
Quality Counts (Maine)
Quality Quest for Health of Illinois
Utah Partnership for Value-Driven Healthcare (HealthInsight)
Wisconsin Collaborative for Healthcare Quality
Wisconsin Healthcare Value Exchange

Regional Health Improvement Collaboratives operate programs that directly address the needs of physician practices that were identified earlier. For example:

- **Collecting and Analyzing Quality and Cost Data**. Most Regional Health Improvement Collaboratives have established a mechanism for collecting and publicly reporting data

on the quality of care delivered by physicians. Unlike many quality reporting initiatives developed by health plans and government agencies, these quality measurement and reporting initiatives are developed and operated with the active involvement and supervision of the physicians for whom quality scores are being reported, so the physicians can ensure that the measures are meaningful and the data are accurate. Although many of these measurement systems rely on health plan claims data, a growing number of Regional Health Improvement Collaboratives, such as Minnesota Community Measurement and the Wisconsin Collaborative for Healthcare Quality, are using clinical data from physicians for quality measurement. Some Regional Health Improvement Collaboratives, such as Massachusetts Health Quality Partners, also collect and report information on consumers' experience with healthcare providers. [15]

- **Providing Training and Coaching to Physicians and Other Providers.** Many Regional Health Improvement Collaboratives are working with providers, either individually or in groups, to help them better organize and deliver health care in order to improve quality and efficiency. For example, the Pittsburgh Regional Health Initiative developed a Preventable Readmission Reduction Initiative that worked with primary care practices to improve care for people with chronic diseases and successfully reduced hospital readmissions for patients with chronic obstructive pulmonary disease.[16]
- **Designing and Implementing Multi-Payer Payment Reforms.** Many Regional Health Improvement Collaboratives are already working to build consensus among the multiple health plans and other payers in their communities on the types of payment reforms which should be implemented, so that physicians and other healthcare providers are not forced to deal with multiple, disparate new payment structures. A few Collaboratives have successfully implemented multi-payer payment reforms in their communities. For example, the Institute for Clinical Systems Improvement reached agreement among all of the major health plans in Minnesota on changes in payment to support better primary care for patients with depression.[17] The Puget Sound Health Alliance is co-sponsoring a demonstration project which will give participating primary care practices in Washington State both greater resources and greater accountability for helping patients avoid unnecessary emergency room visits and hospitalizations, similar to the Accountable Medical Home model described earlier.

What Congress Can Do to Support Local Payment and Delivery Reforms

Congress can help support successful community-driven payment and delivery reforms in several ways.

Provide Access to Medicare Data for Regional Health Improvement Collaboratives

It is impossible for physicians to identify where opportunities for cost reduction exist or how to capitalize on them without access to data. Physicians need information on current utilization patterns and analyses of the likely impact of interventions in order to construct a feasible business case for the investment of resources in new care processes.

Although many Regional Health Improvement Collaboratives have assembled multi-payer databases and sophisticated programs to analyze the data, these databases typically do not contain data on Medicare patients, which makes it impossible to identify care improvement opportunities for Medicare beneficiaries or to help physicians and hospitals design changes in care that will improve quality and reduce costs for the Medicare program. In the few communities where Medicare data has been made available, it has typically been several years old. Data that are out-of-date are of relatively little value in communities where there are active efforts to improve the quality and cost of care; indeed, using old data can be counterproductive since it may unfairly imply that problems exist when, in reality, they have already been addressed. Physicians need access to timely information so that they can measure progress towards improvement, and consumers need timely information so they can choose providers wisely and fairly. Ideally, data should be made available within 30 days after claims have been filed.

Congress can help by requiring that Regional Health Improvement Collaboratives gain access to Medicare claims data as soon as possible so they can help physicians identify the best opportunities to improve quality and reduce costs and prepare to participate in new payment models. CMS should provide the data as frequently as possible and as quickly as possible after claims are filed.

Provide Funding to Support Training and Coaching for Physician Practices

Despite the key role that Regional Health Improvement Collaboratives can play in ensuring the success of federal healthcare reforms in local communities, there is currently no federal funding program that provides support for the work that Regional Health Improvement Collaboratives do to analyze data or to provide training and assistance to physician practices. Although the Department of Health and Human Services (HHS) and the Agency for Healthcare Research and Quality (AHRQ) promoted the creation of multi-stakeholder collaboratives through the Chartered Value Exchange (CVE) program, they do not provide any funding for general operating support of Regional Health Improvement Collaboratives.

Congress can help by providing a modest amount of federal funding to Regional Health Improvement Collaboratives so they can provide the hands-on help that physician practices need to improve quality and reduce costs. Successfully reforming local healthcare delivery systems will require many years of persistent effort by these Collaboratives, and so reliable, multi-year funding will be needed to support their efforts.

Encourage or Require Medicare Participation in Local Multi-Payer Payment Reforms

The most successful, high-impact payment reform projects will be those which address the most important quality and cost issues in a particular community, which have support from both consumers and a broad range of healthcare providers, which have participation by payers other than Medicare, and which have effective local mechanisms of monitoring implementation and resolving problems. As noted earlier, a number of communities have implemented or are in the process of developing multi-payer payment reforms, but a major challenge has been the inability to include Medicare as a partner.

Congress can help by encouraging or requiring Medicare to participate in multi-payer payment and delivery reforms that communities design and implement, particularly the kinds of transitional payment reforms described earlier. The Innovation Center created by Section 3021 of the Affordable Care Act provides Medicare the flexibility to participate in such initiatives, but it would be preferable if the Innovation Center announced an explicit commitment and priority for supporting multi-payer payment reforms that have been developed through a multi-

stakeholder process at the community level. This would not only help support existing projects but encourage the creation of additional such efforts across the country.

Thank you again for the opportunity to testify. I would be pleased to provide any additional detail about these recommendations that would be helpful.

Sincerely,

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[14] See the Network for Regional Healthcare Improvement website (http://www.nrhi.org) for a complete list of Regional Health Improvement Collaboratives.

[15] Other multi-stakeholder Regional Health Improvement Collaboratives that report on the quality of physician care and involve physicians in the process of developing the measures include the Albuquerque Coalition for Healthcare Quality, Aligning Forces for Quality – South Central Pennsylvania, the Alliance for Health, Better Health Greater Cleveland, the California Cooperative Healthcare Reporting Initiative, the Greater Detroit Area Health Council, the Healthy Memphis Common Table, the Integrated Healthcare Association, the Kansas City Quality Improvement Consortium, the Maine Health Management Coalition, the Midwest Health Initiative, the Oregon Health Care Quality Corporation, the Puget Sound Health Alliance, and Quality Quest for Health of Illinois.

[16] More information on the Pittsburgh Regional Health Initiative is available at http://www.prhi.org. Other Regional Health Improvement Collaboratives that work with physicians to improve their performance on quality and cost include the California Quality Collaborative, HealthInsight, the Iowa Healthcare Collaborative, the Institute for Clinical Systems Improvement in Minnesota, the Louisiana Healthcare Quality Forum, and Quality Counts in Maine.

[17] For more information on the "DIAMOND Initiative," see www.icsi.org.

Mr. PITTS. Thank you for those excellent recommendations.

Dr. Chernew, 5 minutes.

STATEMENT OF MICHAEL E. CHERNEW

Mr. CHERNEW. Thank you, Chairman Pitts, Ranking Member Pallone, and Mr. Miller for putting my mike on, and members of the Subcommittee on Health for inviting me to testify on innovative Physician Payment Systems that might be useful alternatives to the Sustainable Growth Rate System that ironically has proven not to be sustainable. Before I commence with my substantive remarks, I would like to emphasize that my comments reflect solely my beliefs and do not reflect the opinions of any organization I am affiliated with, including MedPAC.

Critiquing the SGR is easy, yet identifying a viable alternative to the SGR is difficult. There is unlikely to be a perfect solution, and any path to a solution will take time. That said, I think that increasingly the private sector has developed promising alternatives. I will discuss one option I consider particularly promising today, the alternative quality contract implemented by Blue Cross Blue Shield of Massachusetts known commonly as the AQC.

But before launching into a description of the AQC I would like to speak broadly about payment reform. First, it is important to distinguish between the form of payment, fee-for-service versus bundled, and the level of payment. The form of payment creates incentives that influence behavior, but even the best payment system can function poorly if payment rates are set too low or even too high.

Second, while I recognize that I have been asked to discuss physician payment, the question presupposes a fragmentation of payment that I think is detrimental. Specifically, the existing Medicare System, including the SGR, structures payment by provider type. This creates numerous inequities and paradoxes that makes managing the system and improving coordination of care across settings difficult.

A more bundled system that pays for an episode of care or provides a global budget can allow more flexibility for providers and limit the need for purchasers such as Medicare or private insurers to micromanage payment systems. In a bundled payment model the relevant question is not how do we pay physicians, but instead how do we pay for care.

Implementing a bundled system is not easy but innovative systems do exist, and at a minimum our experience demonstrates their feasibility, and I believe promise. The AQC is one such system.

Briefly, the AQC is integrated into the Blue Cross Blue Shield HMO product and rests on three fundamental pillars. First, a global payment in which providers' systems receive a budget to cover the cost of providing all of an enrollee's care. Second, the AQC incorporates a comprehensive pay-for-performance system that rewards provider groups for performance on 64 quality measures ranging from process measures to outcome measures, from clinical measures to patient experience measures, and third, the AQC includes a significant data and analytic support for participating phy-

sician groups which helps them identify areas to target for improvement and training and other things as well.

The AQC differs from the capitation plans of the 1990s because the contract extends for 5 years and because of the robust quality program and data support.

The model has several strengths. Most importantly it creates a business case for improving quality and efficiency. In contrast, the fee-for-service systems innovative programs that reduce the use of unnecessary or inefficient care are profitable under the AQC. The global budget also provides stability and predictability of spending growth, and the 5-year contract duration and the requirement that patients designate a physician greater facilitates management and accountability.

Global payment systems in the past have raised several concerns. For example, many have worried that they would lead to a lower quality of care. The AQC is designed to prevent this by setting the global budget at least equal to the prior year payment so no provider group will be forced to reduce access to care and by incorporating the quality bonus system. Early evidence suggests that these features have led to an increase, not decrease in the quality of care delivered.

Further, many observers have noted that not all physician groups are capable of functioning in a global budget environment. Certainly this is true, but just because all groups are not ready for bundled payment does not mean we should abandon it, and I would support a multiplicity of approaches.

Moreover, I tend to have a free market orientation that suggests providers will adapt. In fact, if we do not believe such transformation is possible, no amounts of payment reform or other policy changes will solve our problems, and we are doomed to a system that operates far below our aspirations.

Moreover, many solo and small practices participate in the AQC as part of the larger independent practice associations, which demonstrate that the model can succeed outside of large integrated group practices.

The AQC is not without its weaknesses. For example, the AQC is not tied to benefit design, and I believe a greater integration with value-based insurance design would be an improvement. Second, while I am a big believer in markets, any private sector model must contend with issues of provider market power. Because of its size Blue Cross Blue Shield may be better positioned to do this than other smaller plans.

So far the agency has passed the test of the market with enrollment growing from 26 percent to 44 percent of Blue Cross Blue Shield HMO membership as more provider groups have chosen to join. Some AQC principles are already evident in the recently-proposed Accountable Care Organization regulations and in several other bundled payment demonstrations.

Broad application of such models would be facilitated in Medicare if beneficiaries were incented or required to designate a physician without giving up existing benefits or rights regarding choice of provider.

In summary, a fee-for-service physician system for Medicare, SGR or not, generates inherent problems. Bundled payment sys-

tems such as the AQC offer considerable promise as a way forward. These systems are comprehensive and give autonomy to providers which ultimately will be preferable to other strategies to control spending.

Thus I urge you to support ongoing bundled payment demonstrations and others like them which will create a more rational and effective payment system that allows our expectations and aspirations to be met in a fiscally-sustainable manner.

[The prepared statement of Mr. Chernew follows:]

Physician Payment Post SGR

Michael Chernew, PhD

Professor of Health Care Policy

Harvard Medical School

Boston, Massachusetts

Testimony before the Subcommittee on Health

of the House Committee on Energy and Commerce

May 5, 2011

Thank you, Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee on Health for inviting me to testify on innovative physician payment systems that might be useful alternatives to the sustainable growth rate system, that ironically has proven not to be sustainable. Before I commence with my substantive remarks I would like to emphasize that my comments reflect solely my beliefs and do not reflect the opinions of any organization I am affiliated with, including MedPAC.

I believe that we all share the same goal of developing payment systems that provide sufficient support for health care providers, promote access to care for Medicare beneficiaries, encourage delivery of high value, appropriate care and discourage use of wasteful inappropriate care. Moreover given the country's fiscal situation, such a system must be financially viable in increasingly difficult budgetary times. I hope we can agree that the current physician payment system that relies on the SGR does not accomplish those goals. If implemented as designed it would call for approximately a 30 percent reduction in physician fees that would undoubtedly threaten access to care and possibly the viability of many medical practices. Medicare's fee for service foundation does little to encourage cost containment or high quality care and the details of the SGR formula lead to fee reductions that are not tied to any sensible clinical objectives. Moreover, the difficulties associated with patching the SGR have led to disruptions and uncertainties regarding payment that impede progress towards our goals.

Yet while critiquing the SGR is easy, identifying a viable alternative is difficult. There is unlikely to be a perfect solution and, given that the health care system has grown and adapted to the basic fee-for-service structure that the SGR is based on, any path to a solution will take time. That said, I think that increasingly the private sector, which faces many of the same issues as Medicare, has developed promising alternatives. I will discuss one option I consider particularly promising today, the Alternative Quality Contract implemented by Blue Cross Blue Shield of Massachusetts, known commonly as the AQC.

My intent is not to advocate for the AQC or any of the specific details of the AQC, only to note its basic design features, their promise, and possible challenges to models like the AQC. I think several aspects of the AQC are instructive and while evaluation of the AQC's impact is ongoing, many proposed payment reforms share similar traits.

But before launching into a description of the AQC, I would like to speak broadly about payment reform. First, it is important to distinguish between the form of payment (fee-for-service vs bundled payment) and the level of payment. The form of payment creates incentives. Creating the appropriate form of payment can facilitate the creation of appropriate incentives for managing costs, improving quality and achieving other goals. But even if we adopt the best form of payment, it will be a challenge to set the right level of payment. Provider costs vary across and within markets, in some cases due to factors beyond the providers control and in other cases due to factors providers can control. Thus it is difficult to know exactly what prices should be set or even the process by which the prices may be set. Even the best payment system can function poorly if the level of payments are set too low (or too high). In my opinion a discussion of post-SGR payment should primarily focus on the form of payment, not the level of payment. Payment levels (and updates) can be discussed as a second step.

Second, while I recognize that I have been asked to discuss physician payment, I think the question presupposes a fragmentation of payment I think is detrimental. Specifically, the existing Medicare system (including the SGR) structures payment by provider type. We have separate fee schedules for physicians, hospitals, nursing homes, and a whole array of other providers often delivering similar services and treating the same patients. This creates numerous inequities and paradoxes that make managing the system and improving coordination of care across different settings difficult. Just to give one example, a colonoscopy preformed in a physician's office costs Medicare on average about half of the cost if it is performed in a hospital outpatient setting. This largely reflects different treatment of the technical fee for providing the service, which may be justified, but it is difficult to assess the appropriate fee differential, if any (because case mix and other factors are hard to observe).

Many scholars and policy analysts have concluded that moving away from a fee-for-service system is justified. A more bundled system, that pays for an episode of care or provides a global budget can allow more flexibility for providers and obviate the need for purchasers (such as Medicare or private insurers) to micro manage payment systems. Moreover, such a bundled system can facilitate cost containment strategies that avoid slashing per unit price when volume rises, as the SGR does. In a bundled payment model the relevant question is not: how do we pay physicians, but is instead: how do we pay for care.

Implementing such a bundled payment system is not easy, but as I mentioned earlier, innovative systems exist and, at a minimum our experience demonstrates their feasibility (and I believe promise). The AQC is one such system.

Briefly, the AQC is integrated into the Blue Cross Blue Shield's HMO model and rests on three fundamental pillars: First a global payment rate in which a provider system receives a budget to cover the costs of providing all of an enrollee's care. The exact payment rate is set through negotiation between the plan and provider groups, with updates specified for the 5 year duration of the contract. The provider group is at risk if spending on the patient exceeds the payment rate and captures savings if the spending falls below the payment.

In the AQC the payment is tied to the organization (e.g., physician group) that employs the patient's primary care doctor, which in the HMO is chosen by the enrollees because all HMO members are required to designate a primary care doctor. Yet although patients choose a primary care doctor, the AQC does not limit their choice of provider when they seek care (beyond the limits that exist in the HMO product for any enrollee). Specifically, if a patient designates Dr. Smith to be their primary care provider, Dr. Smith's physician group receives the global budget. The patient can then seek care from any network provider (with referral) and the costs will be counted against the budget given to Dr. Smith's practice. If the patient decides to switch primary care

doctors by notifying BCBSMA, then the global budget would be transferred to the new doctor's practice, assuming the new doctor is in a different AQC group. Because the network is very broad, AQC enrollees have access, with referral, to the vast majority of providers. A similar model could be easily adapted to PPO products that require patients to designate physicians.

Second, the AQC incorporates a comprehensive pay-for-performance system that rewards providers groups for performance on 64 quality measures ranging from process measures to outcome measures and from clinical measures to patient experience measures. The quality measures include both physician and hospital oriented measures. The provider group that employs the patient's primary care physician can earn up to 10% of TOTAL fees as a quality bonus above their budget target. Because the bonus is based off of total fees, not primary care fees, the bonus can be quite significant.

Third, the AQC includes significant provider support and data analysis (from Blue Cross Blue Shield of Massachusetts) which helps participating groups identify areas of improvement and manage care in a real time basis. One advantage of having all of the data is that BCBS can see care patterns across the entire network and support provider efforts to react.

The AQC differs from capitation plans of the 1990s because the contract extends for 5 years and incorporates significant performance incentives for quality and health outcomes.

The model has several strengths. Most importantly it creates a business case for improving quality and efficiency. Innovative programs that reduce use of unnecessary care or inefficient care, including reducing readmissions or unnecessary diagnostic or therapeutic procedures would not be viewed as losing revenue from forgone services, but instead be viewed as creating profit. Primary care groups are further incented to direct referral to the most efficient, low cost providers. The global budget also provides

stability and predictability of spending growth. The five year contract duration and the requirement that patients designate a physician greatly facilitate management and accountability by protecting providers against immediate reductions in rates if they achieve efficiency and by obviating physician responsibility for patients they were not aware were in their practice.

Global payment systems in the past have raised several concerns. For example, many have worried that they would lead to reductions and delivery of effective and needed care. The AQC is designed to prevent this by setting the global payment at least equal to the prior year's payment (so no provider group will be forced to reduce access to care). Moreover, health risk adjustment further reduces the risk that providers face and further dampens any incentives to skimp on care. But the most important protection is the quality bonus system. Early evidence suggests that these features have led to an increase, not decrease, in the quality of care delivered.

Further, many observers have noted that not all physician groups are capable of functioning in a global budget environment. Certainly this is true and my most important response to this concern would be that just because all groups are not ready for AQC type payment, we should not abandon it for those that are ready. But beyond that I tend to have the free market orientation that if incentives are set correctly, firms will adapt. We should not underestimate the ability of organizations to evolve to become more efficient. In fact if we do not believe such transformation is possible, no amount of payment reform or other policy changes will solve our problems and we are doomed to a system that operates far below our aspirations. Moreover, the AQC demonstrates that a wide array of physician groups, many with only a handful of physicians can join and succeed in the AQC by banding together to contract in larger groups. Specifically, the AQC has contracts with provider groups of all types, not just the large integrated group practices with affiliated hospitals. Many solo practitioners and small physician practices participate. It can be done.

The AQC is not without its weakness (and Blue Cross Blue Shield of Massachusetts is continually refining the model). For example, the AQC is not tied to benefit design and I believe a greater integration with Value Based Insurance Design would be an improvement. Specifically, Value Based Insurance Design refers to plans that align copayments with value of services or providers, so that patients seek high value. The AQC performance bonuses give health care systems the incentives to encourage high value care, but the patient incentives have not been similarly constructed. Second, while I am a big believer in markets and note that this innovation was developed in the private sector, any private sector model must contend with issues of provider market power. Ultimately the success of the AQC will depend on the ability of Blue Cross Blue Shield to negotiate sustainable payment rates with the providers in their service area and attract enrollees. Because of its size, Blue Cross Blue Shield may be better positioned for success than other smaller plans. So far the evidence suggests that AQC has passed the test of the market, with enrollment growing from 26 percent to 44 percent of the Blue Cross Blue Shield HMO membership as more provider groups have joined.

Certainly Medicare would be able to adopt certain AQC principles and some are evident in recent proposed Accountable Care Organization regulations. Broad application of such a model would be facilitated in Medicare if beneficiaries were incented (or required) to designate a physician, without giving up any existing benefits or rights regarding choice of provider.

In summary, a Fee For Service physician payment system for Medicare, SGR or not, generates inherent problems. In the near term we must work to mitigate those problems, but I am skeptical of our ability to micro manage such payment models and ultimately I believe such a payment system will force a choice, as the SGR illustrates, between reasonable Fee for Service rates and sustainable spending growth. Bundled payment systems such as the AQC offer considerable promise as a way forward. These systems are comprehensive, and give autonomy to providers which ultimately will be preferable to attempts to dictate practice styles in an effort to control budgets. The

Affordable Care Act incorporates a number of provisions that promote different types of bundled payments, including Accountable Care Organizations and demonstrations that implement episode based payment models. As a taxpayer and future Medicare beneficiary I urge you to support these demonstrations, and others like them and to work towards a design of a more rational and effective payment system that allows our expectations and aspirations to be met in a fiscally sustainable manner.

Mr. PITTS. Thank you, Doctor.

Dr. Williamson, you are recognized for 5 minutes.

STATEMENT OF M. TODD WILLIAMSON

Mr. WILLIAMSON. Good morning. My name is Todd Williamson. I am a Board-certified neurologist, and I treat patients every day in my office in Lawrenceville, Georgia, just northeast of Atlanta. I would like to express my sincere thanks to Chairman Pitts and Ranking Member Pallone and the members of this committee for the opportunity to address the critical issue of Medicare's broken Physician Payment System.

As background, I had the honor of serving as the President of the Medical Association of Georgia in 2008, and 2009. I currently serve as the spokesman for the Coalition of State Medical and National Specialty Societies, which includes 16 associations representing nearly 90,000 physicians from across the country. The full membership list is in our written statement.

Medicare is the Nation's largest government-run healthcare program, and it represents the most glaring example of the need for change. As everyone in this room knows the current SGR System is failing to serve our Nation's seniors and physicians. As the gap between government-controlled payment rates and the cost of running a practice grows wider, physicians are finding it increasingly difficult to accept Medicare patients. Our coalition is, therefore, convinced that the key to preserving our Medicare patients' access to quality medical care is overhauling the flawed Medicare payment system.

To address this problem our coalition supports the Medicare Patient Empowerment Act as an essential part of any Medicare reform. This legislation would establish a new Medicare payment option whereby patients and physician would be free to contract for medical care without penalty. It would allow these patients to apply their Medicare benefits to the physician of their choice and to contract for any amount not covered by Medicare. Physicians would be free to opt out or in of Medicare on a per-patient basis, while patients could pay for their care as they see fit and be reimbursed for an equal amount to that pay to participating Medicare physicians.

Patients and physicians should be free to enter into private payment arrangements without legal interference or penalty. Private contracting is a key principle of American freedom and liberty. It serves as the foundation for the patient, physician relationship, and it has given rise to the best medical care in the world. It should, therefore, be a viable option within the Medicare payment system.

Private contracting will help the Federal Government achieve fiscal stability while fulfilling its promise to Medicare beneficiaries. A patient who chooses to see a physician outside the Medicare System should not be treated as if they don't have insurance. Medicare should pay its fair share of the charge and allow the patient to pay any remaining balance.

Private contracting is also the only way to ensure that our patients can maintain control over their medical decisions. The government has the right to determine what it will pay towards med-

ical care, but it does not have the right to determine the value of that medical care. This value determination should be ultimately made by the individual patient.

While private contracting would allow physicians to collect their usual fee in some instances, it would also allow them to collect less in others. It is reprehensible for a physician to be subject to civil and criminal penalties if he or she doesn't collect a patient's co-payment as is now the case. It is irrational for a senior who wants to see a doctor outside the usual Medicare System to be forced to forfeit their Medicare benefits. This simply isn't fair to someone who has paid into the Medicare System their entire working life.

The day the Medicare Patient Empowerment Act becomes law every physician will become accessible to every Medicare patient. Private contracting is a sustainable patient-centered solution for the Medicare Payment System that will ensure our patients have access to the medical care they need.

In summary, Medicare patients should be free to privately contract with the doctor of their choice without bureaucratic interference or penalty. This will empower individual patients to make their medical care decisions while providing the Federal Government with more fiscal certainty.

Thank you for the opportunity to comment today.

[The prepared statement of Mr. Williamson follows:]

Statement of

M. Todd Williamson, M.D.

on the subject of

"The Need to Move Beyond the SGR"

before the

Subcommittee on Health

Energy and Commerce Committee

U.S. House of Representatives

May 5, 2011
10:00 am
2123 Rayburn House Office Building

Coalition of State Medical and National Specialty Societies
c/o Medical Association of Georgia ♦ 1849 The Exchange Suite 200 ♦ Atlanta, GA 30339 ♦ www.mag.org

Executive Summary

The current sustainable growth rate (SGR) physician payment system is failing to serve our nation's seniors and physicians, and as the gap between government-controlled payment rates and the cost of running a practice grows wider, it is increasingly difficult for seniors and the disabled to find doctors who accept new Medicare patients.

The Coalition of State Medical and National Specialty Societies is therefore convinced that the key to preserving our Medicare patients' access to quality medical care is overhauling the flawed Medicare payment system, and to address this problem, Congress should include the Medicare Patient Empowerment Act as an essential part of any Medicare reform. This legislation would:

- Establish a new Medicare payment option whereby patients and physicians would be free to contract for medical care without penalty;
- Allow these patients to apply their Medicare benefits to the physician of their choice and to contract for any amount not covered by Medicare; and
- Physicians would be free to opt in or out of Medicare on a per-patient basis, while patients could pay for their care as they see fit and be reimbursed for an amount equal to that paid to "participating" Medicare physicians.

Patients and physicians should be free to enter into private payment arrangements without legal interference or penalty. Private contracting is a key principle of American freedom and liberty. It serves as the foundation for the patient-physician relationship, and it has given rise to the best medical care in the world. It should therefore be a viable option within the Medicare payment system.

The day the Medicare Patient Empowerment Act becomes law, **every** physician will become accessible to **every** Medicare patient. Private contracting is a sustainable, patient-centered solution for the Medicare payment system that will ensure our patients have access to the medical care they need.

Introduction

Good morning. My name is Todd Williamson; I am a board-certified neurologist and I treat patients every day in my office in Lawrenceville, Georgia, just northeast of Atlanta.

I would like to express my sincere thanks to Chairman Pitts and the Members of this committee for the opportunity to address the critical issue of Medicare's broken physician payment system.

As background, I had the honor of serving as the president of the Medical Association of Georgia in 2008 and 2009. I currently serve as the spokesman for the Coalition of State Medical and National Specialty Societies, which includes sixteen associations representing some ninety thousand physicians from across the country.

The SGR is Fatally Flawed

Medicare is the nation's largest government-run health care program, and it represents the most glaring example of the need for reform. The current sustainable growth rate (SGR) physician payment system, in particular, is failing to serve our nation's seniors and physicians. Enacted as part of the Balanced Budget Act of 1997, the SGR is a formula utilized by Medicare to limit the growth of physician services. This formula is fatally flawed and is structured in a way that does not appropriately account for the costs of caring for Medicare beneficiaries.

Since 2002, the SGR formula has called for reductions in Medicare reimbursements to physicians. In 2002, physician payments were cut by 5 percent, and since then, Congress has intervened 12 times to prevent additional cuts. Unfortunately, Congress has not yet adopted a permanent solution to fixing the SGR; rather it has passed short-term, stop-gap measures that only temporarily prevent steep payment cuts. Once again, on January 1, 2012, physician payments are scheduled to be cut – this time by 29.5 percent -- and these cuts will continue well into the future.

Medicare's physician payment system is not sustainable for physicians, nor is it fiscally stable for the federal government. The cost of repealing the SGR has now ballooned from just under $50 billion in 2005 to over $300 billion today, and the price tag continues to grow each year that Congress puts off permanent reform. Before the costs of reform become financially prohibitive, it is essential that Congress act to reform Medicare's flawed physician payment system in a manner that will also give the government increased budget certainty now and into the future.

Patient Access to Care is at Risk

Existing Medicare underpayments, coupled with the threat of continued steep payment cuts, present serious access to care problems because more and more physicians cannot afford to furnish services to Medicare patients. Baby boomers are now entering the Medicare program, and a shrinking pool of primary care and specialty physicians are making it increasingly difficult for seniors and the disabled to find doctors who accept new Medicare

patients. The American people are well aware of this problem, and according to a survey conducted by the American Medical Association in October 2010, the overwhelming majority – 94 percent – of American adults feel the looming Medicare physician payment cut poses a "serious problem for seniors who rely on Medicare."

Numerous surveys of our nation's physicians have also established the Medicare access to care problem.

- A 2008 survey conducted by The Physicians Foundation found that 82 percent of primary care doctors nationwide believed their practices would be "unsustainable" if proposed cuts to Medicare payments were made and nearly half of all primary care doctors were planning to either reduce the number of patients they saw or stop practicing entirely.
- A 2008 survey conducted by the American Medical Association demonstrated that if Medicare payment rates were cut by 10 percent, 60 percent of physicians would limit the number of new Medicare patients they treat, and if payments were cut by 40 percent, 77 percent of physicians would limit the number of new Medicare patients they treat.
- A 2010 survey conducted by the Surgical Coalition found that 29 percent of surgeons would opt out of Medicare, and of those surgeons remaining as Medicare participating physicians, 69 percent would limit the number of Medicare patient appointments and 45 percent would stop providing certain services.

In order to preserve patient choice and timely access to care, the SGR formula must be repealed.

My Medicare, My Choice

As noted above, as the gap between government-controlled payment rates and the cost of running a practice grows wider, physicians are finding it increasingly difficult to accept Medicare patients. The Coalition of State Medical and National Specialty Societies is therefore convinced that the key to preserving our Medicare patients' access to quality medical care is overhauling the flawed Medicare payment system.

To address this problem, our Coalition supports including the Medicare Patient Empowerment Act as an essential part of any Medicare reform. This legislation would establish a new Medicare payment option whereby patients and physicians would be free to contract for medical care without penalty. It would allow these patients to apply their Medicare benefits to the physician of their choice and to contract for any amount not covered by Medicare. Physicians would be free to opt in or out of Medicare on a per-patient basis, while patients could pay for their care as they see fit and be reimbursed for an amount equal to that paid to "participating" Medicare physicians.

Patients and physicians should be free to enter into private payment arrangements without legal interference or penalty. Private contracting is a key principle of American freedom and liberty. It serves as the foundation for the patient-physician relationship, and it has given

rise to the best medical care in the world. It should therefore be a viable option within the Medicare payment system.

Private contracting is also one way that the federal government can achieve fiscal stability while fulfilling its promise to Medicare beneficiaries. A patient who chooses to see a physician outside the Medicare system should not be treated as if they don't have insurance. Medicare should pay its fair share of the charge and allow the patient to pay the balance. It is also the only way to ensure that our patients can maintain control over their own medical decisions. The government has the right to determine what it will pay toward medical care, but it doesn't have the right to determine the value of that medical care. This value determination should ultimately be made by the individual patient.

While private contracting would allow physicians to collect their usual full fee in some instances, it would allow them to collect less in others. It is reprehensible for a physician to be subject to civil and criminal penalties if he or she doesn't collect a patient's co-payment, as is now the case. It is irrational for a senior who wants to see a doctor outside the usual Medicare payment system to be forced to forfeit their Medicare benefits. This simply isn't fair to someone who has paid into the Medicare system their entire working life.

The day the Medicare Patient Empowerment Act becomes law, **every** physician will become accessible to **every** Medicare patient. Private contracting is a sustainable, patient-centered solution for the Medicare payment system that will ensure our patients have access to the medical care they need.

In summary, Medicare patients should be free to privately contract with the doctor of their choice without bureaucratic interference or penalty. This will empower individual patients to make their medical care decisions, while providing the federal government with fiscal certainty.

Thank you for the opportunity to comment today.

Members of the Coalition of State Medical and National Specialty Societies

Medical Association of the State of Alabama
Arkansas Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association
Medical Association of Georgia
Kansas Medical Society
Louisiana State Medical Society
Mississippi State Medical Association
Medical Society of New Jersey
South Carolina Medical Association
Tennessee Medical Association
American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American Society of General Surgeons
Congress of Neurological Surgeons

Past Presidents of the American Medical Association

Daniel H. Johnson, Jr., MD
AMA President 1996-1997

Donald J. Palmisano, MD, JD, FACS
AMA President 2003-2004

William G. Plested, III, MD, FACS
AMA President 2006-2007

APPENDIX A

Summary of the "Medicare Patient Empowerment Act"

The "Medicare Patient Empowerment Act" would establish a Medicare payment option for patients and physicians (and practitioners) to freely contract, without penalty, for Medicare fee-for-service services, while allowing Medicare beneficiaries to use their Medicare benefits and allowing physicians to bill the patient for all amounts not covered by Medicare. Physicians and practitioners could continue to elect Medicare participating (PAR) or non-participating (non-PAR) status for other beneficiaries they treat.

Specifically, the proposed bill would:

- Allow Medicare beneficiaries to contract with any physician (or practitioner) outside of Medicare at rates established between the patient and physician or practitioner.
- Allow Medicare beneficiaries to submit claims to the Medicare program.
- Allow the physician or practitioner to file claims on behalf of the beneficiary, and the beneficiary could assign payment to the physician or practitioner regardless of whether the patient or physician (or practitioner) files the claim.
- Require Medicare claims to be paid directly to the beneficiary in the amount that would apply to a Medicare PAR physician or practitioner in the Medicare payment area where the physician or practitioner resides (payments would not be adjusted to reflect any incentive/penalty payments that might otherwise apply to the physician or practitioner relating to the PQRI, electronic prescribing, health information technology or cost-quality payment modifier programs).
- Establish that Medicare balance billing limits would not apply to Medicare charges by the physician or practitioner.
- Specify that if a physician (or practitioner) contracts with a beneficiary, the physician (or practitioner) is not considered a Medicare PAR or non-PAR physician or practitioner, and therefore Medicare requirements do not apply to the physician or practitioner for purposes of services furnished under the contract. (If the physician or practitioner is PAR or non-PAR for other patients, the physician or practitioner would have to comply with Medicare requirements for services furnished to those patients.)
- Establish beneficiary protections, such as (i) requiring a written, signed contract that specifies the physician or practitioner fees before services are furnished and provides that the beneficiary will be held harmless if the physician or practitioner were to bill any amounts in excess of the fees specified in the contract; (ii) prohibiting the contract from being entered in an emergency or urgent care situation; (iii) prohibiting contracts with Medicare and Medicaid dual-eligible individuals; and (iv) indicating in the contract whether the physician or practitioner is excluded from participation under Medicare.
- Define "emergency medical condition" and "urgent health care situation" using existing Medicare definitions for these terms.
- Allow physicians and practitioners to continue as a Medicare PAR or non-PAR physician or practitioner with respect to any patient not covered under the contract.
- Pre-empt state laws that limit balance billing.

APPENDIX B

DRAFT

.....
(Original Signature of Member)

112TH CONGRESS
1ST SESSION

H. R. _____

To amend title XVIII of the Social Security Act to establish a Medicare payment option for patients and physicians or practitioners to freely contract, without penalty, for Medicare fee-for-service items and services, while allowing Medicare beneficiaries to use their Medicare benefits.

IN THE HOUSE OF REPRESENTATIVES

Mr. PRICE of Georgia introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to establish a Medicare payment option for patients and physicians or practitioners to freely contract, without penalty, for Medicare fee-for-service items and services, while allowing Medicare beneficiaries to use their Medicare benefits.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Medicare Patient Em-
5 powerment Act".

1 **SEC. 2. GUARANTEEING FREEDOM OF CHOICE AND CON-**
2 **TRACTING FOR PATIENTS.**
3 (a) IN GENERAL.—Section 1802 of the Social Secu-
4 rity Act (42 U.S.C. 1395a) is amended to read as follows:
5 "FREEDOM OF CHOICE AND CONTRACTING BY PATIENT
6 GUARANTEED
7 "SEC. 1802. (a) BASIC FREEDOM OF CHOICE.—Any
8 individual entitled to insurance benefits under this title
9 may obtain health services from any institution, agency,
10 or person qualified to participate under this title if such
11 institution, agency, or person undertakes to provide that
12 individual such services.
13 "(b) FREEDOM TO CONTRACT BY MEDICARE BENE-
14 FICIARIES.—
15 "(1) IN GENERAL.—Subject to the provisions of
16 this subsection, nothing in this title shall prohibit a
17 Medicare beneficiary from entering into a contract
18 with a participating or non-participating physician
19 or practitioner for any item or service covered under
20 this title.
21 "(2) SUBMISSION OF CLAIMS.—Any Medicare
22 beneficiary that enters into a contract under this
23 section shall be permitted to submit a claim for pay-
24 ment under this title, and such payment shall be
25 made in the amount that would otherwise apply
26 under this title if such claim had been filed by a par-

1 ticipating physician or practitioner (as defined in
2 section 1842(i)(2)) in the payment area where the
3 physician or practitioner covered by the contract re-
4 sides. Payment made under this title for any item or
5 service provided under the contract shall not render
6 the physician a participating or non-participating
7 physician, and as such, requirements of this title
8 that may otherwise apply to a participating or non-
9 participating physician would not apply with respect
10 to any items or services furnished under the con-
11 tract.
12 "(3) BENEFICIARY PROTECTIONS.—
13 "(A) IN GENERAL.—Paragraph (1) shall
14 not apply to any contract unless—
15 "(i) the contract is in writing, is
16 signed by the Medicare beneficiary and the
17 physician or practitioner, and establishes
18 all terms of the contract (including specific
19 payment for physicians' services covered by
20 the contract) before any item or service is
21 provided pursuant to the contract, and the
22 beneficiary shall be held harmless for any
23 subsequent payment charged for a service
24 in excess of the amount established under

1 the contract during the period the contract
2 is in effect;
3 "(ii) the contract contains the items
4 described in subparagraph (B); and
5 "(iii) the contract is not entered into
6 at a time when the Medicare beneficiary is
7 facing an emergency medical condition or
8 urgent health care situation.
9 "(B) ITEMS REQUIRED TO BE INCLUDED
10 IN CONTRACT..—Any contract to provide items
11 and services to which paragraph (1) applies
12 shall clearly indicate to the Medicare beneficiary
13 that by signing such contract the beneficiary—
14 "(i) agrees to be responsible for pay-
15 ment to such physician or practitioner for
16 such items or services under the terms of
17 and amounts established under the con-
18 tract;
19 "(ii) agrees to be responsible for sub-
20 mitting claims under this title to the Sec-
21 retary, and to any other supplemental in-
22 surance plan that may provide supple-
23 mental insurance, for such items or serv-
24 ices furnished under the contract if such
25 items or services are covered by this title,

1 unless otherwise provided in the contract
2 under subparagraph (C)(i); and
3 "(iii) acknowledges that no limits or
4 other payment incentives that may other-
5 wise apply under this title (such as the
6 limits under subsection (g) of section 1848
7 or incentives under subsection (a)(5), (m),
8 (q), and (p) of such section) shall apply to
9 amounts that may be charged, or paid to
10 a beneficiary for, such items or services.
11 Such contract shall also clearly indicate whether
12 the physician or practitioner is excluded from
13 participation under the Medicare program
14 under section 1128.
15 "(C) BENEFICIARY ELECTIONS UNDER
16 THE CONTRACT.—Any Medicare beneficiary
17 that enters into a contract under this section
18 may elect to negotiate, as a term of the con-
19 tract, a provision under which—
20 "(i) the physician or practitioner shall
21 file claims on behalf of the beneficiary with
22 the Secretary and any supplemental insur-
23 ance plan for items or services furnished
24 under the contract if such items or services

1 are covered under this title or under the
2 plan; and
3 "(ii) the beneficiary assigns payment
4 to the physician for any claims filed by, or
5 on behalf of, the beneficiary with the Sec-
6 retary and any supplemental insurance
7 plan for items or services furnished under
8 the contract.
9 "(D) EXCLUSION OF DUAL ELIGIBLE INDI-
10 VIDUALS.—Paragraph (1) shall not apply to
11 any contract if a beneficiary who is a eligible
12 for medical assistance under title XIX is a
13 party to the contract.
14 "(4) LIMITATION ON ACTUAL CHARGE AND
15 CLAIM SUBMISSION REQUIREMENT NOT APPLICA-
16 BLE.—Section 1848(g) shall not apply with respect
17 to any item or service provided to a Medicare bene-
18 ficiary under a contract described in paragraph (1).
19 "(5) CONSTRUCTION.—Nothing in this section
20 shall be construed to prohibit any physician or prac-
21 titioner from maintaining an election and acting as
22 a participating or non-participating physician or
23 practitioner with respect to any patient not covered
24 under a contract established under this section.
25 "(6) DEFINITIONS.—In this subsection:

1 "(A) MEDICARE BENEFICIARY.—The term
2 'Medicare beneficiary' means an individual who
3 is entitled to benefits under part A or enrolled
4 under part B.
5 "(B) PHYSICIAN.—The term 'physician'
6 has the meaning given such term by paragraphs
7 (1), (2), (3), and (4) of section 1861(r).
8 "(C) PRACTITIONER.—The term 'practi-
9 tioner' means a practitioner described in section
10 1842(b)(18)(C).
11 "(D) EMERGENCY MEDICAL CONDITION.—
12 The term 'emergency medical condition' means
13 a medical condition manifesting itself by acute
14 symptoms of sufficient severity (including se-
15 vere pain) such that a prudent layperson, with
16 an average knowledge of health and medicine,
17 could reasonably expect the absence of imme-
18 diate medical attention to result in—
19 "(i) serious jeopardy to the health of
20 the individual or, in the case of a pregnant
21 woman, the health of the woman or her
22 unborn child;
23 "(ii) serious impairment to bodily
24 functions; or

1 "(iii) serious dysfunction of any bodily
2 organ or part.
3 "(E) URGENT HEALTH CARE SITUA-
4 TION.—The term 'urgent health care situation'
5 means services furnished to an individual who
6 requires services to be furnished within 12
7 hours in order to avoid the likely onset of an
8 emergency medical condition.".

9 **SEC. 3. PREEMPTION OF STATE LAWS LIMITING CHARGES**
10 **FOR PHYSICIAN AND PRACTITIONER SERV-**
11 **ICES.**

12 (a) IN GENERAL.—No State may impose a limit on
13 the amount of charges for services, furnished by a physi-
14 cian or practitioner, for which payment is made under sec-
15 tion 1848 of the Social Security Act (42 U.S.C. 1395w–
16 4), and any such limit is hereby preempted.
17 (b) STATE.—In this section, the term "State" in-
18 cludes the District of Columbia, Puerto Rico, the Virgin
19 Islands, Guam, and American Samoa.

Mr. PITTS. The chair thanks the gentleman and recognizes Dr. Goertz for 5 minutes.

STATEMENT OF ROLAND A. GOERTZ

Mr. GOERTZ. Chairman Pitts, Mr. Pallone, and members of the subcommittee, I am Dr. Roland Goertz from Waco, Texas, President of the American Academy of Family Physicians. Thank you for the opportunity to testify today on behalf of over 100,000 members of the AAFP. I commend your bipartisan commitment to finding a solution to this critical problem.

Congress understandably is most concerned with controlling federal expenditures for healthcare, especially the rising cost of Medicare. There is growing and compelling evidence that a healthcare system based on primary care will help control these costs, as well as increase patient satisfaction and improve patient health.

We recommend reforms that eventually include a blended payment model that consists of the following three elements.

One, some retention of fee-for-service payment, two, a care coordination fee that compensates for expertise and time requirement for primary care activities that are not now paid for, and three, performance bonuses based on quality.

Simply reforming the fee-for-service system which undervalues primary care preventative health and team-based care coordination cannot produce the results that Congress and patients require. The solution to our dilemma of rising healthcare costs and stagnating quality will be complex, but it must include greater use of transformed team-based primary care.

The evidence for the value of primary care and restraining costs and improving quality is very clear when that care is delivered in a team-based, patient-centered medical home. Growing evidence with PCMH and coordinated systems, particularly those that emphasize improved access to primary care teams, shows that they can reduce total costs, total overall costs by 7 to 10 percent, largely by reducing avoidable hospitalizations and emergency room visits.

We believe that as a policy goal Congress should invest in Medicare reforms that increase primary care payments so they represent approximately 10 to 12 percent of total healthcare spending, particularly if done in ways that improve access to a broader array of services.

Currently primary care is just 6 to 7 percent of overall total Medicare spending, so medical home projects went implemented recoup the entire cost of that implementation. To produce the savings Congress requires primary care cannot remain unchanged. AAFP has already taken the lead in urging its members practices to change but such transformation will take time. That is why we recommend a 5-year transition period. This will provide an opportunity to examine what works and to allow physicians to adopt those best practices that use a blended payment. When this transition is complete, fee-for-service should be a much less significant portion of physician payment.

Meanwhile, it is important to increase the primary care incentive payment to 20 percent and maintain the support for making Medicaid payments for primary care at least equal to Medicare's payments for the same services. Both of these programs, along with

the mandated payment updates that are 2 percent higher for primary care, will help stabilize current practices that have been—seen so much financial turmoil in the past few years and will allow them to begin the process of redesign to the patient-centered medical home model.

During the 5-year period of stability, it will be crucial to encourage as much innovation as possible. The new CMS Center for Innovation needs to be a key focus of this effort. We believe that this center can help CMS cerate market-based, private sector like programs that can significantly bend the healthcare cost curve. We recommend that CMS Innovation Center coordinate the various healthcare delivery models to ensure comparability and completeness of data.

The physician community has always believed strongly in the value of evidence, and it is the responsibility of the Innovation Center to provide credible, reliable, and usable evidence for health system change. When implementation data becomes available, we would encourage Congress to engage in another discussion with the physician community with public and private payers, with consumers to determine not just what works but what is preferred.

In the final analysis healthcare is such an important part of the economy and everyone's lives that we should try to find general agreement in what becomes the final replacement for the current physician payment model.

Mr. Chairman and members of this subcommittee, thank you for the opportunity to share the view of family medicine with you today.

[The prepared statement of Mr. Goertz follows:]

SUMMARY
Testimony to the Health Subcommittee
Energy and Commerce Committee
U.S. House of Representatives

By Roland A. Goertz, MD, MBA
President
American Academy of Family Physicians

May 5, 2011

In considering the replacement for the current Medicare physician payment formula that will help control costs as well as support improved health care delivery, Congress needs to reduce the dependence on fee-for-service and turn to a blended payment system that will support broader use of primary care. The AAFP supports moving the health care system to one based on a team-based primary care model, the Patient-Centered Medical Home. It is designed to coordinate care and to use a broad range of patient encounters, like telephone, e-mail, group visits, health coaching, community services and interoperable coordination of the wide range of health providers, especially for patients with multiple chronic conditions, all of which are not part of the current payment system.

Currently, the private sector has tested the Patient-Centered Medical Home in several demonstrations that have used different sets of patients, settings and providers. These demonstrations are yielding valuable information about what works and how well this model can restrain cost growth. However, the federal government is still working on what it will test with the Medicare, Medicaid and other beneficiaries. For practices, becoming a patient-centered medical home is a major transformation that is expensive and time consuming. Without payment reform, it is probably beyond the economic reach of many small and medium sized practices, especially in rural and underserved areas that do not have the resources that may be in place in other parts of the country.

So to get to the desired goal of a payment system that pays for care coordination and performance improvement, the AAFP recommends a transition period of 5 years that will require increased investment in primary care. This investment includes a mandated payment rate that is at least 2 percent higher for primary care physicians who are providing primary care and preventive health services. It would include increasing the Primary Care Incentive Payment from 10 percent of Medicare allowed charges to 20 percent. And it would permanently extend the provision to make Medicaid payments for primary care and preventive health services at least equal to the rates paid by Medicare for those services.

Meanwhile, in this 5-year transition period, the Innovation Center at CMS should be coordinating all of the various demonstrations and pilots for new models of physician payment. They need to make sure that the data collected is comparable and usable. This data should inform a discussion among payers, providers and consumers regarding what works and what the health care delivery process should include. This discussion should be the basis of the final payment transformation system.

AMERICAN ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

To the

Energy and Commerce

Health Subcommittee

U.S. House of Representatives

By

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May 5, 2011

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Chairman Pitts, Mr. Pallone, and members of the Subcommittee:

Thank you for offering the American Academy of Family Physicians (AAFP) the opportunity to testify this morning on the question of what kind of payment system should replace the Medicare physician fee schedule. On behalf of the 100,300 members and medical students of the AAFP, I commend your bipartisan commitment to finding a solution to this critically important issue. Because many public and private payment systems are pegged to Medicare rates, the decisions made by the Centers for Medicare and Medicaid Services (CMS) for payment of services have a broad applicability to the payment system generally. Therefore, reforming the flawed Medicare payment formula is a necessary part of our responsibility to restrain health care costs nationally and to assure our patients and your constituents that we have a health care delivery system that is built on a foundation of primary care.

According to the Institute of Medicine, primary care is *"the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."* The AAFP is the only physician organization whose entire membership has been trained to provide this primary medical care. However, many members of the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association are also primary care physicians. All of us are committed to helping Congress find a system that pays for the value of health care provided rather than the volume of those services.

Congress, understandably, is most concerned at this time with controlling federal expenditures for health care, especially, given the rapidly rising bill for Medicare and other federal health care programs. There are many reasons for that increase, some of which are beyond the power of the federal government to control. However, there is growing and compelling evidence that a health care system based on primary care, as described by the IOM above, will help control costs, increase patient satisfaction and improve patient health.

It is with that in mind that the AAFP advocates for payment reforms that ultimately include a blended payment system for primary care delivered within the context of a patient-centered medical home (PCMH). This blended payment consists of these elements:

- Fee-for-service payment
- A care management fee that compensates for expertise and time required for primary care activities that are not direct patient encounters
- Performance bonuses based on a voluntary pay-for-reporting/performance system, and for care team members and services that are not eligible for fee-for-service billing

To achieve this payment reform, we recommend that Congress establish a transition period of 5 years with mandated payment updates (with rates 2 percent higher for primary care physicians) for Medicare fee-for-service. In addition, we recommend, during this transition, continuing the Primary Care Incentive Payment, increasing this to 20 percent, and permanently extending the program making Medicaid payments equal to Medicare rates for primary care and preventive health services offered by primary care physicians. During this limited transition period, the CMS Innovation Center should coordinate programs to test delivery system reforms and provide comparable data to demonstrate the most effective reforms in specific settings and systems.

The Flawed Sustainable Growth Rate Formula

The current formula for determining Medicare's physician fee-for-service payment schedule is greatly affected by the Sustainable Growth Rate (SGR). The biggest flaw in the SGR, and hence in the Medicare payment system, is that it attempts to control the volume of health care services at the *individual* physician level by imposing payment penalties *globally* across all physician payments.

The theory is that, when increases in volume exceed established targets, payment rates should decline, signaling to medical practices that they should reduce services. But the incentive is perverse. A medical practice needs to meet certain fixed costs, and as payment rates decline, the logical economic decision

at some point is simply to quit providing services because payments are not covering those fixed costs. This is particularly true for primary care physicians whose practices are predicated on cognitive clinical decision-making (making it infeasible to increase volume to compensate for lower payment rates) and which operate typically on extremely thin margins. At the same time that the payment formula provides a significant disincentive to primary care, we are approaching a shortage of primary care physicians and a need for more because the Baby Boomers are entering the Medicare system and the *Affordable Care Act* extends coverage to millions of otherwise uninsured individuals.

This dilemma touches on the fundamental problem with fee-for-service – i.e., payment is based solely on what procedure is provided to the patient, not the value of the service provided, and thus encourages volume growth. Fee-for-service recognizes medical care as a series of things physicians do. The doctor performs an EKG, or removes a cyst from the patient's eye lid, or provides a session of therapy, or guides parents through childbirth. The physician has provided the patient a service and is paid for doing so by a formula determined by Congress (in the case of Medicare) and by other payers.

But what the formula cannot do is pay for thought, analysis, deduction, discussion and persuasion and for the value that comes from managing the care of the whole person, as well as the value that comes from avoiding unnecessary care. It also cannot adequately value the coordination of care in a highly fragmented health care system. It does not value non face-to-face encounters, group visits, guided patient self-management and other non-traditional mechanisms to deliver care. When a patient walks into a primary care office with a complaint – whether fatigue, a stomach pain or a persistent cough – there are countless possibilities for what may be the underlying cause or causes. It takes knowledge, perception, experience and insight to conduct the right exam that will lead to an accurate diagnosis and effective intervention. It takes sustained, personal relationships to help differentiate the potential causes and tailor diagnosis and treatment. But a fee-for-service payment system undervalues these cognitive skills, preventive health services and care coordination and does not pay for them, apart from a limited, generalized set of office visit codes, labeled "Evaluation and Management."

Comprehensive primary care does, of course, include some procedural activities for which a fee-for-service payment is appropriate within the current payment construct. However, such procedures are not the core of primary care, which is a specialty that goes beyond such procedures both in behavior and value. A patient sees a primary care physician to understand his or her current health condition, to have perplexing symptoms evaluated, to learn how to take responsibility for her or his own health which may include a change in diet and exercise patterns to prevent disease. A patient also sees a primary care physician to help understand how to manage chronic diseases – like diabetes, asthma, osteoporosis, depression – often all at once, rather than separately. Fee-for-service pays for individual actions, whereas primary care physicians coordinate these otherwise separate actions and help prevent diseases that would otherwise require expensive procedural treatments.

Consequently, fee-for-service does not value comprehensive care in which the family physician practice provides most of what the patient's needs, including individual and population care management, behavioral health, behavior change coaching, facilitating social services, and making appropriate referrals. What is the value of managing a patient's multiple chronic conditions in such a way that he or she may continue to lead a productive life? What is the value of helping a patient successfully manage his or her health in such a way as to avoid costly hospitalizations and procedural services? Fee-for-service has no answers to these questions and will not support the full array of services needed to address them.

The Value of Primary Care

The evidence for the value of primary care in restraining health care costs and improving quality is very clear when that care is delivered in a team-based Patient Centered Medical Home. For example, findings from the Dartmouth Health Atlas Data demonstrate good geographic correlations with having more primary care, particularly family medicine, and having lower Medicare costs and reduced "ambulatory care sensitive" hospitalizations; i.e., hospitalizations that should not happen if patients have good access to primary care. There is also growing evidence that experiments with PCMH and

Accountable Care Organizations (ACO)—particularly those that emphasize improved access to more robust primary care teams—can reduce total costs by 7-10 percent, largely by reducing avoidable hospitalizations and emergency room visits.[1]

Primary care is just 6-7 percent of total Medicare spending, so medical home experiments are recouping the entire costs of care in those settings, not just the added investments.[2] These findings hold true in integrated systems like Geisinger, insurance experiments like Blue Cross Blue Shield of South Carolina, or individual system efforts like Johns Hopkins. The key factor across all of these is increased investments in the primary care setting. Based on the early results of these experiments, we believe that to achieve the savings that primary care will generate, which will more than offset the cost of the investment, Medicare should increase primary care payments, so that they represent 10-12 percent of total health care spending, particularly if done in ways that improve access to a broader array of services.[3] An evaluation of a primary care-based ACO, funded by the Agency for Healthcare Research and Quality, and conducted by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care (an editorially independent research center and division of the AAFP) is showing that over the longer term, these investments could offset inpatient costs by 50 percent or more.

The Medicare Payment Advisory Commission (MedPAC) has long argued that Medicare's payment system undervalues primary care and overvalues procedures and technology, and supports many of the payment changes we recommend. Like MedPAC, we think that there is an accepted bias in the system that favors procedures and which makes it difficult to take into account the often declining amount of time and work involved in procedures, as physicians become more experienced with them

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[1] Grumbach K, Grundy P. **Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States.** 11-16-2010.

[2] Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. J Gen Intern Med. 2007;22(3):410–5.

[3] Phillips RL Jr., Bazemore AW. What is Primary Care and Why It Must Be Central to US Health System Reform. Health Affairs. 2010: 29(5): 806-810.

and the associated technology improves. This leads to an overvalued payment for procedures and undervalued cognitive payments.

While the AAFP, and other primary care physician organizations, are strongly committed to the PCMH model, we do not discount other potential payment reforms. But the evidence shows that to achieve the savings that Congress is looking for, and to improve the quality of health care delivered to millions of patients in the country, reform must include investment in primary care. In a relatively short time, the current PCMH demonstrations show that these investments produce returns that are budget-neutral, at least, and that provide improved quality and patient satisfaction.

Patient Centered Medical Home

Since fee-for-service alone encourages utilization, does not check avoidable duplication of service, misuses resources and leads to inefficiency and unnecessary costs, we believe reforming the Medicare physician payment system with just a different fee-for-service formula will not accomplish those Congressional goals of restraining increases in health care costs and improving the quality of health care. The payment system should actively encourage care management and preventive health and reward quality improvement. To do all of that, we have come to believe that payment reform, at least for primary care delivered by a PCMH team, requires these components:

- fee-for-service for discrete services provided to patients
- a care management fee for the more global care management and coordination provided to patients, often non-face-to-face, in a patient-centered medical home
- pay-for-performance that will reward efforts to improve all the elements of health care and that recognizes demonstrated value to the system.

Over time, the percent of fee-for-service payments should be decreased as the care management fee and pay-for-performance are increased, thus moving away from a dependence on a system that encourages volume. This blended payment system for medical home teams should facilitate the

transformation of practices, so that all of the team's participants perform their own unique tasks in a coordinated way. This means extensive investments not just in health information technology but also in interoperable systems, not just with hospitals and other health care centers, but also with community services.

Transition to a New Payment Model

Payment reform should foster this necessary transformation. But such transformation will take time. We recommend five years of mandated updates to the physician fee schedule that include a higher payment rate (of at least 2 percent) for primary care physicians (defined as those with specialty designations of family medicine, general internal medicine, geriatrics, and general pediatric medicine) who deliver primary care and preventive health services. For this transition, Congress should increase the Primary Care Incentive Payment from 10 percent to 20 percent and should permanently continue federal support for the Medicaid requirement that payments to primary care physicians for primary care and preventive health services be at least equal to Medicare's payments.

The goal would be to use this period to implement care management fees and pay-for-performance for primary care physician practices that have become a Patient Centered Medical Home. This will provide an opportunity to examine what works in this regard and to adopt those best practices in a blended payment model. There must be a specific termination date for the SGR at the end of this period of stability and analysis. With a fixed termination to the extension, the mandate to implement the best alternative will be clear, and when this transition period is completed, fee-for-service should be a much less significant portion of physician payment.

Meanwhile, it is important to increase the Primary Care Incentive Payment to 20 percent and maintain the support for making Medicaid payments for primary care and preventive health services offered by primary care physicians at least equal to Medicare's payments for the same services. Both of these programs, along with the mandated payment updates that are 2-percent higher for primary care

physicians, help stabilize current practices that have seen so much financial turmoil is the past few years and allow them to begin the often expensive and time-consuming process of redesign to the Patient Centered Medical Home model. Above all, these programs are important statements about the societal value of Family Medicine and primary care.

They also signal to medical students that the largest payer of health care services believes in the value of primary care. The continuation of these programs confirms an emerging national awareness for those students who are deciding their specialty training now. Facing staggering debt loads, students who would otherwise prefer to concentrate on providing primary care are instead making the decision to choose a specialty that will generate enough earnings to pay for their student loans. Medicare's need for primary care physicians will only grow as the Baby Boom population in the U.S. ages, so these payment incentive programs are just part of the effort to show more students that they can afford to be the physicians which they want to become and which the nation needs.

Finally, geographic adjustment of physician payments should ensure equitable payment to providers and access to beneficiaries. Current adjustment policies are neither aligned with one another nor of the magnitude to promote equitable distribution of the primary care workforce, and as a result, frequently penalize physicians in rural and underserved areas. Congress should include targeted geographic practice payment adjustments that offer incentives for better physician workforce distribution, and call upon CMS to monitor the interactions of all current and future payment adjustments. Specifically, CMS should monitor the collective impact of geographic adjustments on total provider reimbursements, workforce distribution, and beneficiary access and quality. Otherwise, maldistribution will continue long after the ratio is balanced between primary care and specialized physician workforce unless the

geographic payment adjustments are focused on providing incentives to lead physician practices to locate where they are most needed.[4]

During this period of stability, it will be crucial to encourage as much innovation as possible. The new CMS Center for Innovation will be a key focus of this effort. Whether it is the Patient Centered Medical Home, the new Accountable Care Organizations, or bundled payment experiments, the CMS Center for Innovation should coordinate all of the system tests. The CMS Innovation Center has the potential to be an extremely valuable tool to test potential payment reforms that could generate substantial savings for Medicare and improved quality of health care delivery. We believe that this Center can help CMS create market-based, private sector-like programs that can significantly bend the health care cost curve because it has effective authority to implement promising pilots and demonstrations. We recommend that the CMS Innovation Center should coordinate the various health care delivery testing programs to ensure comparability and thoroughness of the data. The physician community believes strongly in the value of evidence and it is the responsibility of the Innovation Center to provide credible, reliable and usable evidence of health system delivery reform.

When the implementation data ultimately is available, we would encourage Congress to engage in another discussion with the physician community, with public and private payers and with the consumers, to determine not just what works, but also what is preferable. In the final analysis, health care is such an important part of the economy and everyone's personal lives that we should try to find general agreement in whatever becomes the final replacement for the current physician payment system.

[4] Xierali I, Bazemore AW, Phillips Jr RL, Petterson SM, Dodoo MS, Teevan B. A perfect storm: changes impacting Medicare threaten primary access in underserved areas. Am Fam Physician. 2008 Jun 15;77(12):1738.

Summary

The AAFP advocates for Medicare payment reforms that ultimately include a blended payment system for team-based Patient Centered Medical Homes and similar reforms based on primary care. This blended payment is one that consists of:

- Fee-for-service payment
- Care management fee that compensates for expertise and time required for primary care activities that are not direct patient encounters
- Performance bonus based on a voluntary pay-for-reporting/performance system.

To achieve this payment reform, we recommend that Congress establish a transition period of 5 years with mandated payment updates (with a rate 2-percent higher for primary care physicians who provide primary care and preventive health services). In addition, we recommend continuation of the Primary Care Incentive Payment, increased to 20 percent, and of the Medicaid payment of Medicare rates for primary care and preventive health services offered by primary care physicians. During this limited transition period, the CMS Innovation Center should coordinate programs to test delivery system reforms and provide comparable data to demonstrate the most effective reforms in specific settings and systems.

Chairman Pitts, Mr. Pallone, we are pleased to continue to work with you and others in Congress who hope to make the changes needed to restrain health care costs and improve its quality in this nation. Thank you for your long-standing commitment to make health care better.

Mr. PITTS. The chair thanks the panel for their opening statements, and I will now begin the questioning and recognize myself for 5 minutes.

Dr. Williamson, you advocate allowing physicians to privately contract with beneficiaries above Medicare payments. One concern with this arrangement is that sick patients may be at a disadvantage entering into a contract without sufficient knowledge about what they need or about the quality of care they are contracting for.

Is there a way to structure this so that patients have more information about what they are contracting for? For example, could you combine private contracting with quality measurement and reporting or other tools such as shared decision making? Would you respond to that, please?

Mr. WILLIAMSON. Thank you for the question, and that is a great question. I understand those concerns, and I would point out several items about that Medicare Patient Empowerment Act.

Number one, there is a lot of openness in this act. Patients have to agree upfront what they are agreeing to before any care is delivered.

Number two, this is merely an option within the current existing Medicare System, so this would not change any of the current ways that Medicare is financed otherwise. There are sufficient protections we believe already existing in the current Medicare Patient Empowerment Act as written so that urgencies or emergencies as currently defined under Medicare would be exempt from private contracting and also dual eligible patients, those patients that are most impoverished that are eligible for Medicaid, would not be eligible for private contracting.

In terms of linking private contracting with quality measures and the other items that you outlined, this is something that physicians are trained to do, and I would say with respectful disagreement to some of the things that were said today, physicians are taught in medical school how to control costs. They are taught how to communicate with their peers. They are taught how to analyze data. This is something that we are taught from the very first day of medical school. I took a course called analytical medicine, and these things are already integral. Could we do more to emphasize these things? Absolutely, but I think within the Medicare Patient Empowerment Act there are sufficient protections to address your concerns.

Thank you.

Mr. PITTS. Thank you. Dr. Hoyt, your organization has done a lot of very good work on quality measures. Can you give us an assessment of where we are today in terms of measuring quality? Are we just measuring processes, or can we also measure outcomes? How close are we to being able to come up with a metric that will help us decide how to pay for quality?

Mr. HOYT. Thank you. Yes. I think the way to characterize quality programs today is that probably the best example would be the National Surgical Quality Improvement Program or NSQIP, where outcomes in addition to processes of care can be measured.

A very specific example. The implementation of that program in 112 hospitals over a 3-year period reduced complications, major

surgical complications by about one complication per day per hospital. If you ascribe about $10,000 to an average complication, which is probably a low figure, and multiply that out that turns out to be a savings of about $2.5 million per hospital. If you roll that kind of program across all 4,000 hospitals, you are talking potentially billions of dollars each year save one program. You add to that comparative effectiveness, you add to that other cost reduction strategies, and I think that physicians can bring a lot.

But the quality program tool, if you will, is proven.

Mr. PITTS. Thank you. Dr. McClellan, there are several moving parts to this puzzle. On the one hand there are a number of forces pushing providers away from traditional fee-for-service towards the newer payment and delivery system such as ACOs and bundling payment agreements and medical homes, even capitation models.

Yet on the other hand it seems that fee-for-service will continue to have a role at least for the foreseeable future. As we put the effort into developing these newer payment and delivery systems, what can we do to fee-for-service to make it less inflationary and more value based?

Mr. MCCLELLAN. Mr. Chairman, I agree with you. I think fee-for-service and Medicare is going to continue to play a significant role for some time. I think what you have heard from the panel today, there are a lot of ways, including proven ways, to help make fee-for-service work more effectively with these other kinds of reforms, and, you know, if you—some of the reforms that you mentioned that are taking place in hospital payments and other parts of the Medicare Program, the episode payments involving hospitals, the accountable care payments, it would be very helpful if physicians could get better financial support in their own payment system to enable them to lead all of those efforts. And right now with fee-for-service staying the way it is, they are staying behind.

So I think there are some real opportunities for alignment. We are not talking about, you know, radically changing the system, discarding all fee-for-service payments now, but, again, especially if these efforts can start with physician identified and physician-led efforts like you just heard about from Dr. Hoyt, they have the performance measures. These are things that Medicare could be paying to report on as part of its quality reporting payments instead of some of the other approaches that are being used now. It would be much more in line with where physicians are telling us we can improve care and save money, ideas that they already know how to do.

Mr. PITTS. Thank you. My time has expired.

Recognize the ranking member for 5 minutes for questioning.

Mr. PALLONE. Thank you, Mr. Chairman. I have three questions to three different people, so I am going to try to rush through them, and I hope you will bear with me.

Some of the ideas that were mentioned today by the panel reminded me of the bill which I mentioned in my opening that the House passed I guess last year or the year before, which addressed the SGR problem in a larger sense. That was the Medicare Physician Payment Reform Act of 2009, H.R. 3961.

Now, I am not suggesting we simply go back to that now because the Affordable Care Act creates a lot of new opportunities for fixing

the SGR that we should build off today. But that bill, H.R. 3961, would have fixed the problem, and so I would like to get Mr. Goertz's thoughts on, you know, on it.

As you may recall, it provided a guaranteed update during a transition to a new payment system, it would have created fairer growth targets by eliminating items not paid under the physician fee schedule, it would have provided an extra growth allowance for primary care services, and allowed ACOs to opt out of the spending targets. So I just wanted to ask Mr. Goertz about your thoughts on this legislation, what you like about it, and what maybe we could do better now that we are post Affordable Care Act?

In about 1 minute.

Mr. GOERTZ. I might be able to give you a 1-minute response, but it won't cover all those topics.

Mr. PALLONE. I know. I know.

Mr. GOERTZ. Our organization, I don't remember the exact position on that legislation that we took, but if it satisfies the three elements that I mentioned because fee-for-service has inerrant positives and negatives. The positive is that it incents you work harder. The negatives is that it is inherently inflationary.

So there has got to be some control on that. So we believe that if you put a patient coordination fee element into that that allows us to increase the things that we don't get paid for in communication with patients and the rest of the other physicians and team members that are needed, it will work. It will work.

Now, the way the current model works it just simply puts everybody in one pool and treats them all the same way. The quality measures are mainly process right now, but we are making big strides in getting to the outcome decisions that are necessary for that, and what mix of those three things eventually evolve I think are going to be very interesting to watch. I don't know what the answers are, but all three work synergistically to have a better system than any one of them by themselves.

Mr. PALLONE. Well, thank you. Now, you mentioned fee-for-service. Let me ask Dr. McClellan the second question.

Are there examples where physicians or provider-led organizations have stepped up to do the right thing, you know, under fee-for-service and the payment system has hurt them from doing that? You suggested that there might be cases, but, you know, give me an example of maybe where physicians were actually financially punished for doing the right thing, and, you know, I mean, that is the last thing I would like to see happen.

Mr. MCCLELLAN. Lots of examples. One of the first meetings I had as CMS Administrator was with the leaders of a number of group practices that were doing things like working with nurse practitioners and pharmacists to do support for adherence medication, forming transition teams to help prevent readmissions. Point out that Medicare pays for none of that, and to the extent that it works they could bill less for the things that Medicare does pay for.

Another good example is Virginia Mason Medical Center in Seattle that implemented some steps to lower costs and improve outcomes for patients with common problems like back pain. They were penalized financially and has made it very difficult for them to sustain their programs.

Mr. PALLONE. All right. Well, thanks.

Now, last, Dr. Wilson, you, you know, I want to commend your proposal. It is clear that the AMA and the two other societies seated with you today took our request seriously and put some time into the response.

But I am wondering if you could just attempt to give us your view of the consensus amongst the physician community, if any, and what we should do about the problems with the Physician Payment System? Is there a consensus at this point would you say?

Mr. WILSON. In a general sense——

Mr. PALLONE. I don't know that that mike is on.

Mr. WILSON [continuing]. I would say yes, and I think you heard that this morning that around certain principles, and that is we have a payment system that does not work. We need to get rid of it. We need to have a period of stability as we move to a different way of delivering care and paying for care, and you have heard a variety of options about models that might be effective. I think there is a great deal of consensus around there.

Now, when we get down to the fine ink, fine print, clearly we will all have differences about what will work, but I think we should also have a realization that what will work in one part of the country will not work in another part of the country, and that is why we have continued to talk about a variety of options, not picking a one size that we expect will fit all. I can take you to my home State of Florida where what works in the Pan Handle doesn't work in Central Florida where I live and doesn't work in South Florida. So I think we need to keep that in mind.

There is a temptation to feel like we ought to figure out one rule, and that solve it all. This system is so complex that we need to preserve that, and as a matter of fact, the Affordable Care Act in talking about accountable care organizations, I think, recognize that. It talked about a variety of models for those structures that would work. I think we need to keep that in mind, but I am impressed also as I go around the country talking to physicians. They understand there are ways that this can be done better, and they want to be involved in the process.

Thank you.

Mr. PALLONE. Thank you, gentlemen. Thank you, Mr. Chairman.

Mr. PITTS. The chair now recognizes the distinguished chairman of the full committee, the gentleman from Michigan, Mr. Upton, for 5 minutes.

Mr. UPTON. Well, thank you, Mr. Pitts, and again, I just want to reiterate from this committee's viewpoint that I very much appreciate all of the input, not only from you today but the dozens of organizations that responded to the letter that was bipartisan that Mr. Waxman and I and others signed looking for information. This is on our short list of getting things done really this summer. Got a number of different things that are there, but this is an issue that we need to grapple with. It is time. We are way too late, and I appreciate the expertise, the questions of particularly Dr. Burgess, the vice chair of this subcommittee in addition to Mr. Pitts, Mr. Pallone, Mr. Waxman, and others.

Personally I like the idea of taking the time, a number of different years, to look at a whole number of different models and see

what might work best. I know from my district's perspective I have got some pretty urban areas in terms of Kalamazoo with two great hospital facilities with lots of physicians, Borgess and Bronson, as well as Lakeland Hospital in the county that I live in, and I have got some counties that frankly are very rural, some that don't even have a four-lane road practically. And so it is—we are a diverse Nation and different healthcare, and we need to look at those different priorities that are there for sure, and I just want to—again appreciate your time today.

The question that I have and I want to focus this first to Professor Chernew but others might want to comment, you know, the IPAB was created by the Affordable Care Act as we all know. A number of folks on both sides of the aisle have expressed concern about the board and how it functions. For one thing as we know that the board sets expenditure targets, imposes spending cuts based on those targets, and we know that beginning 2018, the target will be based on GDP.

Sounds a lot like SGR which we are trying to get rid of, and since hospitals are exempt from IPAB cuts through the rest of the decade, it seems that the IPAB has the potential to undermine any serious efforts a physician payment reform.

And I would like to get your comments as it relates to that. So we will start with Professor Chernew and anyone else that would like to comment would be great.

Mr. CHERNEW. First let me say, Go Blue.

Mr. UPTON. Yes. Absolutely.

Mr. CHERNEW. Having been in Michigan for 15 years but——

Mr. UPTON. We lost a basketball guy this week. I don't know if you heard.

Mr. CHERNEW. I think the IPAB is yet an unknown quantity. I think in its best it could be supportive of all the things that one does here and at its worst it could create problems that you discussed, and I think the challenge like much of aspects of the ACA is how to implement the proposals. What you have heard here around the table about payment reform I think is a stunning consensus about both the problems of the SGR. I heard from the chairman and the others who spoke and the notion that reforming payment is going to have some basic principles, and you mentioned some. The others mentioned the transition and stuff, and I would like to think that the IPAB can be used as a tool to backstop if problems arise in those, but I certainly think that if one isn't careful in various ways there would be concerns.

And so like most things the devil is going to be in the details and how to make it work is a bigger question than one can address in the time that we have here.

Mr. UPTON. Anybody else like to comment?

Mr. WILLIAMSON. Our coalition has opposed the IPAB for a number of reasons, some have been stated. We have concerns about the fact that it is comprised of non-elected officials with minimal accountability and the fact that its recommendations would automatically become law if the Congress didn't act within a fairly short period of months. So our coalition has opposed that entity.

Mr. WILSON. Thank you, Mr. Chair. The AMA from the start has said that this—the Affordable Care Act is a big step forward to

health system reform, but it is just a step, and there is some challenges associated with it. There are things that were left out, and that is medical liability reform as well as a fix for the Medicare physician payment. And there is some things in the bill that we have problems with, and one of them is the Independent Payment Advisory Board, the IPAB. As it is presently structured. We do not support it.

Our concern is and maybe this would be a good place to float this, and that is 20 years from now we might be sitting here, some of us, talking about how to correct the problems associated with it. So it is not impossible that it could serve a function, but as presently constituted we could—we see it basically another target for physicians to meet, potential double jeopardy with an SGR as well as the pronouncements from this body.

So we believe significant changes need to be made.

Mr. UPTON. Great. I know my time has expired. I just want to add the Tort Reform is also on our short list of getting things done.

So thank you very much.

Mr. PITTS. The chair thanks the gentleman, and now recognizes the distinguished gentleman from Michigan, the ranking Member emeritus, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy, and I would like to direct my attentions to Dr. Wilson, Dr. Goertz, and Dr. Hoyt, and I would like to do this against the background of getting their helpful and necessary advice on how we will proceed to solve a problem that is going to cost more every year.

Now, gentlemen, like all of you I believe we have to change or repeal the seriously flawed SGR formula. Each of you seems to be in agreement that a 5-year stability period is needed for Medicare physician payments to allow providers to plan ahead as well as to allow demonstration projects of different payment models.

Is a 5-year stability period an adequate amount of time to phase out SGR and for physicians to prepare for a new payment system? Yes or no? In other words, is 5 years enough time to do the job?

Mr. WILSON. Well, Mr. Chair——

Mr. DINGELL. If you want to qualify that I will be glad to receive that for the record.

Mr. WILSON. I will qualify it. We think the 5 years because we do think we are going down a different road. This is going to be a challenge. It will not be easy.

On the other hand, we don't want an indefinite period of time. We think there is an urgency about moving forward, and we also believe that as things come——

Mr. DINGELL. Doctor, I hate to be discourteous, but I have got a lot of questions. If I get yes or no, I will get through them.

Mr. Goertz, Dr. Hoyt?

Mr. GOERTZ. We would commit to a 5-year period to do everything possible to make the transition.

Mr. DINGELL. Dr. Hoyt.

Mr. HOYT. I would agree.

Mr. DINGELL. All right. Now, we have heard from many of you about the need for demonstration projects. How many demonstration projects would be necessary to determine the effectiveness of a new system? Starting with Dr. Wilson. Just horseback answer.

Mr. WILSON. Thank you, Mr. Chair—Congressman. The—it depends on how they work out.

Mr. DINGELL. True.

Mr. WILSON. And if we are fortunate that the first project works out, then we are there, and that is why we are doing demonstration projects. We don't know how it is going to turn out.

Mr. DINGELL. The other two panelists, please.

Mr. GOERTZ. Well, I would posit to you that at least for the elements that I am talking, have referred to, the patients in a medical home, I think there are more than enough demonstration projects that already show the benefit of that. Now, if you are talking about overall change, I think you are going to have to have enough demonstration projects that represent all the regions of the country, all the demographic variations that are appropriate, but I don't think that has to be an onerous number.

Mr. DINGELL. Thank you. Doctor.

Mr. HOYT. And I don't know the number, but particularly in surgery we would need demonstration projects to fulfill the needs of surgeons practicing in already integrated health systems like Geisinger or Kaiser. Then we have 55 percent of our members that are still practicing in solo or small group practice, and solutions for them are needed as well.

Mr. DINGELL. Thank you. Now, the same panelists, if you please. I introduced in the prior Congress H.R. 3961. That included reforms that may offer some solutions to the current payment problems. As you are well aware, next January Medicare physicians are facing a 29.5 percent cut if the SGR problem is not addressed.

Do you have any that H.R. 3961 would have prevented the 29.5 percent cut we are expecting in January? Yes or no?

Mr. WILSON. Yes.

Mr. DINGELL. Doctor?

Mr. GOERTZ. Yes, it would have definitely helped.

Mr. DINGELL. Doctor?

Mr. HOYT. Yes.

Mr. DINGELL. One of the proposed reforms included in H.R. 3691 or rather 3961 was creating two categories of physician services; one for evaluation management and preventative services and the second to cover all other services. Primary and preventative services would be permitted to grow at GDP plus 2 percent while other services would be allowed to grow at the rate of GDP plus 1 percent.

Do you think this is a good idea? Yes or no?

Mr. WILSON. That is one of the challenges of prescriptive formulas and that is to know that you got it right, and I think the answer would be I do not know.

Mr. DINGELL. Thank you, Doctor.

Doctor?

Mr. GOERTZ. We certainly ascribe to the rebalancing that the primary care elements would have done. The overall I don't know also.

Mr. DINGELL. Now, we have a whole series of problems here, one of which is we are putting target limits on all kinds of services being paid for by Medicare. Should we limit spending targets to

physician services, or should we cover all other kinds of services? Starting with Dr. Wilson, if you please.

Mr. WILSON. Thank you. I think if we are going to have targets, then they should include everyone.

VOICE. Microphone.

Mr. WILSON. I am sorry. I think if we are going to have targets, they should include the health system in general. I think what we are understanding dealing with the SGR that targets are not a very effective way to do what we want to do.

Mr. DINGELL. Thank you. Dr. Goertz.

Mr. GOERTZ. Unless you consider the overall healthcare system, you can't make it efficient.

Mr. DINGELL. I note, Mr. Chairman, I am over my time. Thank you for your courtesy.

Mr. PITTS. The chair thanks the gentleman and recognizes the distinguished vice chairman of the subcommittee, the gentleman from Texas, Dr. Burgess, for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. So much to ask. We always do reserve the right to submit questions in writing. I will not get through the list of things in front of me, and I know that these are not yes or no questions.

Dr. Wilson, Dr. McClellan, whoever feels most comfortable answering this or both of you, actually, Dr. McClellan, your old boss at Department of Health and Human Services, Mike Leavitt, had a demonstration project that the physician group practice demonstration project that now has moved into the ACO realm, and many of us were somewhat excited about the concept of ACOs, and a lot of the Medicare payment reform perhaps could have been tied to the ACO. But then a couple of weeks ago we got the rule out of the Center for Medicare and Medicaid Services, with which you are intimately familiar, and it was almost unreadable and certainly unworkable, so now that everyone knows what a unicorn is, I don't think any exist in practice, do they?

Mr. MCCLELLAN. Well, as you know, the regulatory process involves stats and especially in new areas like this one there are going to be lots of comments on whatever the agency puts out first, and I have heard some statements recently from some of the leadership at CMS that they are definitely listening closely to the comments, and they want to address on the issues that have been raised about the proposed regulation.

I don't think that like many of the other ideas that we have talked about here today, though, that we are just talking about unicorns in terms of doing reforms and payment that support physician leadership and improving care and lowering costs. There are a number of ACO-like programs in existence now. Dr. Chernew talked about the Massachusetts Blue Cross Alternative Quality Contract. That has a lot of new kinds of support for physicians for the kinds of delivery reforms that we have talked about. Dr. Hoyt talked about a lot of experience with Episode and statements that have helped surgeons.

Mr. BURGESS. Let me interrupt you for a moment because I know you know so much about this, and I am going to ask you to respond to part of this in writing, but under the rule that came out I don't know that they could exist, and perhaps they could respond to me

in writing about whether or not their programs could continue to exist.

Dr. Wilson, you talk a little bit about physician leadership, and this is going to be so critical. Whatever evolves as the answer to this conundrum it is going to take physician leadership, and what are you doing now as the head, the consummate insider of organized medicine in the free world? What are you doing to recruit that physician leadership?

We all know whatever it is doctors don't like anything moving in their cage, we don't like change, but when it happens, it is going to take champions within the profession to lead that change.

How are you preparing for that?

Mr. WILSON. Well, thank you, Congressman. I assume that means in addition to praying. The AMA is actually devoting a great deal of its resources to trying to provide information to physicians through papers on this subject, through webinars, through information on our Web site, through seminars around the country to help physicians understand what an ACO might look like and understanding that the definition is fluid and that what is in the private sector may look different than that in the Medicare sector.

So we are committed to that. Just the week before last I did a webinar just looking at the proposed rules. So we think that is an important part of what the AMA needs to do, and I would just state——

Mr. BURGESS. Let me just interrupt you for a second. That would include other payment models other than just the ACO?

Mr. WILSON. Absolutely. Absolutely, and I would just say that as I have gone around the country and looking at physician organizations, they are onboard and trying to do that as well. So they are—this is a big job, there are a lot of people who are involved, and we think it is important, and we agree with that.

Mr. BURGESS. Well, and I would just point out, I mean, I have already gotten some criticism, the twitter verse, for acknowledging that there were so many doctors on the panel. We had never had doctors on the panel when we were doing healthcare reform. I just do need to point that out, and I thought we needed you when we were doing healthcare reform, but there is not a day that goes by that I don't hear from some doctor or some group who has some idea about—I dare say you can't go into a surgery lounge anywhere in the country where this problem wouldn't be solved within 15 minutes with time for coffee.

Now, Dr. or Mr. Miller and Dr. Chernew, I need to ask you in what limited time I have left, both of what I heard you describe what you were proposing, I will admit getting a very cold sensation because it sounded so much like capitation under the HMO model of the 1990s.

How are each of you different from capitation?

Mr. MILLER. Well, it is different from capitation in a number of critical ways. First of all it is risk adjusted so that you don't get penalized for having sicker patients. There are limits on the amount of risk that you would take. So if you get a usually expensive patient, you don't end up having to pay for that all out of the same amount of money. That gets covered, and there are quality

bonuses attached to it so that you don't end up being rewarded for delivering low-quality care.

And I think that when we talk to physicians about this, I was just in Colorado this past weekend, had 100 doctors, we actually had them sort of be inside the payment model, and to talk about how they would change care because of the greater flexibility that they would have, and at the end we said, so, which would you rather be in? These new payment models or the existing payment model, and it was about 99 to one people said I would like to be in the new payment model because of the opportunities it gives me to be able to deliver better quality care.

Mr. BURGESS. Mr. Chernew, just very briefly.

Mr. CHERNEW. I would just add——

Mr. BURGESS. All right. Are you finished your answer? All right.

Mr. CHERNEW. Apparently.

Mr. PITTS. Did you have something——

Mr. BURGESS. I was just wanting Dr. Chernew to respond to the issue of capitation.

Mr. CHERNEW. A 5-year—I agree with everything Dr. Miller said and the 5-year duration of the contract makes a big difference, because if you are effective in lowering costs, they can't come in the next year and just lower and lower your capitation rate. The rates always go up, the capitation. I think that is an important fact.

Mr. PITTS. OK. Thank the gentleman and now recognize the distinguished ranking member of the full committee, the gentleman from California, Mr. Waxman, for 5 minutes.

Mr. WAXMAN. Thank you very much, Mr. Chairman. I know we try to be liberal on time, and I will try to stay within the 5 minutes, but knowing the President I am sure I could go over.

I have always been a supporter of allowing managed care choice for Medicare beneficiaries. My district, Kaiser Permanente, Kaiser Health Plan and Permanente Medical Group, have been leaders in providing high-quality care at a reasonable cost.

In many cases, however, managed care gets out of control, loses its bearings, patients have been denied necessary treatments and care, has been rationed by some private plans.

Dr. Chernew, I want to address this question to you because your testimony describes the alternative quality contract of Blue Cross Blue Shield Massachusetts is pursuing. Can you tell whether and how that model guards against the incentives for doctors that deny needed treatment to their patients?

Mr. CHERNEW. Very briefly there is—the rates are set so that they don't go down so no organization is forced to reduce access to care. The rates go up at a slower rate than they otherwise might have. There is the quality bonus system that protects against care which includes outcome measures as well as process measures, includes patient experience measures, as well as just process measures, and our preliminary evidence suggests, in fact, the quality has risen under the AQC, and again, it tends to be a more doctor-oriented system where the doctors have autonomy to do what they were trained and want to do as opposed to insurer micro-managing the care. The doctors have much more flexibility as Mr. Miller emphasized than you might have in other systems. So I think it is a very doctor-leadership friendly design.

Mr. WAXMAN. In Medicare, of course, we are pursuing some similar projects in the form of accountable care organizations and other shared savings arrangements. Can you draw any lessons for Medicare from the Blue Cross Blue Shield Massachusetts experience to date?

Mr. CHERNEW. I do think there is a lot of similarities. I think some of the advantages that Blue Cross has had is, for example, you have to choose a physician, designate a physician. I think that is similar to the contracting that Dr. Williamson mentioned. You have to pick a physician that helps—it works. There is an up side and down side risk as some of the ACL regulation gets out, so I do think there are broader lessons in the AQC, the performance measures, but we would have to have a longer conversation to go into all the things. But there are parallels, and I do think it speaks well of where some of the innovations are going.

Mr. WAXMAN. Many of the physician groups that responded to our letter, bipartisan letter, seeking comment asked that Medicare allow physicians to choose from a menu of options for different payment models in the future. Do you agree that Medicare needs to be able to deal with physicians and hospitals in a more personalized, specific way, less of a one-size-fit-all approach?

Mr. CHERNEW. I do think that multiple approaches will be useful. I think they have to be structured in a way to avoid aspects of selection across the different programs, but subject to those caveats I think there is unlikely to be a one-size-fits-all solution.

Mr. WAXMAN. As we look at the ways to change the incentives in order to truly fix the payment system, we have to be sure we do no harm the quality of care in the process and hopefully rebuild incentives that actually improve the quality of care.

So Dr. Miller, I was very interested in your ideas on regional health collaboratives. During my time as chairman of the Oversight Committee, separate committee from this one, one of the most striking things we learned was about—was a project in Michigan that was implementing a checklist to reduce healthcare-associated infections. Many people took away from that the idea that we ought to have checklists, but what we also heard and maybe more importantly at this hearing was the importance of people coming together to improve care. The checklist was only a tool to allow for collaboration at the local level.

MedPAC has recently begun a discussion about ways to improve quality of care. They are contemplating changes to the Medicare Quality Improvement Organizations and heard testimony from a regional health collaborative.

Dr. Miller, do you think that the QIOs should be significantly modified to allow for more entities to participate, and can these collaboratives play a more direct role in payment reform aside from the critical role of improving quality?

Mr. MILLER. Well, I think the collaboratives are already doing around the country things that we want to see happen. They are measuring and reporting on quality long before Medicare was doing that. They have been working to work with both hospitals and physicians to help them be able to restructure the way they deliver care. Pittsburgh Regional Health Initiative in Pittsburgh was doing those infection reduction projects back in the 1990s.

What everybody kept running into was the problem that the way the payment system was structured actually either didn't support the care changes that they had found would work or would penalize them for doing that, and so that is why we now see a number of the collaboratives around the country that are working on payment reform efforts and have brought together the commercial health plans and Medicaid plans to agree on different approaches to payment. The biggest thing that is missing is Medicare being at the table.

I think the QIOs in a number of communities, some of the QIOs are operating as regional health collaboratives, and I think that in other cases they are working together. I think there is plenty to be done to be able to improve the way the healthcare system works and rolls for everybody. I think the issue is to have that local focus and to be able to have the kinds of improvement customized to what are the specific problems and the specific needs in that particular community, and that is what we don't have right now is a good system for being able to support that local customization.

Mr. WAXMAN. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Kentucky, Mr. Guthrie, for 5 minutes.

Mr. GUTHRIE. Thank you very much, Mr. Chairman. I guess, Dr. McClellan, I will ask you this since you were at CMS in the 2000s. I have been looking at the Sustainable Growth Rate. I got elected 2 years ago, so I am new at this, and I don't like to go back and say, well, there is a problem in the past. We have to fix it, but it would be kind of nice to know since we are trying to come up with a new system, were you there when the Sustainable Growth Rate was designed? Because looking at the map of it, it ties, essentially ties it to the gross domestic product, which even the gross domestic product drops. People don't quite go into the positions, so it seemed like a bad model to begin with, and I don't know if—did people come together and say, you may not have been here, but just history of it, this was the right thing to do and now we are here 10, 12 years later going, we have to do something different?

Because my question gets to whatever we do is going to have to save costs in the system, and so whatever system we have it going to save the costs of at least the growth. Right now it is cut, it is not trying to slow growth, it is cutting, which is wrong, but I just want to know the history of the SGR and why you think it was supposed to work and didn't.

Mr. MCCLELLAN. Well, I will try to give you a brief history. I wasn't there back in the days of the Balanced Budget Amendment or Balanced Budget Act that established the SGR more than a decade ago. It was driven exactly as you said, by concerns about rising costs in the Medicare Program and the need to find a way to take costs out, and you know, unfortunately, the traditional thing that we do when we can't figure out the direct way to save money while improving care is when all else fails, just cut the payment rates, and that is what was built into the formula.

So I wasn't here when that started. I was here 5 years ago at CMS as you mentioned when this subcommittee was also having hearings about the challenges of reforming the SGR, and I think what has happened in the 5 years since is a couple of things.

One is the concerns about rising costs and the sustainability of the Medicare Program have increased a lot, along with the cost about the affordability of our healthcare system overall, and the second is we have a lot more evidence and a lot more leadership from physicians as has come up repeatedly today on ways to do it better so that you don't depend on crossing your fingers that some statutory formula is actually going to be implemented, and you do depend on the people who are in the best position to do something about this problem, and that is physicians.

So the steps that we have talked about today, I think it is time to begin implementing them to move away from the SGR and save money at the same time.

Mr. GUTHRIE. I agree, agree completely. I just wanted to kind of figure—we were sitting here a dozen years ago saying this is going to fix the problem, but I guess people must have thought even when they did it, this really isn't going to fix the problem. So when you do—things come as gimmicks, and this is not going to work. You have got to have sustainable changes into that.

The thing on quality of care, a lot of times we talk about teachers, and they say, we want to be paid for the quality of instruction and how do you measure it. I mean, the measurables come into play because the teacher says, well, if I am in a school with a certain demographic, then I may—and I am with a school of a different demographic, I am being compared to each teacher. And so, I mean, how do you—because if you have a less-healthy population you are treating, you are going to have less outcome just by nature than if you have a healthy group.

So how do you determine—anybody want to talk? How about Dr. Hoyt?

Mr. HOYT. Yes. I think that is a great question, and the way you do that is, first of all, through statistical risk adjustment of patient population so you are comparing apples to apples, physician to physician, practice to practice.

Mr. GUTHRIE. Another formula?

Mr. HOYT. And then secondly, you really need to pick matrix that are going to be relevant to improving the patient care process, and I think by having leadership models like people have talked about we are actually training leaders to become qualitologists or quality leaders in organizations by having these inter-State collaboratives so that we share best practice. And then what you individually do with the database is you array against a particular complication, let's say surgical infection, all of the providers. That can be hospitals or that could be an individual physician, and what you then get is the performance of all those providers across that complication. You are going to have some outliers that are doing well, some outliers that are doing poorly.

What happens is those people get together, and they improve, and that is the affect we are trying to get to.

Mr. GUTHRIE. I only have 30 seconds, but the surgical infections is what the hospital is doing there. What about some of the behaviors that—what the patient brings to it like someone who is pregnant. So——

Mr. HOYT. That needs an additional——

Mr. GUTHRIE. And I know you want to incentivize having better prenatal care, but are there doctors that that is what you want to do is say you kind of really manage that. A lot of times it will be different for different physicians based on the way their patient populations react. And how do you account for that?

Mr. HOYT. Well, I think that is an additional strategy. You know, in my field, trauma, the way we do that is you work on road traffic safety initiatives, you work on gun control or whatever because you are trying to go upstream from the problem, and every aspect of medicine has preventative areas that are essential.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentlelady from California, Ms. Capps, for 5 minutes for questions.

Mrs. CAPPS. Thank you all for being here. I have long been a supporter of fixing the SGR problem. It is an issue that causes difficulty for providers and consumers alike. In addition, providers who are able to keep their patients healthier and lower overall costs are often penalized even more.

But the conversation often stops at the crisis point—how do we make it to the next fix?—and rarely moves onto one where we can discuss our vision for healthcare system in the future and how to get there. That is why I thank Chairman Pitts and Ranking Member Pallone for engaging in this important topic today, and I have two—an idea to bring before Dr. McClellan and Mr. Miller.

There has been so much talk about the role of doctors in the healthcare system, but if we are really going to move to a more comprehensive, prevention-focused system of care, I believe it is important to acknowledge the role that other healthcare providers bring to the table in keeping our Nation healthy, including nurses, nurse practitioners, physicians' assistants, and many new kinds of models of delivering care.

This hearing and many before it have drawn our attention to the needs to move away from volume-based medicine and toward a more holistic model where the rewards are for providing great care for a patient rather than a lot of tests and procedures. As a nurse, I can tell you that nurses and nurse practitioners get that. In previous hearings we have heard about how many successful programs—we have heard about some successful programs, for examples, the Guided Care Program at Johns Hopkins and how they rely on nurse managers or nurse practitioners to provide the complex services that frail Medicare and Medicaid patients often need. In addition, nurses have patient education skills that can help to manage chronic diseases for many people.

So, Dr. McClellan, will you talk briefly about the possibilities for nurse practitioners, physicians' assistants, and other non-physician practitioners in some of these new care models like medical homes or accountable care organizations, please? Then I will turn to you——

Mr. MCCLELLAN. Every single one of these reforms has involved more reliance on other health professionals. I can't think of any, not medical homes, not these episode-based programs, improve surgical outcomes and reduce complications, not programs for palliative and supportive care for patients with complex illnesses. They don't rely much more than we have in the past on nurse practitioners, nurses, pharmacists, and other allied health professionals

in delivering care. And that gets back to the core problem we have been talking about today, which is that Medicare's traditional fee-for-service program doesn't do much to pay for these other forms of care in order to target these services to the right patients, though, you need physicians working with these other health professionals making decisions. You need more flexibility for them to lead, and that is hopefully where these payment reforms will take us.

Mrs. CAPPS. And so that is one of the areas where you want to see us go forward.

Mr. MCCLELLAN. Absolutely.

Mrs. CAPPS. OK, and of course, underlying all of this is the shortage of primary docs, and everyone is fixated on that. There are—we need more incentives for people to rise to those kinds of primary care services from these other professions as well. I am seeing you nod so I think you agree.

Mr. MCCLELLAN. I think so, and just to go back to the example in Massachusetts that Dr. Chernew was talking about, one of the features of that alternative quality contract is a lot more resources for primary care doctors to coordinate care, and some of them who I have talked to said they feel this is more like concierge's medicine almost. They are able to really spend the time managing the patients' problems and aren't being reimbursed just on a short, you know, 5-minute visit basis.

Mrs. CAPPS. Good. OK. Maybe Mr. Miller, and if there is time, Dr. Chernew, you may want to chime in, too.

Mr. MILLER. I organized and ran a project in Pittsburgh over the past 3 years focused on reducing hospital readmissions for patients with chronic disease. We made a lot of changes in various procedures, but the most important single thing that we did was that we hired two nurses to work with those chronic disease patients to help them, educate them to go into their homes to figure out what they needed to be able to manage their care better. We had to use a foundation grant locally to pay for them because they could not be paid for by——

Mrs. CAPPS. There is no funding stream right now.

Mr. MILLER. My instructions to the nurses when we hired them was your job is to keep 13 people out of the hospital in the next year because that will actually pay for your salary, and they beat that target by a significant amount. We reduced readmissions by 44 percent in the course of 1 year, and we ended up having to lay off one of those nurses at the end because there was no way to continue her under the current healthcare payment system. In the other case, fortunately, the hospital was willing to pick her up to put her on salary to continue to do that work to help the patients stay out of the hospital.

Mrs. CAPPS. Great example. So the results are pretty short-term.

Mr. MILLER. The results at quick, they are dramatic, and the intervention is very simple. It is simply—it is a perfect example of something where the current payment system does not pay for that. Now, whenever you do pay for it, you want to have them focusing on a specific target——

Mrs. CAPPS. Right.

Mr. MILLER [continuing]. that will actually save you some money and not have that nurse diverted into doing all kinds of other things that might be desirable but will not save the program money. That is why whenever we did the program we said the focus is specifically on keeping, reducing readmissions of patients, and they were able to do that, and it was actually a very empowering thing for the nurses and for the physicians to be able to have that resource that they could use for their patients and be able to use it for the patients that they knew needed help but that they didn't have the time to be able to provide for them.

Mrs. CAPPS. And I have run out of time, but I will look for your written testimony, Dr. Chernew. If you would like to submit—if you want to zero in or boar in on the way that this impacts in the Massachusetts Program as well, I would appreciate that.

I will yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Louisiana, Dr. Cassidy, for 5 minutes for questions.

Mr. CASSIDY. Dr. Wilson, I am also a member of the AMA, and I like all your suggestions except that I don't see how we pay for them. In fact, one of the—I was disappointed as many members of the AMA were in the AMA support of PPACA because frankly the low-hanging fruit of savings in Medicare didn't go to shore up Medicare or to fix the SGR. It went to create another entitlement, which arguably is going to make our situation worse.

So do you have any—I don't see inherent in your testimony now that the savings for Medicare have been used outside of Medicare how we pay for this.

Mr. WILSON. Well, one of the challenges of the whole healthcare system is that the costs are multi-factorial, and we have not in this hearing because it is not a part of this hearing talked about the biggest driver for cost in this country in healthcare, we spend 78 percent of what we spend on healthcare on chronic disease. And so—and most of that preventable. So that is another area we need to be involved with.

The area of tort reform CBO has suggested that a cap of $250,000 on non-economic damages would reduce the federal budget by $54 billion over the coming years. So we think they have a variety of things in this legislation that will start to address that, and that is where we need to look, but it is a variety of things. There are parts of this legislation that look at the whole area of simplification, administrative simplification, insurance forms, things that don't contribute to health——

Mr. CASSIDY. Let me interrupt just because I have such limited time. I always say, though, anything that creates according to the CBO enumerable boards, bureaucracies, and commissions does not decrease administrative costs.

But Dr. Chernew, now, I am very interested in what you described Blue Cross doing in Massachusetts. But on the other hand, Massachusetts, which is kind of a forerunner of PPACA, has the highest, I mean, literally, the highest private insurance premiums in the Nation, and so my concern is that, again, the forerunner of PPACA has resulted in the highest private insurance premiums in the Nation. So how has the program you described, which is incred-

ibly intriguing, thwarted that, contributed to that? I mean, it seems kind of a discordance where you have high premiums and yet you have what is on paper seems like an effective intervention.

Mr. CHERNEW. Right. I am not prepared to defend all of Massachusetts and the differences of Massachusetts healthcare. We could discuss it at greater length, but I think the easy answer to your question is the AQC wasn't designed initially to save money in the first years. As I mentioned in response to an earlier question, it doesn't lower the amount of money that any physician group gets paid, and in fact, the physician groups are more efficient. A lot of that is captured by the physicians. It is not captured by the plan.

The goal of the AQC has been to give physicians the power to control that trend through say, for example, a very primary care center the way Dr. Goertz described, and so the evaluations of what it is going to do are ongoing but ultimately its impact on spending and trends are specified in the 5-year trajectory and relative to what had been projected in Massachusetts, which had been growing at about the same rate, it was designed to save money off of trend, not to lower fees.

And so in the end what matters is how much you allow the——

Mr. CASSIDY. Is there an initial indication that it is saving money on the trend?

Mr. CHERNEW. There has only been 1 year of experience so——

Mr. CASSIDY. And then let me ask you another because I have such limited time. Now, the medical loss ratio, is that 15 percent in Massachusetts?

Mr. CHERNEW. I am not aware of what the medical loss ratio is in Massachusetts.

Mr. CASSIDY. And the only reason I ask that is because clearly there is an informational infrastructure required of the insurance companies.

Mr. CHERNEW. Yes.

Mr. CASSIDY. Now, on the other hand if you have high premiums, again, if you have the highest in the Nation, 15 percent of something high gives you something pretty high. Fifteen percent in a lower State which doesn't have this sort of precursor PPACA which may be lower, that absolute dollar is less.

Can you incorporate this with an artificial medical loss ratio of 15 percent?

Mr. CHERNEW. I agree with the premise of your question that there is going to be some spending that is not countered in the medical loss ratio that is very important to control spending, and you want to make sure that medical loss ratios don't impede your ability to innovate, and if that is the gist of your question, I agree with you.

Mr. CASSIDY. OK. Fantastic. Dr. McClellan, now, I got to tell you, I see my New England Journal of Medicine article which shows that ACOs and these demonstration projects which are picked to succeed, that they typically don't succeed in terms of saving money, and when everybody says we are going to save money with ACOs and yet the best analysis from the best demonstration project show that they don't, how can we hang our hat on this, particularly after that incomprehensible rule put out by CMS?

Mr. MCCLELLAN. Well, setting aside the rule I think the New England Journal you are referring to summarized the experience under a demonstration program that we started while I was there, and what it found was that out of the ten groups that participated every single one of those physician groups significantly improved the care for their beneficiaries. They led to significant overall savings in Medicare costs, and five out of the ten got to levels of savings of 2 percentage points per year, which is in the kind of realm that would make Medicare——

Mr. CASSIDY. Now, if I may quote, "It seems highly unlikely that the newly-established, independent practices would be able to average the necessary 20 percent of return on their investment." I am quoting from the article. "The main investment of"—I could go on, but it actually disputes a little bit your assertations.

Mr. MCCLELLAN. Well, I think what the article is pointing out is that for physicians to change their practices in ways that improve care takes an investment upfront, and if all they are getting is this shared savings on the backend, that by itself may not be enough, and that is essentially one of the core concerns that people have raised about the proposed regulation, and I agree.

We need to be looking at reforms that give enough support upfront to enable the kinds of backend savings to bend the cost curve. What we are seeing in a lot of the private insurers who have implemented ACOs is a combination of approaches. They don't just like pick one and do that for 5 years and then wait and do something else. They are trying to comprehensively work with providers to solve this problem.

So they do something like medical home payments upfront as we talked about before, more resources for primary care.

Mr. CASSIDY. Let me interrupt. The chairman has been very generous, but we are already a minute, 20 over. I appreciate that. I would appreciate your complete response——

Mr. MCCLELLAN. I would be delighted to follow up with you.

Mr. CASSIDY [continuing]. And I would like to submit for the record something that Dr. Goertz would agree with from Qliance regarding the direct medical home, for the record.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

Statement of Garrison Bliss, MD

Chief Medical Officer, Qliance Medical Group

Seattle, WA

Energy and Commerce Subcommittee on Health

Hearing on "The Need to Move Beyond the SGR"

May 5, 2011

Chairman Pitts, Ranking Member Pallone, distinguished members of the Subcommittee on Health. It is my pleasure to present testimony to subcommittee today regarding ideas to help the Federal Government move beyond the Medicare Sustainable Growth Rate (SGR) payment formula. First and foremost, I hope to bring a primary care physician's perspective to the debate and offer some concrete and rather simple solutions to the huge problems facing primary care providers with Medicare and private insurance alike.

I have lived on the front lines of primary care for over 30 years, working as a primary care internist in Seattle. I have witnessed the gradual deterioration of primary care and the growth of unsustainable inflation in health care, an inevitable consequence of a fundamentally flawed payment system for primary care.

In 1997 I walked away from the world of fee-for-service medicine, not to seek my fortune, but to explore the possibility of creating a *direct* primary care model that can provide high functioning care that focuses on quality treatment rather than volume. Primary care is the foundation of all health care and the health of primary care drives the health of the rest of the system. It was the best decision I have made in my life. Our highly efficient, flat monthly fee pricing was based on age, not health status—then ranging from $35 to $65 per month. We provided unrestricted access to our care. We stopped all fee-for-service billing to our patients or their insurers. And, we limited our practice to 800 patients per physician in order to be able to focus on quality and promised same day care.

In 2007, utilizing these same principles, I co-founded a new health care company called Qliance, which I believe represents the next generation in direct primary care. It too was built on a monthly fee concept, currently ranging from $49 to $89 per month depending on age. It is constructed to meet or exceed the objectives of the much discussed Patient Centered Medical Home model, but it is also is designed to eliminate the incentives which have brought US healthcare to its knees. All services we provide are included in our monthly fee. A few expensive supplies are charged at our cost. Our providers have the luxury of spending a minimum of 30 minutes with each patient. We limit our patient panels to 800 per provider (compared to 2500 to 3500 in the fee-for-service world). We are open 7 days per week and 12 hours per day on weekdays, giving patients same or next day appointments for any urgent issue, plus 24x7 after-hours phone access to a physician on call. And, our patients have a personal physician who knows them as an individual. We are also deploying an electronic medical record that optimizes clinical care, not billing reimbursement. In sum, we have removed all of the health care misdirection produced by fee-for-service, along with the built-in 40% transaction costs that plague primary care under that system, a system that drives physicians to see 25 to 35 patients a day to cover reimbursement overhead. Our physicians typically see 10-12 patients a day plus provide a handful of phone and email consultations. They have the time to fully treat their patients instead of rushing from one abbreviated appointment to the next.

The result of this effort has been a simple, effective, efficient and humane kind of primary care delivery system, a rarity in America today. Our patients use primary care voraciously (we estimate at least 4-8 times as many face-to-face hours per patient each year). That translates into a dramatic drop in the need for emergency room, hospital and specialist care as well as procedures, surgeries, advanced imaging and the attendant costs and risks these entail (see our 2010 data below). It also translates into

happier patients and providers, and holds the promise to give graduating medical students a reason to aspire to being primary care physicians again.

Direct Primary Care Medical Homes (DPCMH)

Utilizing the direct primary care medical home (DPCMH) model described above, our physicians have the time to provide the 90% of care most people need to see a doctor for, including routine primary and preventive care, urgent care, and chronic disease management. We also coordinate all care beyond the scope of the primary care we provide directly, an increasingly important service in achieving better medical outcomes at affordable cost in our currently fragmented health care system. We intend to reinsert the concepts of value and humanity back into the health care system. We track not only the quality of our work, but also the quality of patient experience in our clinics. Our patient satisfaction levels put us in the top 1% of all businesses in the United States and far ahead of the general health care sector. We are also building into our next generation health information systems tools that will assess the quality, efficiency, price and patient satisfaction of those we refer to. Our patients will have transparency not only for their costs in our system, but for those outside our system. We intend to put patients in the driver's seat and empower them to make decisions that work for them. We wish to be their trusted advisor, not their gatekeeper. As patients accept more financial responsibility for their care, they are interested in spending their money wisely and getting optimal health, not just the most expensive care their insurer will allow. We believe that by putting Direct Primary Care Medical Homes on the front end of the delivery system, health care will be more effective and patient-centered while driving down costs and unnecessary utilization. And our early data strongly support that conclusion.

Analysis of our internal data on our under-65 patients' utilization of downstream, non-primary care services shows that, under the Qliance model, the utilization of emergency room, hospital, specialty care, advanced radiology and surgical care are greatly diminished, as seen below in Table 1. This decrease in utilization translates to a net savings of approximately 22% in overall healthcare costs.

Table 1: Utilization Data – Qliance Members Under 65 (2010)

Type of Referral	Qliance # per year (1,000)**	Benchmark*	Difference
ER visits	56	158	-65%
Hospitalizations (visits)	34	53	-35%
Hospitalizations (in days)	105	184	-43%
Specialist Visits	670	2000	-66%
Advanced Radiology	300	800	-63%
Surgeries	22	124	-82%
Primary Care Visits	3548	1847	+92%

*Based on regional benchmarks from Ingenix and other sources.
**Based on best available internal data, may not capture all non-primary care claims

Source: Qliance Medical Group non-Medicare patients, 2010 (n=3,088)

Why not make DPCMH available to Medicare Patients?

There is no provision to cover monthly fee based payments to primary care physicians who treat Medicare patients. Section 1301 (a) (3) of the Patent Protection and Affordable Care Act (Public Law 111-148) () would allow state-based healthcare exchanges to offer coverage through a DPCMH plan operating in combination with a wrap-around insurance policy as long as the two together satisfy all exchange coverage requirements. There is, however, no option to offer the DPCMH model to patients enrolled in Medicare. Despite this, many Medicare patients choose to pay DPCMH plans like Qliance directly out of pocket —above and beyond the cost of fee-for-service Medicare. This has the strange effect of patients subsidizing Medicare with reduced downstream costs—funded by their own contributions. Not all Medicare patients can afford this. Clearly, Medicare patients would benefit from these innovative arrangements, and if the Qliance data holds, the Federal Government would benefit through cost savings.

DPCMH plans are now offered in as many as 24 states—and provide all primary care services. Under a DPCMH model providing primary care services, insurance would be required only for hospitalization, advanced radiology, surgery and specialty care—to which it is better suited. But as the data in Table 1 suggests, Medicare patients would likely use a lot less of these more expensive services, saving Medicare significantly in the form of administrative expenses and downstream costs.

We think it is imperative that in any redesign of the current payment system incentivize Medicare patients to get as much primary care as they can consume by enrolling in a DPCMH plan. Rather than just trying to fix the SGR yet another time, we urge Congress to consider innovative Medicare payment reforms, such as the flat monthly fee DPCMH model. Only by fixing the underlying problem of relying - exclusively upon a fee-for-service model to finance primary care will Congress truly be able to rein in costs and improve health outcomes in the Medicare population.

* The intent of the provision is to require the Secretary to permit state exchanges to offer health plans with a Direct Primary Care Medical Home (DPCMH) operating in conjunction with a wrap around insurance product as qualified coverage, so long as the two together meet all the applicable requirements for plans in the exchange.

Mr. PITTS. Thank—the chair thanks the gentleman and now recognizes the gentlelady from Wisconsin, Ms. Baldwin, for 5 minutes for questions.

Ms. BALDWIN. Thank you, Mr. Chairman, and I also want to extend my gratitude to the panel for being here and also to add my comments to those who mentioned earlier that it is great to see the bipartisan leadership of this subcommittee and full committee working together on this critical issue.

As we talk today about the importance of repealing the Sustainable Growth Rate, we also have to focus on replacing the Medicare Fee-For-Service Payment System with a model that has some better incentives aligned rewarding quality, controlling costs, and I would like to sort of add the new layer of incenting us to involve patients as partners in their healthcare, something I haven't heard a lot about, but of course, we have a panel of physicians, and I am sure later in this session as we dig down in this issue that we will hear from patient groups and that role, too.

We are all representatives, we all represent certain geographical areas of this country, and as such we tend to follow closely what is happening in our home turf. I happen to represent South Central Wisconsin in the U.S. Congress, and I think based on what I have learned from some of my home State practitioners, there is a lot we can learn from what is going on in the State of Wisconsin.

Providers there have been at the forefront of adopting innovative models that have demonstrated high quality and value. They have proved that implementing a system where there is a high level of integration and where doctors are responsible for managing patient populations can produce high quality and low cost care.

I guess I want to focus a little bit on one such delivery model that has produced successful outcomes in Wisconsin, and Dr. Goertz has talked about it extensively in his testimony, the patient-centered medical home. That model focuses on the productive roll a primary care physician can play in providing and coordinating care, and we know how important the primary care field is in improving healthcare outcomes. They recommend preventative measures, help patients manage chronic conditions, and keep patients out of high-cost emergency room settings.

I know all of you know that in a medical home model the practice-based care team takes collective responsibility for a patient's ongoing care, and this team coordinates the patient's care across care settings and fields and maintains a personal relationship, the patient, with their personal care physician.

One system in my district, Dean Health System, has tested the patient-centered medical home model, and when establishing this model, they hit an initial roadblock which was basically finding that the fee-for-service model and Medicare, i.e., rewarding volume, is inherently contradictory to the patient-centered medical home model. This model relies on primary care providers carrying out and providing a significant number of tasks that improve quality and enhance efficiency, but these tasks are not reimbursable through the relative value unit-based compensation model.

What Dean did instead was to establish its own reimbursement model to ensure sufficient reimbursement for this primary care model. Their innovative approach has really paid off. The quality

of care in the systems medical homes has improved notably, and these models have achieved considerable improvements in efficiency measures.

Today all of Dean's pilots have been certified by the National Committee for Quality Assurance. But, furthermore, there has been great patient feedback in terms of their happiness and satisfaction with this model. Their perception of access and satisfaction are higher for these patients who receive care through their medical home model.

But perhaps the most notable achievement is that by embracing these innovative models Dean has achieved significant cost savings. Overall the system saw medical costs increase by only 2 percent in 2010, compared to the national average of 10.5 percent. Also, their pharmacy costs did not increase at all in 2010, while pharmacy costs across the Nation increased 9 percent last year.

The successes that they had and other providers in Wisconsin have achieved would not have been possible in this sort of fee-for-service construct. For this reason up to this point the medical home model has really been limited to the private sector to the greatest extent.

So, Dr. Goertz, could you elaborate a little bit on how moving away from the fee-for-service model and expanding the patient-centered medical home to public payers like Medicare could help realize the goal of providing this high quality care for lower costs but also this increased potential of involving patients in managing and in partnership with their physicians and nurses in managing their own care?

Mr. GOERTZ. Thank you for that question. One of the interesting things about the patients in the medical home is when we evolved that in the early 2000s, we took in a lot of information from patients themselves about what they wanted and designed it, and to the chagrin of our members we designed it without caring about how it was going to be paid for. And then we turned around and said, how are we going to pay for this model that we designed to give the care for patients the way we know it can be done and still have the resources to run the practices.

So my response is the commercial payers and the models that they have already put in place show it works, but it takes looking at the entire spectrum where costs are laid in the system, and until you allow us to look at the entire panorama of where costs are, you are never going to fix it. You just can't, and that—the patient-centered medical home seeks to have the patient get the care where they need it by the right people in the team without regard to those other pieces, and it seeks to involve the patient in how care is given.

Mr. PITTS. The chair thanks the gentlelady and recognizes the gentleman from Pennsylvania, Dr. Murphy, for 5 minutes for questions.

Mr. MURPHY. Thank the panel. It is good to see some of you here again.

Back in the 1990s when I was a State Senator I authored and we passed into law, actually got bipartisan support, a Patient Bill of Rights Law, and much of that was dealing with at that time the problems of managed care, where we found out it was more about

managing money from people outside the doctor's office and with insurance companies than it really was about managing care.

So I am wondering, Mr. Miller, if you could elaborate a little bit more on this. You and I have had conversations in the past, but if you could give, and I apologize I couldn't do some of this before. I had run into other things. Give me an example or two of how this actually works and we make sure the incentive is not to not provide services because the breakdown before of managed care was if somebody had a pool of money in their account, they kept that money by not providing care.

Could you tell us how it actually works to make sure they are providing better care?

Mr. MILLER. Well, in several ways. First of all, I think that it is important that this be controlled by physicians, not by health plans, and I think that is really the promise of whatever the unicorn ultimately looks like when you talk about accountable care organizations is that those really need to be controlled by the healthcare providers, the physicians, the nurses, et cetera, not by outside health plans. So that is number one because I think they will be very reluctant to deliver poor quality care.

The second thing is to actually have good measurement of the quality of care so that they know how they are doing and the public knows how they are doing, and that is happening in a number of communities around the country that are reporting on the quality of care so that patients can make good choices.

I think the second thing, third thing is that there needs to be choices about where patients can go which is why it is very important to not have requirements and regulations that only limit this to being very large organizations or that encourage consolidation of entities into one large monopoly but to be able to let small practices be able to participate in this particular fashion.

And I think that is what we—there are models like that around the country where physician practices are taking capitation payments, risk adjusted or otherwise, and are delivering very high-quality care to their patients, and they are in control.

Mr. MURPHY. As this becomes an issue, I know one of the battles we had was the issue of any willing, qualified provider, and I always felt that if you eliminated people from being able to—providers from being able to compete by quality for service, they were out of the loop, and those—once they had locked in a contract, it was actually a disincentive for them because they didn't have the competition anymore. Is that what you are referring to by allowing patients actually to have some choices?

Mr. MILLER. Yes. That is right, and patients having choices based on both what the cost and the quality of the care is rather than either being locked into a particular provider because of what an insurance company determines or essentially having no choice because of the nature of the organization and the community. So to have a maximum number of opportunities to choose their provider I think helps to support that.

Mr. MURPHY. I mean, this is an area that dealing with actual disease management is such a huge issue in healthcare in America, and yet I am still amazed that the way that Medicare and Medicaid work, designed in 1965, and I would venture to guess that

none of us as healthcare providers would want to brag to our patients, by the way, I bought no equipment since 1965, haven't read a single medical journal, or been to continuing education credits from 1965, and proud of it, but that is how our system works. You only get paid if you poke, prod, push, pull, or pinch someone but not if you make them better.

A secondary I just want—this whole panel can help. I think it is the absurdity, so I am correct in understanding that if someone is on Medicare, and a physician is taking, you know, balanced billing, and they say to the patient, you know, look. I understand you are low income. I will just take whatever Medicare pays me, and I will leave it at that. They are not allowed to do that? Is that correct, panel?

Mr. WILLIAMSON. That is correct. That is correct.

Mr. MURPHY. So as a doctor I am saying, you know, I am just going to waive this. "Here. You baked a pie for me, good enough, thank you, Mrs. Smith. You can walk away." Then that doctor is committing a crime?

Mr. WILLIAMSON. Civil and criminal penalties. Yes, sir.

Mr. MURPHY. And how big is the penalty?

Mr. WILLIAMSON. I don't have that number. I am sorry.

Mr. MURPHY. But it is big. Civil and criminal penalty.

Mr. WILLIAMSON. It gets the attention of doctors.

Mr. MURPHY. And if a doctor also says, you know, I think I can do this better by managing, by making calls to you, making sure you are taking your medication. It is like 75 percent of prescriptions aren't taken correctly from beginning to end. If a doctor decides to have a nurse in the office manage that call and take care of those things and actually keep that person out of the hospital but doesn't even bill for that providing a service, does this also go under the category of they are doing something illegal? They are providing a service and care without billing for it?

Mr. GOERTZ. That is not illegal. You just don't get any compensation for helping the patient.

Mr. MURPHY. Oh, well, that is—OK. But it still comes down to so if—it is absolutely amazing, and Mr. Chairman, I hope we get more into this, because the Medicare and Medicaid systems in my mind are so hopelessly outmoded that the old tool, when everything looks like a hammer, everything—when the only tool is a hammer, everything looks like a nail, and all Congress knows how to do is giveth and taketh away. We spend a dollar, we take away a dollar.

But on this issue to have spent nearly almost half a century of time using the same system without fixing this is preposterous, and I believe it is imperative to the physicians' abilities to work on these things to change the system.

So I hope we can get back to this in the future. Thank you.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from New Jersey, Mr. Lance, for 5 minutes for questions.

Mr. LANCE. Thank you, Mr. Chairman. Good afternoon to this distinguished panel. Following up on Congresswoman Baldwin's questioning which I found very interesting, Mr. Miller, in your testimony to do mention the accountable medical homes as being a type of transition payment system, and in your comments you dis-

cuss developing specific targets for reducing utilization of healthcare services outside the physician practice.

How would these targets be developed, and are they ready to be employed in the near term?

Mr. MILLER. Yes. In fact, the State of Washington and the Puget Sound Health Alliance have been working on this and are implementing that program this month where a group of small primary care practices around the State have done that.

Now, getting there was a challenge because, first of all, you have to have the data to be able to determine what your current rates of ER visits and hospitalizations are, and that was a real challenge to primary care practices to even think about it because they don't have that data right now. Surprising enough it was even difficult for some of the health plans to deliver that data to them, but once we were able to get it, it made clear that there were fairly high rates of emergency room utilization for non-urgent reasons.

And so the idea was to give the primary care practices some flexible resources that they could use to hire a nurse, to have longer office hours, et cetera, and to—and we calculated that with the kinds of reductions, just to take ER visits, the kinds of reductions in ER visits that many of the medical home programs that Dr. Goertz talked about have achieved, that they would be able to save more money for the health plans and the amount of flexible resources that they were getting upfront.

So a number of practices have signed up to do that this year through the payment, and the challenge locally was to get eight different health plans and Medicaid to agree, and Medicare is not at the table.

Mr. LANCE. And in your judgment why is that the case? Why is Medicare not at the table?

Mr. MILLER. Because Medicare does not have a payment model now that would support that. In fact, Washington applied to be in the multi-payer advanced primary care demonstration and was not selected. And so they will be actually, they will be saving Medicare money because they will do it for all of their patients, not just their Medicaid and commercial patients, but they won't get the money to be able to support that at the level that they really need.

Mr. LANCE. Thank you. In your remarks, Dr. Chernew, in your prepared remarks you state, and I am quoting now, "Just to give one example, a colonoscopy performed in a physician's office costs Medicare on average about half of the cost if it is performed in a hospital outpatient setting. This largely reflects different treatment of the technical fee for providing the service, which may be justified, but it is difficult to assess the appropriate fee differential, if any because case mix and other factors are hard to observe."

Could you elaborate for me a little bit on that?

Mr. CHERNEW. Sure. So fee-for-service systems are incredibly unwieldy, and ours is particularly unwieldy, and the amount you get paid for something depends on where it is done, because, remember, there is payments to the physician, but there is also payments to a facility. And so if you move the service from one setting to another setting, in some cases the physician is getting both the professional and the technical fee, and in other cases the physician is just getting the professional part. The technical part is going some-

where else, but those technical fees aren't fixed. It differs based on what is in the physician fee and what is in say the hospital setting. And so there is differences, and that is just one example of where the difference is.

It is easy to say that, well, we should set them the same, technical should be the same, and what people in the hospital would tell you is, yes, but the patients that we are seeing in the hospital have a whole series of other comorbidities, it is more difficult to treat them for one reason or another. Our technical fee, albeit higher, is justified because of some aspect of the patient or the care we deliver that is different than the care that is delivered if you are doing the same procedure in a physician's office.

If you knew what that cost difference was, if someone came down from on high and told you this was what the cost difference was, you might be able to manage that reasonably well.

Mr. LANCE. So we have a responsibility working together on a bipartisan capacity with experts such as the distinguished panel here to try to overcome that to make it less expensive.

Mr. CHERNEW. So my view is we will be hopelessly mired in the morass of fee management if we stay for too long in a basically fee-for-service system.

Mr. LANCE. Yes.

Mr. CHERNEW. And so moving away from the system in my view is a long-run solution. We have to mitigate the problems in the short run no doubt, but I am not a believer in the government's ability or anyone's ability to micromanage these crazy fee schedules all that well.

Mr. LANCE. Thank you, and I hope we not hopelessly mired in the system. Thank you very much, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. That concludes the first round of questions, and we will go now to follow up. I will yield first to Dr. Burgess for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

Dr. Goertz, if I could ask you because this has come up several times on, I think Dr. Wilson mentioned the 78 percent of the people in Medicare who suffer from chronic disease. So the universe of people that are dual eligibles and I think Dr. Williamson said he would exclude those from the direct contracting, but honestly, that may be the group where you want to focus the direct contracting.

If you provided each of the dual eligibles with a concierged physician, a navigator, a facilitator that could be with them through all this, maybe a doctor, maybe a nurse practitioner, we could argue about that, but it seems like that is, you know, Willie Sutton used to rob banks because that is where the money was. I mean, Dr. Berwick has told us this is where the money is. Dr. Wilson reaffirmed today that this is where the money is. Eighty percent of Medicare, which is a lot, is spent by 20 percent of the patients.

What do you think about that?

Mr. GOERTZ. Our organization is in favor of any innovative model that addresses coordination and information sharing among all the team members who need to take care of that patient.

Mr. BURGESS. But here is the problem. Mr. Miller told us that Medicare has no payment model for that type of activity. Is that—did I understand that correctly?

Mr. GOERTZ. In our opinion it does not.

Mr. BURGESS. So really all the smart people at the table if you will tell us how to construct that demonstration project where we can demonstrate that level of savings, I mean, I will be happy to take that to Dr. Berwick and spend some time with him and see if we cannot either administratively or legislatively make that change happen because, I mean, truly that is the low-hanging fruit that we should be talking about. Is that not correct? Does anybody disagree with that?

So, again, we have offered a challenge to the panel assembled here today. Help us craft that as a, whatever you want to call it, demonstration project or whatever, and let's see if we can do so in a way. We have got to be careful because Dr. McClellan worked very hard on the physician group practice demonstration project with Secretary Leavitt, and now, of course, we have got a series of rules that are unworkable.

So it is, there is a problem in our system, and we have all identified it, but this is one that I would be anxious to work with you all on this and even, you know, Dr. Williamson, I thank you for bringing the idea forward that, oK, we would separate this group of patients out of direct contracting, but really if we are going to save the money, we won't call it direct contracting because that upsets too many people, but let's help that group of patients navigate the system and spend dollars more efficiently. That is where we could perhaps do the most good, not on the margins of the people who might, in fact, be in a direct contracting type of world.

Yes, sir.

Mr. MILLER. I just say quickly, the models that we talked about can help with that, but it is also an example of how you can't have one size fits all, because some of those patients who need much more intensive help need to have a payment model that supports that, and it may be a lot of money for different things than they are getting now with the opportunity to save a lot of money on the other side.

And there has been a lot of attention recently, for example, the Boeing model on the West Coast has focused on some of those highly-complex patients, project in New Jersey is focused on those kind of patients and showing very significant savings.

But you also have to have some very significant reach change in the way care is delivered and a payment model to support that.

Mr. BURGESS. Yes, and I would not quarrel with that. You know, one of the things that I have heard over and over again today when Ms. Capps was in here talking about nurse practitioners, very frustrating. I mean, again, Dr. McClellan and Secretary Leavitt working on the Medicare Advantage Program in the mid 2000s, which we, of course, robbed in the Patient Protection Affordable Care Act and now given a waiver, but this was the whole idea if I remember correctly. It was a disease-management care coordination, electronic health records, you do all these things in return for perhaps a little bit more reimbursement in the Medicare Advantage System.

Dr. McClellan, do I recall that system correctly?

Mr. MCCLELLAN. Yes. There have been a number of steps to try to get even specialized Medicare Advantage Plans or dual eligibles

and people with complex illnesses, and those programs can work, but you are right. This is the population that could benefit the most from well-coordinated care and has the most fragmented payments. So it is a lot of obstacles to overcome.

Mr. BURGESS. Well, could we use that leverage and pivot, you know, perhaps our discussion of SGR reform to actually get to a more sensible system for those patients that are involved with spending the most money in the Medicare System? I mean, would that not be a correct approach to take?

Mr. MCCLELLAN. I agree, and I think it, again, highlights the importance of this effort focusing on clear opportunities to improve care for particular kinds of patients, particular types of medical care and recognizing that the physician payment system can make a big difference in that, but there are other changes that are going on and other opportunities in Medicare today to reinforce and support those changes through steps like the measures used in the Medicare Advantage Program and the way the Medicare Advantage Program is set up.

So those are all feasible.

Mr. BURGESS. Well, let me just say just as a wrap-up, Dr. Wilson, I really want you to concentrate on the maintenance of professionalism within our profession. As we see more of these things develop, ACOs, whatever the system is, there is an inherent danger for the doctor not to be the advocate for the patient, and historically we know that is correct relationship for the doctor to have with the patient. The health plan can't advocate for the—adequate advocate for the patient, the hospital can't be an adequate advocate. It has to be the physician. There has to be the maintenance of the professionalism within the profession, and I thank you for taking on that task.

Mr. PITTS. The chair thanks the gentleman. We are voting on the floor. We are going to try to wrap this up.

I will recognize Mr. Pallone for follow up and then Dr. Gingrey.

Mr. PALLONE. I just wanted to ask either Dr. Chernew or Dr. Miller, you can both respond if you want, the idea that Medicare should abdicate its responsibilities to protect seniors from exorbitant cost sharing in the name of private contracting, the idea that Medicare shouldn't place limits on the cost of care has been floated in a bill that was introduced by Representative Price and supported by some physician witnesses before the committee.

The idea of unlimited balanced billing, of course, is not new, but it is one of the oldest requests of providers in Medicare to be able to charge whatever you want. But I want talk about the beneficiary impact. We don't have any beneficiary representatives on the panel here today, which is a shame, but I note that ARP in a letter strongly opposes efforts to increase beneficiary costs through private contracting. As I understand it this idea of balanced billing is not something that is very common in private sector networks.

So maybe I will ask Dr. Chernew, in your work observing private health plans have you noticed a trend towards allowing physicians to bill enrollees in network, whatever they like, and if Mr. Miller wants to respond, too.

Mr. CHERNEW. I have not noticed that trend, and I will save longer responses if you want.

Mr. MILLER. I think that the key thing is that there is no one change that is either desirable or necessary that will fix the system, that multiple things have to be done simultaneously, and that keeping the current fee-for-service structure and simply trying to fix it with one change may not do the kind of thing that you want and may lead to other kinds of problems.

I do think that it makes sense, though, that patients have more sensitivity to the cost of services and that physicians and providers not be constrained as to whether they can deliver care based on what Medicare decides to pay them.

So mechanisms that would enable them to set the right price as Dr. Chernew said earlier, as well as what the payment structure is, are going to be very important. But I think that you have to have a comprehensive set of reforms that changes the way the payment is made as well as what the patients' responsibility is.

Mr. PALLONE. I mean, I just wanted to mention, you know, choices beneficiaries would be forced to make in this situation because they are just overwhelming. I asked my staff to look at what a patient would need to consider by way of prices and in negotiation with a physician over a course of several treatment options for prostate cancer, for instance, and just to read a few, and maybe I will enter it into the record, extensive prostate surgery which there are five variations listed for Medicare with prices ranging from $1,100 to $1,700, removal of prostate, three variations ranging from $900 to $1,100, intensity modulated radiation therapy, seven—$567 per dose, but the number of doses required varies significantly from person to person. The dose plan for that therapy, $400 to $2,100. I mean, just to give you some examples.

Dr. Chernew.

Mr. CHERNEW. I guess what I would say broadly is the concern that I would have with these types of programs for starters—actually, let me say for starters, I believe in markets. I am an economist. I like markets as much as the next guy, in fact, probably more so. I am concerned in this case about market power. I am concerned that while I believe consumers can drive down prices for iPads, I am not so sure they can do that in healthcare for some of the reasons that you say.

In Ann Arbor there was a situation where the faculty, I have been told anecdotally lobbied to get dental coverage for routine care. It was $60. They got the coverage for $60 per visit. The prices went up to $120.

So I think if there is competition, you can solve these problems. I am not so sure there always is, and you have to be worried about. I think it is particularly hard in the Medicare population because you have a lot of people, at least like my grandparents, that are cognitively impaired, and so there is a concern about their ability to do some of these things, and obviously there is issues of disparities.

My biggest concern would be that it would give you all frankly a path to keep Medicare rates lower than they otherwise would be, and I think that you shouldn't have an excuse for under-funding Medicare, and I worry that this might give you that excuse.

But on the other hand I haven't studies this particular issue, and I don't have a particular position on it, but I do have the concerns that I outlined going forward in such a way.

Mr. PALLONE. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman, and we are running out of time. Dr. Gingrey, you are recognized for questioning.

Mr. GINGREY. Mr. Chairman, thank you very much, and I will try to get right to it.

Dr. McClellan, I have got a letter in my hand that was actually sent to the House GOP Doctors' Caucus, April 15, 2011, subject: Reforming the Medicare Physician Payment System. The letter advocates new payment model options, including pay for performance, bundle payments to groups of physicians, or even blending elements of multiple models. The letter states that allowing Medicare to create multiple care models is important because there is no one-size-fits-all payment model that will achieve physicians and policymakers objectives for improved care and affordability. I am kind of quoting from the letter.

What are your thoughts on the value of multiple care models as a solution to the SGR problem?

Mr. MCCLELLAN. Well, Dr. Gingrey, you heard today there are a lot of models that can help support better care. I think what unifies them is not the jargon but the fact that they all can be linked to specific, meaningful steps to give patients better care that the surgeons have identified, the primary care physicians have identified, that all of these leaders from Madison have identified. And by focusing the reforms that this committee undertakes on actually achieving those improvements in care, I think we can target them more effectively.

I would emphasize that that not only means leadership for physicians on identifying specific kinds of payment reforms but especially leadership on identifying how they can make care better by changing the payments because Medicare doesn't support all this now, and then accountability for doing that. You know, the quality impact, we have talked a lot about measures, and the cost impact, too, and that is a challenge, but we know so much more than we did a few years ago about this. There is so much more physician leadership now on these questions and especially with so many physicians in the House hopefully we can have——

Mr. GINGREY. Yes. We got 21 now.

Mr. MCCLELLAN. Right.

Mr. GINGREY. Yes. I saw—I will stick with you just for a second, in your opinion does the solution to the SGR, Sustainable Growth Rate, lie simply in reforming how providers are paid, or do you believe a review of how Medicare benefits are structured, whether—we have talked about concierge care, even the private contracting I know has come up a number of times this morning might help bring about meaningful reform in physician payments.

Mr. MCCLELLAN. Benefit reforms would really help and would emphasize that a lot of these private sector implementations of payment reforms go along with benefit reforms to actually save beneficiaries money by giving it more financial support to stay with their meds, to take their meds, to stay out of the hospital.

Mr. GINGREY. Well, I know Dr. Williamson also talked about that in his testimony, and, Todd, I will go to you on this. You cite the benefits of private contracting within Medicare including the ability for the physicians to charge seniors less than they pay today in their out-of-pocket costs. As a medical provider of neurology why can't you charge a poor senior less than the Medicare-required rate?

Mr. WILLIAMSON. We would subsequently be subsequent to penalties, criminal and civil as I said, and you know, I can tell you doctors want to do that a lot, but they can't. That is one thing that we frequently hear from our practice managers is you can't do this.

And, you know, our premise is that doctors and patients should be free to define the value of their interaction. You know, the government has the responsibility to fulfill its promise to Medicare recipients. It was suggested earlier that private contracting might get the government a pass to not fulfill that promise. That is not what the Medicare Payment Empowerment Act is about. It wouldn't change any of the existing benefits that patients now have under Medicare. What it would allow is patients to have the option, if they could afford and they chose to, to spend their own money on their medical care, and it would not require them to forego their Medicare benefits if they want to see a doctor outside the Medicare System as they have to do now, which we think is wrong. And we think it is wrong for a doctor to have to opt out of Medicare for 2 years if he or she provides care and accepts payment for that care to a Medicare patient.

Mr. GINGREY. I had another part to that, but Mr. Chairman, I know we have got about a half a minute left on the vote, so I will yield back and just say thank you to all seven of our witnesses. You all have been fantastic today. We really appreciate it. Thank you.

Mr. PITTS. The chair thanks the gentleman.

This has been an excellent hearing, excellent testimony, and I think we have taken a big step today in moving beyond previous discussions of the deficiencies of the Sustainable Growth Rate System to an examination of the kind of payment and delivery system we need and how to get there.

First of all, I want to thank all of the groups that responded to the committee's bipartisan letter asking for their suggestions. Their input has been very valuable, and I want to thank this distinguished panel of experts who took the time to testify here today in an effort to help solve this difficult but extremely important problem.

I want to remind the members that they have 10 business days to submit questions for the record. I ask that the witnesses all agree to respond promptly to those questions.

With that the subcommittee is adjourned.

[Whereupon, at 12:58 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Congressman Marsha Blackburn
Opening Statement for Energy and Commerce
Health Subcommittee Hearing
"The Need to Move Beyond the SGR"
May 5, 2011

The time is well past for Congress to fully and finally address the issue of the Sustainable Growth Rate formula (SGR), upon which physician payments are based. The solution to this ongoing problem is a *permanent* fix to increase access to physicians, to pay doctors an amount reflecting the true cost of services provided, and to use a sound funding mechanism that will prevent future formula-driven cuts.

As you know the Sustainable Growth Rate formula has been used by the Center for Medicare and Medicaid Services to determine the annual physician fee schedule and to moderate the growth in spending within the Medicare program. From 1999 through 2001, annual fee increases ranged from 2.3 percent to 5.5 percent.

However, in 2002, the SGR resulted in an approximate 5 percent reduction in physician fees. Expected physician fee declines in following years were averted by the passage of new legislation that overrode the SGR formula. By averting such cuts, Congress has created a $298 Billion hole of debt. We cannot continue down this path - physicians and patients deserve better.

In the past few months, the Energy and Commerce Committee staff has held meetings with various stakeholders, physician groups, and others to solicit input on how to best reform/replace the current payment system. I am pleased that the Committee is committed to thoughtful work on this issue and, ultimately, a legislative solution.

If we are genuine about reforming the physician payment system, we must implement policies that reimburse according to quality, not volume. Continuing the practice of temporarily increasing Medicare physician payment rates with the threat of another round of higher cuts in the near future will lead us right back where we started – a fiscally unsustainable and functionally volatile system that will increase the deficit.

It is imperative that legislation that will ensure seniors can continue to see their doctor and achieve a true, permanent solution that protects seniors' access to care, physicians' ability to serve their community, and the taxpayers' right for responsible representation.

While there is not an easy, one-size-fits-all answer to this issue, I appreciate witness input into common themes that both policymakers and stakeholders can explore to move beyond the SGR, and positively change the physician payment system.

I yield back.

ALLIANCE FOR INTEGRITY IN MEDICARE

Closing the Self-Referral Loophole and Preserving Medicare Integrity

PARTNERS IN THE COALITION

American Clinical Laboratory Association

April 28, 2011

The Honorable Fred Upton
Chairman
House Committee on Energy & Commerce

The Honorable Henry Waxman
Ranking Member
House Committee on Energy & Commerce

The Honorable Joe Barton
Chairman Emeritus
House Committee on Energy & Commerce

The Honorable John Dingell
Chairman Emeritus
House Committee on Energy & Commerce

The Honorable Joseph R. Pitts
Chairman, Subcommittee on Health
House Committee on Energy & Commerce

The Honorable Frank Pallone
Ranking Member, Subcommittee on Health
House Committee on Energy & Commerce

The Honorable Michael C. Burgess
Vice Chairman, Subcommittee on Health
House Committee on Energy & Commerce

Dear Chairmen and Ranking Members:

On behalf of the Alliance for Integrity in Medicare (AIM), a coalition committed to ending the practice of inappropriate physician self-referral in Medicare, we applaud your bipartisan efforts to find a permanent solution to the flawed Medicare physician payment formula. Our coalition believes Medicare physician payment reform is critical to stabilizing and enhancing the Medicare program moving forward. However, we are concerned that payment solutions alone will not sufficiently address questionable referral practices that run counter to your efforts to curb costs and achieve long-term sustainability of the program. Therefore, we urge Congress to consider addressing unintended loopholes within the current physician self-referral law in concert with reforming the Medicare physician payment formula.

The undersigned organizations, representing thousands of health professionals in the fields of advanced diagnostic imaging, anatomic pathology, physical therapy, and radiation therapy, are extremely concerned that misapplication of the in-office ancillary services (IOAS) exceeption to the physician self-referral law is potentially leading to increased spending, unnecessary overutilization of services, and could also lead to compromised patient choice and care. Congress created the ancillary services provision to allow physicians to offer services that were integral to a single visit to the physician's office. A common feature of these four services is that each requires time to complete outside of an office visit, specialized training, and independent professional judgment to perform.

The expansive use of the IOAS exception by physician groups in a manner not originally contemplated by the law undercuts the purpose of the law and can substantially increase costs to the Medicare program and its beneficiaries. As you know, the Government Accountability Office is investigating self-referral in all four of these service areas. Their report and recommendations are expected later this year.

As a way to help offset part of the costs of repealing the Sustainable Growth Rate formula before moving to a new payment system, we recommend Congress remove advanced diagnostic imaging, anatomic pathology, physical therapy and radiation therapy from the IOAS exception, while preserving the ability of robust, integrated multi-specialty group practices to offer these services. Not only would removing these services from the IOAS exception represent sound health care policy, aligning incentives to reward independent medical judgment, patient choice and quality over financial benefit, but it also could potentially produce substantial savings to the Medicare program that could be used to pay for part of the costs of a physician payment fix.

We appreciate your dedication to providing long-term payment stability for physicians and health professionals that treat Medicare patients and look forward to working with you toward a permanent solution. Please contact Dave Adler, director of government relations for the American Society for Radiation Oncology, at 703-839-7362 if you have any questions.

Sincerely,

The Alliance for Integrity in Medicare

American Clinical Laboratory Association
American College of Radiology
American Physical Therapy Association
American Society for Clinical Pathology
American Society for Radiation Oncology
Association for Quality Imaging
College of American Pathology
Radiology Business Management Association

March 10, 2011

The Honorable John A. Boehner
Speaker
United States House of Representatives
H-232 US Capitol
Washington, DC 20515

The Honorable Nancy Pelosi
Democratic Leader
United States House of Representatives
H-204 US Capitol
Washington, DC 20515

Dear Speaker Boehner and Democratic Leader Pelosi:

The undersigned organizations urge Congress to begin working in a bipartisan, bicameral manner to enact legislation this year that will eliminate Medicare's sustainable growth rate (SGR) formula and lay the groundwork for adoption of broader physician payment and delivery reforms.

Last year, Congress was required to act five times to pass short-term measures (for as short as one month) to stop Medicare physician payment cuts scheduled for 2010. On three occasions Congress failed to act before cuts were implemented, causing disruptions in processing Medicare payments. These payment uncertainties and delays created serious problems for many physician practices and jeopardized seniors' access to care. Ultimately, Congress and the Administration worked together in a bipartisan manner to develop offsets and pass the "Medicare and Medicaid Extenders Act of 2010," which stabilized Medicare physician payments through 2011. It is our hope that Congress can again work together this year to end the cycle of temporary patches once and for all and develop a long-term and meaningful solution to this issue.

Throughout the past year, Senators and Representatives of both parties, as well as President Obama, have expressed support for permanently addressing the SGR. Both the final report of the National Commission on Fiscal Responsibility and Reform and the President's Fiscal Year 2012 Budget recommended eliminating the SGR. Each year a true solution is postponed, the cost of eliminating the flawed SGR formula grows. As work begins on the Fiscal Year 2012 budget resolution, we believe that this is the year for Congress to make eliminating the SGR one of its highest priorities.

The physician community is committed to taking a leading role in developing and pilot testing payment and delivery reforms that can provide a foundation for replacing the SGR and improving the Medicare physician payment system. We look forward to building upon last year's bipartisan effort to permanently replace the SGR with a workable system that keeps pace with practice costs and ensures that seniors, the disabled, and military families receive the high quality care that they have been promised for years to come.

Sincerely,

AMDA – Dedicated to Long Term Care Medicine
American Academy of Allergy, Asthma and Immunology
American Academy of Dermatology Association
American Academy of Emergency Medicine
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians

American Academy of Home Care Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology – Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Academy of Sleep Medicine
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Allergy, Asthma and Immunology
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Mohs Surgery
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Phlebology
American College of Physicians
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Geriatrics Society
American Medical Association
American Medical Group Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society for Reproductive Medicine
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society of Hematology
American Society of Nephrology
American Society of Nuclear Cardiology
American Society of Pediatric Nephrology

American Society of Plastic Surgeons
American Society of Transplant Surgeons
American Thoracic Society
American Urogynecologic Society
American Urological Association
Child Neurology Society
College of American Pathologists
Congress of Neurological Surgeons
Heart Rhythm Society
Infectious Diseases Society of America
Joint Council of Allergy, Asthma and Immunology
Medical Group Management Association
North American Spine Society
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Maternal-Fetal Medicine
Society for Vascular Surgery
Society of Critical Care Medicine
Society of Gynecologic Oncologists
Society of Hospital Medicine
Society of Nuclear Medicine
The Endocrine Society
The Society of Thoracic Surgeons

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association

Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society

cc: U.S. House of Representatives

Michael D. Maves, MD, MBA, Executive Vice President, CEO

April 26, 2011

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Mr. Chairman:

The American Medical Association (AMA) is pleased to respond to the Committee on Energy and Commerce's bipartisan letter of March 28, 2011, requesting our suggestions on developing a pathway toward reforming the Medicare physician payment system. We want to acknowledge the Committee's continued efforts to address this problem, most recently the Committee's bipartisan effort last December to prevent the 25 percent cut under the current sustainable growth rate (SGR) formula from taking effect for one year, thereby allowing the necessary time to work on this complex issue. We laud the Committee's continued commitment, under both Republican and Democratic leadership, to develop a permanent, sustainable solution and welcome the opportunity to provide you with our ideas.

This letter lays out a three-prong approach to reforming the physician payment system:
(1) repeal the SGR; (2) implement a five-year period of stable payments; and (3) transition to an array of new payment models designed to enhance care coordination, quality, appropriateness and costs. Repealing the SGR, implementing a period of stable payments and laying the pathway for a new payment system must be enacted concurrently to ensure an optimal reform approach.

We certainly recognize that reforming the Medicare physician payment system is a daunting task. We are eager to continue to work with members of the House and the Senate on both sides of the aisle to lay the ground work for reform. Over the course of the next weeks and months, we look forward to continuing this dialogue and providing all Members with additional data, information and policy ideas.

Repeal the Sustainable Growth Rate

As part of the Balanced Budget Act of 1997, Congress enacted the SGR formula for the determination of physician payment updates under Medicare Part B. The SGR was intended to function by reducing Medicare payment updates to offset the growth in utilization of physician services exceeding gross domestic product (GDP) growth. Specifically, actual growth in spending on physician services is compared to a cumulative target growth rate linked to GDP, using 1996 as the base year. When actual growth exceeds the cumulative target, payment updates are reduced and will be less than practice cost growth. While well intentioned, the formula is fundamentally flawed. The growth in the cost of caring for Medicare beneficiaries has historically grown faster than the GDP due to technological advances in care, an aging population, expansion of the Medicare program and other factors. It is simply not appropriate for policymakers in 1997 to define what health care spending should be in 2011 or any other

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year. Additionally, the concept of a global target affecting the actions of individual physicians is flawed in that there is no individual incentive to reduce spending.

Since 2002, the SGR formula has annually called for reductions in Medicare reimbursements. Payments were cut by 5 percent for 2002. Congress has intervened on 12 separate occasions since then to prevent additional cuts from being imposed. Five separate bills were passed to stop a 22 percent cut in 2010 alone. On all 12 occasions, the funding necessary to reform a formula that is universally judged to be fatally and fundamentally flawed was not provided. Therefore, the current Congress is challenged by the prospect of even steeper cuts than previous Congresses. As a result, the 10-year cost of a long-term solution has grown from about $48 billion in 2005 to nearly $300 billion today, and physician payments are scheduled to be cut by 29.5 percent on January 1, 2012, and those cuts continue for many years to come.

The only way to start on a path to permanently reform the physician payment system is to repeal the SGR. Medical technology, Medicare coverage and benefits, and the cost of running a medical practice have all changed drastically since 1996 yet the SGR has failed to adequately recognize those changes. Repeal of the SGR would also provide stability to patients covered by other payers that tie their rates to Medicare including military members, their families, and retirees in TRICARE, retired Federal employees, and those enrolled in state Medicaid programs.

Period of Stable Payments

Due to the fundamentally flawed nature of the SGR and budget baseline effects from congressional interventions to halt scheduled SGR cuts, physician practices have faced fiscal uncertainty over the last decade. As policymakers, stakeholders and experts work to develop and transition to a new Medicare physician payment system, we recommend that for the period 2012-2016, physicians be provided with positive Medicare physician payment updates that keep pace with the growth in medical practice costs. Providing statutory updates for five years will provide predictability and fiscal stability for physician practices at a time in which they will also be making significant investments in health information technology and quality improvement initiatives.

A replacement for the SGR should not be another one-size-fits-all formula. Rather, replacing the SGR should involve transitioning to a new generation of payment models that reward physicians and hospitals for keeping patients healthy, managing chronic conditions in a way that avoids hospitalizations, and, when acute care episodes occur, delivering high quality care with efficient use of resources. We envision physicians choosing from a menu of payment models, selecting ones that best address their patients' needs, specialty, practice type, capabilities and community. We believe that statutory payment updates for five years will allow time for demonstrations and pilots of new Medicare and private sector payment models to take place. During this time, evidence should be available on how to properly structure and implement those models with the most promise, while addressing issues such as risk adjustment and attribution. We believe this process should be dynamic, enabling physicians to transition into those models as they become available.

Further, we believe this period will provide Congress the opportunity to act on legislation to create a new Medicare physician payment system that incorporates those models by September 30, 2015. The bill establishing five years of statutory updates could include provisions requiring congressional action by such date and provide for congressional "fast-track" procedures to ensure consideration of such legislation. The Centers for Medicare and Medicaid Services (CMS) would begin implementation of the

new payment system, adopted by Congress, through the proposed and final 2016 Medicare Physician Payment Rule, which would become effective on January 1, 2017.

New Payment Model Options

Since Medicare's creation in 1965, previous administrations and congresses have enacted changes to the Medicare physician payment system about every decade or so to address evolving Medicare fiscal constraints. For numerous years since the SGR was implemented, Congress, stakeholders and policy experts such as the Medicare Payment Advisory Commission (MedPAC) have grappled with ideas on how to replace the SGR. In this section we outline several payment models that are being, or will be, demonstrated or piloted in Medicare and the private sector, and possible transition payment models. As the demonstration and pilot process continues to be fluid, so should our discussion about a new system and model ideas.

Demonstration and Pilot Models

An array of approaches to physician payment and delivery reform are being tested in Medicare and the private sector. Approaches include pay-for-performance, bundled payments, medical homes and accountable care organizations, as well as approaches that blend elements of multiple models. This diversity is important because there is no one-size-fits-all payment model that will achieve physicians' and policymakers' objectives for improved care and affordability. These pilot projects are an important means for policymakers and physicians to learn how new models work, how best to structure them, their savings potential, the capabilities practices need to be able to implement these changes, and which models work best for different specialties, communities and practice types before more widespread application. Additionally, it is important to test transitional approaches to reform that will give physicians sufficient time and resources to develop the infrastructure and care management capabilities that will be needed to succeed under a different payment system.

Acute Care Episode (ACE) Demonstration (P.L. 108-173, Sec. 646)

- A tested shared savings model for combined hospital and physician payments.
- Rewards efficiencies while improving quality.

Section 646 of the Medicare Modernization Act of 2003 (MMA) authorized demonstrations to test incentives for delivering improved quality of care and efficient allocation of resources. The ongoing three-year 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. For example, a report indicates that within 18 months of starting the demonstration, 150 orthopaedic surgeons at Baptist Health System in San Antonio, saved $4 million by negotiating discounted prices on supplies and implantable knee and hip joints and shared gains of $558,000. In the absence of the demonstration authority, this so-called "gainsharing" between hospitals and physicians would be prohibited by law. The design also requires each site to have a physician-hospital organization so that there is joint governance and oversight of the project. The first ACE site began its program in May 2009.

National Pilot Program on Payment Bundling (P.L. 111-143, Sec. 3023)

- Next step in the evolution of the ACE demonstration.
- Expands model beyond cardiovascular and orthopaedic services; also to include outpatient care.

By January 1, 2013, the U.S. Department of Health and Human Services (HHS) secretary is required to establish a Medicare pilot program for integrated care. This pilot will include episodes of care involving a hospitalization, broader than the ACE demonstration, to improve the coordination, quality and efficiency of health care services, such as: (1) physician services delivered inside and outside of an acute care hospital setting; (2) other acute care inpatient services; (3) outpatient hospital services, including emergency department services; (4) post-acute care services, including home health, skilled nursing, inpatient rehabilitation, and inpatient services furnished by long-term care hospitals; and (5) other services the secretary determines are appropriate. The secretary will also establish a payment methodology, including bundled payments or bids for episodes of care. Payment will be made to the entity that is participating in the pilot program.

Extension of Gainsharing Demonstration (P.L. 109-171, Sec. 5007; P.L. 111-148, Sec. 3027)

- Expands on the ACE demonstration project for inpatient services.

Section 5007 of the Deficit Reduction Act of 2005 (DRA) authorized a gainsharing demonstration program to test and evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care. Similar to the ACE demonstration described above, the project allows hospitals to provide gainsharing payments to physicians that represent a share of the savings incurred through their collaborative efforts. This project began October 1, 2008, and was extended for two years by the ACA. The project consists of two sites: Beth Israel Medical Center, New York City and Charleston Area Medical Center, West Virginia.

Physician Group Practice (PGP) Demonstration (P.L. 106-554, Sec. 412)

- A tested ambulatory care model with increased savings potential over time.

Section 412 of the Benefits Improvement and Protection Act of 2000 (BIPA) mandated the five-year PGP demonstration to test incentives for encouraging better care coordination, improving quality and lowering Medicare expenditures. Ten group practices were competitively selected to participate and many of the lessons learned from the first few years of experience with the PGP demonstration are being applied in developing the new Medicare Shared Savings program. For example, the Regulatory Impact Statement in the recently released proposed rule details the PGP sites' start-up and operating costs as a way of estimating costs to participate in the Shared Savings program (i.e., based on the PGP demonstration, CMS estimates average start-up and first year operating expenses of $1,755,251). 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 have been able to meet quality benchmarks. CMS expects a number of the PGP groups to transition to accountable care organizations within the Shared Savings Program.

Patient-Centered Medical Home (P.L. 109-432, Sec. 204)

- Primary care model for improved care management and coordination.

Section 204 of the Tax Relief and Health Care Act of 2006 (TRHCA) mandated a three-year Medicare demonstration of the patient-centered medical home in up to eight states to provide targeted, accessible, continuous and coordinated care to patients with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment. Although CMS obtained demonstration design options from Mathematica Policy Research which it shared with the AMA and primary care specialty societies and secured recommended relative value units for the care management payment from the AMA/Specialty Society Relative Value Scale Update Committee, CMS recently announced that they would not pursue this project. It is possible that the shared savings nature of the program has presented an implementation barrier, as the law is structured such that the care management payments to primary care physicians will be offset by the savings that the Medicare medical homes generate. Instead of the Medicare medical home, CMS decided to first put in place a Multi-payer Advanced Primary Care Initiative. This demonstration is also in eight states and involves providing monthly care management payments to physicians who serve as a patient's medical home. The eight states are Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. In addition to Medicare, the program involves private payers and Medicaid. The project is expected to be operational by the middle of 2011 and will last for three years.

Medicare Shared Savings Program (P.L. 111-148, Sec. 3022)

- ACO model built around primary care but potentially encompassing specialty and facility services, scheduled to begin in 2012.

Section 3022 of the Patient Protection and Affordable Care Act (ACA) requires the HHS secretary to establish the Medicare Shared Savings Program by January 1, 2012. The law allows accountable care organizations (ACOs) comprised of groups of physicians, networks of individual practices, joint ventures between hospitals and physicians, hospitals employing physicians, and others to participate in the Medicare Shared Savings Program. To qualify, an ACO must agree to be accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries for which it is assigned. An ACO must have physicians who provide primary care to at least 5,000 Medicare patients and have in place: (1) a formal legal structure that would allow the organization to receive and distribute payments for any shared savings; (2) a leadership and management structure that includes clinical and administrative systems; (3) defined processes to promote evidence-based medicine; and (4) processes to report on quality and cost measures. Payments for services provided by physicians and other ACO participants will be made by Medicare according to the usual hospital and physician payment schedules. Additionally, ACOs will be able to share among their participants a portion of Medicare savings achieved in excess of a benchmark. ACOs must agree to participate in the program for at least three years. On April 7, 2011, CMS published in the *Federal Register* a Notice of Proposed Rulemaking on the ACO program with a 60-day comment period. In addition to the proposed rule, the government is also seeking comments on proposed waivers and safe harbors from self-referral, anti-kickback, gainsharing civil monetary penalties, and antitrust laws that would otherwise prohibit the type of coordinated activities and monetary distributions that successful ACOs will require.

Independence-at-Home Demonstration Program (P.L. 111-143, Sec. 3024)

- Designed to avoid costly institutional care.

By January 1, 2012, the HHS secretary is required to establish an independence-at-home demonstration program to bring primary care services to the homes of high-cost Medicare beneficiaries with multiple

chronic conditions. Health teams could be eligible for shared savings if they achieve high-quality outcomes, patient satisfaction and cost savings. The HHS secretary will estimate an annual per capita spending target for the estimated amount that would have been spent under Parts A and B in the absence of the demonstration, with the target adjusted for certain risks. A medical home practice could receive an incentive payment based on actual savings achieved in comparison to the target. This demonstration project is still under development.

Community Health Team Support for Patient-Centered Medical Homes (P.L. 111-148, Sec. 3502)

- Expanded model to support primary care across disciplines.

The HHS secretary is required to provide grants or enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional "health teams" to support primary care practices (including obstetrics and gynecology practices) within their local hospital service areas, and to provide capitated payments to primary care providers according to criteria established by the secretary. The health teams could, for example, collaborate with patient-centered medical homes in coordinating prevention and chronic disease management services, or develop and implement care plans that integrate preventive and health promotion services.

Proposed Transitional Models

Many of the Medicare demonstration projects outlined above hold great promise for identifying winning payment reform pathways that can simultaneously improve patient care quality and coordination, improve physician operating margins, and reduce the rate of growth in Medicare spending. This is particularly true for the ACE and PGP demonstration programs, which are the only ones that have actually been underway for any length of time. At the same time, the bundling, ACO and medical home demonstrations have a common limitation, which is their sole reliance on shared savings as a means to accomplish their reform objectives. The PGP demonstration has made it clear that there are significant upfront investments required for participation in these new models but demonstration designs limit the incentive payments to distributions of shared savings and do not assist practices with these upfront costs or provide any assurance that they will ever recover them. Shared savings distributions, if they are achieved at all, are not paid until long after these initial investments are required.

In addition to having access to financial reserves, participation in any of the new payment and delivery models requires physician practices to have certain capabilities, including: (1) the ability to obtain and analyze large amounts of data on patient utilization and costs for their own services as well as services provided by others; (2) skills to improve quality and cost performance and report performance measures; (3) ability to identify inappropriate utilization and reduce it; (4) knowledge of evidence-based practices that achieve good outcomes; (5) ability to share information with other physicians and providers at the point of care; and (6) ability to manage patient care in a coordinated way and experience managing risk. In the past, these skills have not been taught in medical school or residency training. Physicians need to acquire these skills through their experience in practice. With the vast majority of medical practices qualifying as small businesses and involving a small number of physicians, it is important to put in place transitional models that will help small and solo practices to develop these capabilities.

To address both of these limitations the AMA recommends that several transitional models be tested by Medicare, in addition to the demonstrations described above. A more detailed discussion of these and other transitional approaches is available in "Transitioning to Accountable Care: Incremental Payment

Reforms to Support Higher Quality, More Affordable Health Care," a paper by Harold D. Miller of the Center for Healthcare Quality & Payment Reform available at www.paymentreform.org.

Partial Capitation

Section 3022 of the ACA authorized but did not require CMS to include partial capitation models in the Medicare Shared Savings Program. In its recent proposed rule, CMS indicates that it is not proposing any partial capitation models at this time, although they may be addressed separately by the Center for Medicare and Medicaid Innovation. Under this payment model, an ACO would agree to accept a pre-defined monthly per-patient payment during a multi-year period that would be used to cover all of the costs of care for a defined group of patients. The payment would be risk-adjusted and would be lower than what CMS would project paying for those patients under the regular Part A and B payment schedules. This model would enable physician practices with experience in successfully managing capitation contracts under Medicare Advantage and commercial insurance, such as North Texas Specialty Physicians, to deliver care to Medicare fee-for-service beneficiaries as well as guaranteed savings to the Medicare program. Additionally, it would provide a means for practices to recoup their upfront investments, reward physicians for achieving savings through the way a particular treatment is delivered even if the treatment would have the same DRG or CPT code in fee-for-service Medicare, and permit them to gain experience managing risk.

Virtual Partial Capitation

A variant of the model above would define a per-patient budget for a defined group of patients instead of making an upfront payment. Individual physicians who volunteered to participate would bill for individual services as they will do in Medicare Shared Savings Program, the total billings would then be compared to the budget, and the payments to the physicians and other providers in the ACO would be adjusted up or down to keep total payments within the budget. This approach gives physicians the flexibility to use alternative treatment approaches, as in capitation, without requiring them to have the capability to pay claims to other providers.

Condition-Specific Capitation

This model would involve making a prospective payment covering all of the services related to a particular condition or combination of conditions for a population of patients, rather than the full range of conditions as in the partial capitation model described earlier. Under condition-specific capitation, a specialty physician practice, multi-specialty group, or IPA would be paid a pre-defined amount to cover the costs of all of the care needed to address a particular condition, whether that care is provided by physicians in the organization receiving the payment or other physicians. For example, a multi-specialty group or IPA could be paid a fixed amount to cover the costs of all services associated with care related to its patients' congestive heart failure, including all physician services, hospital care, rehabilitation, etc. (This payment model could also be structured as a "virtual" payment or budget, as described above for virtual partial capitation.) This would enable primary care and specialty physician practices to work together to take accountability for the subset of patients and patient care they felt they could most effectively manage; over time, they could expand to additional types of patients in order to accept a broader partial capitation payment.

Accountable Medical Home

In contrast with the shared savings approach to medical homes, the accountable medical home model would give a primary care practice, multi-specialty group, or independent practice association (IPA) the upfront resources needed to restructure the way primary care is delivered to its patients in return for a commitment to reduce the rate at which those patients use emergency rooms for non-urgent visits, are admitted and readmitted to the hospital for ambulatory care sensitive conditions, and order diagnostic tests or other ancillary services that may be inappropriate. Accountable medical homes could improve patient care and achieve savings for the Medicare program in several key areas without being penalized for the costs of specialized services they are not in a position to control. In the State of Washington, the Puget Sound Health Alliance and the Washington State Health Care Authority are currently putting this model in place for commercial payers and Medicaid plans. CMS could use the approach they have developed in the Medicare program.

Warranties for Inpatient Care

Adoption of a model like Geisinger Health System's ProvenCare could be a beneficial transitional model for Medicare payment reform. Physicians and hospitals providing treatment for specified conditions would determine a Medicare payment rate that would allow them to offer a warranty for the inpatient treatment and not charge more for addressing infections, complications or other defined adverse events that may occur during the course of the patient's care. Offering such a warranty provides an economic incentive for improving quality and preventing complications from occurring. As quality improves over time and rates of warrantied complications diminish, the physicians and hospitals will be able to reduce the bundled payment rate to save money for Medicare while still obtaining higher margins on their own operating costs. At least initially, the price of the warrantied services is likely to be higher than what Medicare pays for a service with no complications because of the need to cover the costs of treating complications that will arise in a certain number of cases. Since Medicare would no longer be paying separately for the complications covered by the warranty, this method would save money in total. In contrast to the current payment system, this would reward the physicians and hospitals for preventing complications and delivering better quality care rather than paying more when complications arise. Most consumer products that are sold with a warranty do cost more than those without a warranty. Consumers purchase warrantied products not only as a protection against costly repairs but also because they know that the manufacturer must offer a high-quality product in order to manage its own financial risks. The warranty model is also a good transitional model because, as Geisinger did, physicians could begin with one service, like cardiac surgery, and then expand it to other areas as they gain experience with the approach.

Mentoring Programs

Perhaps the simplest way for small and solo practices to develop capabilities like analyzing patient utilization, quality and cost data, sharing information with others to prevent duplicate tests, adopting evidence-based measures and improving quality and cost performance is to learn from those who have done it. Another transitional model, therefore, would be for Medicare to provide financial and technical support to small physician practices that are working with Regional Health Improvement Collaboratives[1]

[1] For more information see "Regional Health Improvement Collaboratives: Essential Elements for Successful Healthcare Reform," Network for Regional Healthcare Improvement, www.nrhi.org.

or partnering with high performing groups in order to learn from them. The Mayo Clinic Affiliated Practice Network, Henry Ford Physician Network, Pittsburgh Regional Health Initiative, and Oregon Health Care Quality Corporation are several examples of this type of mentoring approach.

While replacing the SGR is critical, it must be done correctly. We believe this proposed framework, and timeline, are critical to developing the evidence-base necessary to ensure a reformed Medicare physician payment system meets our mutual goal of improving the Medicare program while ensuring beneficiaries' continued access to care. We look forward to continuing to work with House and Senate members on both sides of the aisle on repealing the SGR and transitioning to a system that incorporates new payment models designed to enhance care coordination, quality, appropriateness and cost.

Again, thank you for affording us this opportunity to work with you on replacing the SGR with a sustainable payment system.

Sincerely,

Michael D. Maves, MD, MBA

cc: House Energy and Commerce Committee Members
Cecil B. Wilson, MD

Memo to: House Republican Leadership, Majority Ways & Means and Energy & Commerce Committees Staff

From: American Medical Association Staff

Date: April 14, 2011

Subject: Reforming the Medicare Physician Payment System

The AMA welcomes this opportunity to provide you with feedback on reforming the Medicare physician payment system, per your request at the March 11, 2011, stakeholders meeting. This initial memorandum of ideas lays out a three-prong approach to reforming the physician payment system: (1) repeal the sustainable growth rate (SGR); (2) implement a five year period of stable payments; and (3) transition to an array of new payment models designed to enhance care coordination, quality, appropriateness and costs. Repealing the SGR, implementing a period of stable payments and laying the pathway for a new payment system must be enacted concurrently to ensure an optimal reform approach.

We certainly recognize that reforming the Medicare physician payment system is a daunting task. We are eager to continue to work with members of the House and the Senate on both sides of the aisle to lay the ground work for reform. Over the course of the next weeks and months, we look forward to continuing this dialogue and providing all Members with additional data, information and policy ideas.

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Period of Stable Payments

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A replacement for the SGR should not be another one-size-fits-all formula. Rather, replacing the SGR should involve transitioning to a new generation of payment models that reward physicians and hospitals for keeping patients healthy, managing chronic conditions in a way that avoids hospitalizations, and, when acute care episodes occur, delivering high quality care with efficient use of resources. We envision physicians choosing from a menu of payment models, selecting ones that best address their patients' needs, specialty, practice type, capabilities and community. We believe that statutory payment updates for five years will allow time for demonstrations and pilots of new Medicare and private sector payment models to take place. During this time, evidence should be available on how to properly structure and implement those models with the most promise, while addressing issues such as risk adjustment and attribution. We believe this process should be dynamic, enabling physicians to transition into those models as they become available.

Further, we believe this period will provide Congress the opportunity to act on legislation to create a new Medicare physician payment system that incorporates those models by September 30, 2015. The bill establishing five years of statutory updates could include provisions requiring congressional action by such date and provide for congressional "fast-track" procedures to ensure consideration of such legislation. The Centers for Medicare and Medicaid Services (CMS) would begin implementation of the new payment system, adopted by Congress, through the proposed and final 2016 Medicare Physician Payment Rule, which would become effective on January 1, 2017.

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Extension of Gainsharing Demonstration (P.L. 109-171, Sec. 5007; P.L. 111-148, Sec. 3027)

- Expands on the ACE demonstration project for inpatient services

Section 5007 of the Deficit Reduction Act of 2005 (DRA) authorized a gainsharing demonstration program to test and evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care. Similar to the ACE demonstration described above, the project allows hospitals to provide gainsharing payments to physicians that represent a share of the savings incurred through their collaborative efforts. This project began October 1, 2008, and was extended for two years by the ACA. The project consists of two sites: Beth Israel Medical Center, New York City and Charleston Area Medical Center, West Virginia.

Physician Group Practice (PGP) Demonstration (P.L. 106-554, Sec. 412)

- A tested ambulatory care model with increased savings potential over time

Section 412 of the Benefits Improvement and Protection Act of 2000 (BIPA) mandated the five-year PGP demonstration to test incentives for encouraging better care coordination, improving quality and lowering Medicare expenditures. Ten group practices were competitively selected to participate and many of the lessons learned from the first few years of experience with the PGP demonstration are being applied in

developing the new Medicare Shared Savings program. For example, the Regulatory Impact Statement in the recently released proposed rule details the PGP sites' start-up and operating costs as a way of estimating costs to participate in the Shared Savings program (i.e., based on the PGP demonstration, CMS estimates average start-up and first year operating expenses of $1,755,251). 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 have been able to meet quality benchmarks. CMS expects a number of the PGP groups to transition to accountable care organizations within the Shared Savings Program.

Patient-Centered Medical Home (P.L. 109-432, Sec. 204)

- Primary care model for improved care management and coordination

Section 204 of the Tax Relief and Health Care Act of 2006 (TRHCA) mandated a three-year Medicare demonstration of the patient-centered medical home in up to eight states to provide targeted, accessible, continuous and coordinated care to patients with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment. Although CMS obtained demonstration design options from Mathematica Policy Research which it shared with the AMA and primary care specialty societies and secured recommended relative value units for the care management payment from the AMA/Specialty Society Relative Value Scale Update Committee, CMS has not yet selected the states for the project or moved forward with its implementation. It is possible that the shared savings nature of the program has presented an implementation barrier, as the law is structured such that the care management payments to primary care physicians will be offset by the savings that the Medicare medical homes generate. Instead of the Medicare medical home, CMS decided to first put in place a Multi-payer Advanced Primary Care Initiative. This demonstration is also in eight states and involves providing monthly care management payments to physicians who serve as a patient's medical home. The eight states are Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. In addition to Medicare, the program involves private payers and Medicaid. The project is expected to be operational by the middle of 2011 and will last for three years.

Medicare Shared Savings Program (P.L. 111-148, Sec. 3022)

- ACO model built around primary care but potentially encompassing specialty and facility services, scheduled to begin in 2012

Section 3022 of the Patient Protection and Affordable Care Act (ACA) requires the Health and Human Services (HHS) secretary to establish the Medicare Shared Savings Program by January 1, 2012. The law allows accountable care organizations (ACOs) comprised of groups of physicians, networks of individual practices, joint ventures between hospitals and physicians, hospitals employing physicians, and others to participate in the Medicare Shared Savings Program. To qualify, an ACO must agree to be accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries for which it is assigned. An ACO must have physicians who provide primary care to at least 5,000 Medicare patients and have in place: (1) a formal legal structure that would allow the organization to receive and distribute payments for any shared savings; (2) a leadership and management structure that includes clinical and administrative systems; (3) defined processes to promote evidence-based medicine; and (4) processes to report on quality and cost measures. Payments for services provided by physicians and other ACO participants will be made by Medicare according to the usual hospital and physician payment schedules. Additionally, ACOs will be able to share among their participants a portion of Medicare savings achieved in excess of a benchmark. ACOs must agree to participate in the program for at least three years. On April 7, 2011, CMS published in the *Federal Register* a Notice of Proposed Rulemaking on the ACO program with a 60-day comment period. In addition to the proposed rule, the government is also seeking comments on proposed waivers and safe harbors from self-referral, anti-kickback, gainsharing civil monetary penalties, and antitrust laws that would otherwise prohibit the type of coordinated activities and monetary distributions that successful ACOs will require.

Independence-at-Home Demonstration Program (P.L. 111-143, Sec. 3024)

- Designed to avoid costly institutional care

By January 1, 2012, the HHS secretary is required to establish an independence-at-home demonstration program to bring primary care services to the homes of high-cost Medicare beneficiaries with multiple chronic conditions. Health teams could be eligible for shared savings if they achieve high-quality outcomes, patient satisfaction and cost savings. The HHS secretary will estimate an annual per capita spending target for the estimated amount that would have been spent under Parts A and B in the absence of the demonstration, with the target adjusted for certain risks. A medical home practice could receive an incentive payment based on actual savings achieved in comparison to the target. This demonstration project is still under development.

Community Health Team Support for Patient-Centered Medical Homes (P.L. 111-148, Sec. 3502)

- Expanded model to support primary care across disciplines

The HHS secretary is required to provide grants or enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional "health teams" to support primary care practices (including obstetrics and gynecology practices) within their local hospital service areas, and to provide capitated payments to primary care providers according to criteria established by the secretary. The health teams could, for example, collaborate with patient-centered medical homes in coordinating prevention and chronic disease management services, or develop and implement care plans that integrate preventive and health promotion services.

Proposed Transitional Models

Many of the Medicare demonstration projects outlined above hold great promise for identifying winning payment reform pathways that can simultaneously improve patient care quality and coordination, improve physician operating margins, and reduce the rate of growth in Medicare spending. This is particularly true for the ACE and PGP demonstration programs, which are the only ones that have actually been underway for any length of time. At the same time, the bundling, ACO and medical home demonstrations have a common limitation, which is their sole reliance on shared savings as a means to accomplish their reform objectives. The PGP demonstration has made it clear that there are significant upfront investments required for participation in these new models but demonstration designs limit the incentive payments to distributions of shared savings and do not assist practices with these upfront costs or provide any assurance that they will ever recover them. Shared savings distributions, if they are achieved at all, are not paid until long after these initial investments are required.

In addition to having access to financial reserves, participation in any of the new payment and delivery models requires physician practices to have certain capabilities, including: (1) the ability to obtain and analyze large amounts of data on patient utilization and costs for their own services as well as services provided by others; (2) skills to improve quality and cost performance and report performance measures; (3) ability to identify inappropriate utilization and reduce it; (4) knowledge of evidence-based practices that achieve good outcomes; (5) ability to share information with other physicians and providers at the point of care; and (6) ability to manage patient care in a coordinated way and experience managing risk. In the past, these skills have not been taught in medical school or residency training. Physicians need to acquire these skills through their experience in practice. With the vast majority of medical practices qualifying as small businesses and involving a small number of physicians, it is important to put in place transitional models that will help small and solo practices to develop these capabilities.

To address both of these limitations the AMA recommends that several transitional models be tested by Medicare, in addition to the demonstrations described above. A more detailed discussion of these and other transitional approaches is available in "Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care," a paper by Harold D. Miller of the Center for Healthcare Quality & Payment Reform available at www.paymentreform.org.

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Virtual Partial Capitation
A variant of the model above would define a per-patient budget for a defined group of patients instead of making an upfront payment. Individual physicians who volunteered to participate would bill for individual services as they will do in Medicare Shared Savings Program, the total billings would then be compared to the budget, and the payments to the physicians and other providers in the ACO would be adjusted up or down to keep total payments within the budget. This approach gives physicians the flexibility to use alternative treatment approaches, as in capitation, without requiring them to have the capability to pay claims to other providers.

Condition-Specific Capitation
This model would involve making a prospective payment covering all of the services related to a particular condition or combination of conditions for a population of patients, rather than the full range of conditions as in the partial capitation model described earlier. Under condition-specific capitation, a specialty physician practice, multi-specialty group, or IPA would be paid a pre-defined amount to cover the costs of all of the care needed to address a particular condition, whether that care is provided by physicians in the organization receiving the payment or other physicians. For example, a multi-specialty group or IPA could be paid a fixed amount to cover the costs of all services associated with care related to its patients' congestive heart failure, including all physician services, hospital care, rehabilitation, etc. (This payment model could also be structured as a "virtual" payment or budget, as described above for virtual partial capitation.) This would enable primary care and specialty physician practices to work together to take accountability for the subset of patients and patient care they felt they could most effectively manage; over time, they could expand to additional types of patients in order to accept a broader partial capitation payment.

Accountable Medical Home
In contrast with the shared savings approach to medical homes, the accountable medical home model would give a primary care practice, multi-specialty group, or independent practice association (IPA) the upfront resources needed to restructure the way primary care is delivered to its patients in return for a commitment to reduce the rate at which those patients use emergency rooms for non-urgent visits, are admitted and readmitted to the hospital for ambulatory care sensitive conditions, and order diagnostic tests or other ancillary services that may be inappropriate. Accountable medical homes could improve patient care and achieve savings for the Medicare program in several key areas without being penalized for the costs of specialized services they are not in a position to control. In the State of Washington, the Puget Sound Health Alliance and the Washington State Health Care Authority are currently putting this

model in place for commercial payers and Medicaid plans. CMS could use the approach they have developed in the Medicare program.

Warranties for Inpatient Care

Adoption of a model like Geisinger Health System's ProvenCare could be a beneficial transitional model for Medicare payment reform. Physicians and hospitals providing treatment for specified conditions would determine a Medicare payment rate that would allow them to offer a warranty for the inpatient treatment and not charge more for addressing infections, complications or other defined adverse events that may occur during the course of the patient's care. Offering such a warranty provides an economic incentive for improving quality and preventing complications from occurring. As quality improves over time and rates of warrantied complications diminish, the physicians and hospitals will be able to reduce the bundled payment rate to save money for Medicare while still obtaining higher margins on their own operating costs. At least initially, the price of the warrantied services is likely to be higher than what Medicare pays for a service with no complications because of the need to cover the costs of treating complications that will arise in a certain number of cases. Since Medicare would no longer be paying separately for the complications covered by the warranty, this method would save money in total. In contrast to the current payment system, this would reward the physicians and hospitals for preventing complications and delivering better quality care rather than paying more when complications arise. Most consumer products that are sold with a warranty do cost more than those without a warranty. Consumers purchase warrantied products not only as a protection against costly repairs but also because they know that the manufacturer must offer a high-quality product in order to manage its own financial risks. The warranty model is also a good transitional model because, as Geisinger did, physicians could begin with one service, like cardiac surgery, and then expand it to other areas as they gain experience with the approach.

Mentoring Programs

Perhaps the simplest way for small and solo practices to develop capabilities like analyzing patient utilization, quality and cost data, sharing information with others to prevent duplicate tests, adopting evidence-based measures and improving quality and cost performance is to learn from those who have done it. Another transitional model, therefore, would be for Medicare to provide financial and technical support to small physician practices that are working with Regional Health Improvement Collaboratives* or partnering with high performing groups in order to learn from them. The Mayo Clinic Affiliated Practice Network, Henry Ford Physician Network, Pittsburgh Regional Health Initiative, and Oregon Health Care Quality Corporation are several examples of this type of mentoring approach.

While replacing the SGR is critical, it must be done correctly. We believe this memorandum outlines a timeline that is critical to developing the evidence-base necessary to ensure a reformed Medicare physician payment system meets our mutual goal of ensuring beneficiaries' continued access to care. We look forward to continuing to work with House and Senate members on both sides of the aisle on repealing the SGR and transitioning to a system that incorporates new payment models designed to enhance care coordination, quality, appropriateness and cost.

* For more information see "Regional Health Improvement Collaboratives: Essential Elements for Successful Healthcare Reform," Network for Regional Healthcare Improvement, www.nrhi.org.

Michael D. Maves, MD, MBA, Executive Vice President, CEO

April 26, 2011

The Honorable Joe Pitts
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Representative Pitts:

The American Medical Association (AMA) is pleased to respond to the Committee on Energy and Commerce's bipartisan letter of March 28, 2011, requesting our suggestions on developing a pathway toward reforming the Medicare physician payment system. We want to acknowledge the Committee's continued efforts to address this problem, most recently the Committee's bipartisan effort last December to prevent the 25 percent cut under the current sustainable growth rate (SGR) formula from taking effect for one year, thereby allowing the necessary time to work on this complex issue. We laud the Committee's continued commitment, under both Republican and Democratic leadership, to develop a permanent, sustainable solution and welcome the opportunity to provide you with our ideas.

This letter lays out a three-prong approach to reforming the physician payment system:
(1) repeal the SGR; (2) implement a five-year period of stable payments; and (3) transition to an array of new payment models designed to enhance care coordination, quality, appropriateness and costs. Repealing the SGR, implementing a period of stable payments and laying the pathway for a new payment system must be enacted concurrently to ensure an optimal reform approach.

We certainly recognize that reforming the Medicare physician payment system is a daunting task. We are eager to continue to work with members of the House and the Senate on both sides of the aisle to lay the ground work for reform. Over the course of the next weeks and months, we look forward to continuing this dialogue and providing all Members with additional data, information and policy ideas.

Repeal the Sustainable Growth Rate

As part of the Balanced Budget Act of 1997, Congress enacted the SGR formula for the determination of physician payment updates under Medicare Part B. The SGR was intended to function by reducing Medicare payment updates to offset the growth in utilization of physician services exceeding gross domestic product (GDP) growth. Specifically, actual growth in spending on physician services is compared to a cumulative target growth rate linked to GDP, using 1996 as the base year. When actual growth exceeds the cumulative target, payment updates are reduced and will be less than practice cost growth. While well intentioned, the formula is fundamentally flawed. The growth in the cost of caring for Medicare beneficiaries has historically grown faster than the GDP due to technological advances in care, an aging population, expansion of the Medicare program and other factors. It is simply not appropriate for policymakers in 1997 to define what health care spending should be in 2011 or any other

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year. Additionally, the concept of a global target affecting the actions of individual physicians is flawed in that there is no individual incentive to reduce spending.

Since 2002, the SGR formula has annually called for reductions in Medicare reimbursements. Payments were cut by 5 percent for 2002. Congress has intervened on 12 separate occasions since then to prevent additional cuts from being imposed. Five separate bills were passed to stop a 22 percent cut in 2010 alone. On all 12 occasions, the funding necessary to reform a formula that is universally judged to be fatally and fundamentally flawed was not provided. Therefore, the current Congress is challenged by the prospect of even steeper cuts than previous Congresses. As a result, the 10-year cost of a long-term solution has grown from about $48 billion in 2005 to nearly $300 billion today, and physician payments are scheduled to be cut by 29.5 percent on January 1, 2012, and those cuts continue for many years to come.

The only way to start on a path to permanently reform the physician payment system is to repeal the SGR. Medical technology, Medicare coverage and benefits, and the cost of running a medical practice have all changed drastically since 1996 yet the SGR has failed to adequately recognize those changes. Repeal of the SGR would also provide stability to patients covered by other payers that tie their rates to Medicare including military members, their families, and retirees in TRICARE, retired Federal employees, and those enrolled in state Medicaid programs.

Period of Stable Payments

Due to the fundamentally flawed nature of the SGR and budget baseline effects from congressional interventions to halt scheduled SGR cuts, physician practices have faced fiscal uncertainty over the last decade. As policymakers, stakeholders and experts work to develop and transition to a new Medicare physician payment system, we recommend that for the period 2012-2016, physicians be provided with positive Medicare physician payment updates that keep pace with the growth in medical practice costs. Providing statutory updates for five years will provide predictability and fiscal stability for physician practices at a time in which they will also be making significant investments in health information technology and quality improvement initiatives.

A replacement for the SGR should not be another one-size-fits-all formula. Rather, replacing the SGR should involve transitioning to a new generation of payment models that reward physicians and hospitals for keeping patients healthy, managing chronic conditions in a way that avoids hospitalizations, and, when acute care episodes occur, delivering high quality care with efficient use of resources. We envision physicians choosing from a menu of payment models, selecting ones that best address their patients' needs, specialty, practice type, capabilities and community. We believe that statutory payment updates for five years will allow time for demonstrations and pilots of new Medicare and private sector payment models to take place. During this time, evidence should be available on how to properly structure and implement those models with the most promise, while addressing issues such as risk adjustment and attribution. We believe this process should be dynamic, enabling physicians to transition into those models as they become available.

Further, we believe this period will provide Congress the opportunity to act on legislation to create a new Medicare physician payment system that incorporates those models by September 30, 2015. The bill establishing five years of statutory updates could include provisions requiring congressional action by such date and provide for congressional "fast-track" procedures to ensure consideration of such legislation. The Centers for Medicare and Medicaid Services (CMS) would begin implementation of the

new payment system, adopted by Congress, through the proposed and final 2016 Medicare Physician Payment Rule, which would become effective on January 1, 2017.

New Payment Model Options

Since Medicare's creation in 1965, previous administrations and congresses have enacted changes to the Medicare physician payment system about every decade or so to address evolving Medicare fiscal constraints. For numerous years since the SGR was implemented, Congress, stakeholders and policy experts such as the Medicare Payment Advisory Commission (MedPAC) have grappled with ideas on how to replace the SGR. In this section we outline several payment models that are being, or will be, demonstrated or piloted in Medicare and the private sector, and possible transition payment models. As the demonstration and pilot process continues to be fluid, so should our discussion about a new system and model ideas.

Demonstration and Pilot Models

An array of approaches to physician payment and delivery reform are being tested in Medicare and the private sector. Approaches include pay-for-performance, bundled payments, medical homes and accountable care organizations, as well as approaches that blend elements of multiple models. This diversity is important because there is no one-size-fits-all payment model that will achieve physicians' and policymakers' objectives for improved care and affordability. These pilot projects are an important means for policymakers and physicians to learn how new models work, how best to structure them, their savings potential, the capabilities practices need to be able to implement these changes, and which models work best for different specialties, communities and practice types before more widespread application. Additionally, it is important to test transitional approaches to reform that will give physicians sufficient time and resources to develop the infrastructure and care management capabilities that will be needed to succeed under a different payment system.

Acute Care Episode (ACE) Demonstration (P.L. 108-173, Sec. 646)

- A tested shared savings model for combined hospital and physician payments.
- Rewards efficiencies while improving quality.

Section 646 of the Medicare Modernization Act of 2003 (MMA) authorized demonstrations to test incentives for delivering improved quality of care and efficient allocation of resources. The ongoing three-year 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. For example, a report indicates that within 18 months of starting the demonstration, 150 orthopaedic surgeons at Baptist Health System in San Antonio, saved $4 million by negotiating discounted prices on supplies and implantable knee and hip joints and shared gains of $558,000. In the absence of the demonstration authority, this so-called "gainsharing" between hospitals and physicians would be prohibited by law. The design also requires each site to have a physician-hospital organization so that there is joint governance and oversight of the project. The first ACE site began its program in May 2009.

National Pilot Program on Payment Bundling (P.L. 111-143, Sec. 3023)

- Next step in the evolution of the ACE demonstration.
- Expands model beyond cardiovascular and orthopaedic services; also to include outpatient care.

By January 1, 2013, the U.S. Department of Health and Human Services (HHS) secretary is required to establish a Medicare pilot program for integrated care. This pilot will include episodes of care involving a hospitalization, broader than the ACE demonstration, to improve the coordination, quality and efficiency of health care services, such as: (1) physician services delivered inside and outside of an acute care hospital setting; (2) other acute care inpatient services; (3) outpatient hospital services, including emergency department services; (4) post-acute care services, including home health, skilled nursing, inpatient rehabilitation, and inpatient services furnished by long-term care hospitals; and (5) other services the secretary determines are appropriate. The secretary will also establish a payment methodology, including bundled payments or bids for episodes of care. Payment will be made to the entity that is participating in the pilot program.

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A variant of the model above would define a per-patient budget for a defined group of patients instead of making an upfront payment. Individual physicians who volunteered to participate would bill for individual services as they will do in Medicare Shared Savings Program, the total billings would then be compared to the budget, and the payments to the physicians and other providers in the ACO would be adjusted up or down to keep total payments within the budget. This approach gives physicians the flexibility to use alternative treatment approaches, as in capitation, without requiring them to have the capability to pay claims to other providers.

Condition-Specific Capitation

This model would involve making a prospective payment covering all of the services related to a particular condition or combination of conditions for a population of patients, rather than the full range of conditions as in the partial capitation model described earlier. Under condition-specific capitation, a specialty physician practice, multi-specialty group, or IPA would be paid a pre-defined amount to cover the costs of all of the care needed to address a particular condition, whether that care is provided by physicians in the organization receiving the payment or other physicians. For example, a multi-specialty group or IPA could be paid a fixed amount to cover the costs of all services associated with care related to its patients' congestive heart failure, including all physician services, hospital care, rehabilitation, etc. (This payment model could also be structured as a "virtual" payment or budget, as described above for virtual partial capitation.) This would enable primary care and specialty physician practices to work together to take accountability for the subset of patients and patient care they felt they could most effectively manage; over time, they could expand to additional types of patients in order to accept a broader partial capitation payment.

Accountable Medical Home

In contrast with the shared savings approach to medical homes, the accountable medical home model would give a primary care practice, multi-specialty group, or independent practice association (IPA) the upfront resources needed to restructure the way primary care is delivered to its patients in return for a commitment to reduce the rate at which those patients use emergency rooms for non-urgent visits, are admitted and readmitted to the hospital for ambulatory care sensitive conditions, and order diagnostic tests or other ancillary services that may be inappropriate. Accountable medical homes could improve patient care and achieve savings for the Medicare program in several key areas without being penalized for the costs of specialized services they are not in a position to control. In the State of Washington, the Puget Sound Health Alliance and the Washington State Health Care Authority are currently putting this model in place for commercial payers and Medicaid plans. CMS could use the approach they have developed in the Medicare program.

Warranties for Inpatient Care

Adoption of a model like Geisinger Health System's ProvenCare could be a beneficial transitional model for Medicare payment reform. Physicians and hospitals providing treatment for specified conditions would determine a Medicare payment rate that would allow them to offer a warranty for the inpatient treatment and not charge more for addressing infections, complications or other defined adverse events that may occur during the course of the patient's care. Offering such a warranty provides an economic incentive for improving quality and preventing complications from occurring. As quality improves over time and rates of warrantied complications diminish, the physicians and hospitals will be able to reduce the bundled payment rate to save money for Medicare while still obtaining higher margins on their own operating costs. At least initially, the price of the warrantied services is likely to be higher than what Medicare pays for a service with no complications because of the need to cover the costs of treating complications that will arise in a certain number of cases. Since Medicare would no longer be paying separately for the complications covered by the warranty, this method would save money in total. In contrast to the current payment system, this would reward the physicians and hospitals for preventing complications and delivering better quality care rather than paying more when complications arise. Most consumer products that are sold with a warranty do cost more than those without a warranty. Consumers purchase warrantied products not only as a protection against costly repairs but also because they know that the manufacturer must offer a high-quality product in order to manage its own financial risks. The warranty model is also a good transitional model because, as Geisinger did, physicians could begin with one service, like cardiac surgery, and then expand it to other areas as they gain experience with the approach.

Mentoring Programs

Perhaps the simplest way for small and solo practices to develop capabilities like analyzing patient utilization, quality and cost data, sharing information with others to prevent duplicate tests, adopting evidence-based measures and improving quality and cost performance is to learn from those who have done it. Another transitional model, therefore, would be for Medicare to provide financial and technical support to small physician practices that are working with Regional Health Improvement Collaboratives[1]

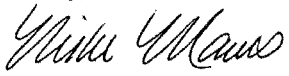
[1] For more information see "Regional Health Improvement Collaboratives: Essential Elements for Successful Healthcare Reform," Network for Regional Healthcare Improvement, www.nrhi.org.

or partnering with high performing groups in order to learn from them. The Mayo Clinic Affiliated Practice Network, Henry Ford Physician Network, Pittsburgh Regional Health Initiative, and Oregon Health Care Quality Corporation are several examples of this type of mentoring approach.

While replacing the SGR is critical, it must be done correctly. We believe this proposed framework, and timeline, are critical to developing the evidence-base necessary to ensure a reformed Medicare physician payment system meets our mutual goal of improving the Medicare program while ensuring beneficiaries' continued access to care. We look forward to continuing to work with House and Senate members on both sides of the aisle on repealing the SGR and transitioning to a system that incorporates new payment models designed to enhance care coordination, quality, appropriateness and cost.

Again, thank you for affording us this opportunity to work with you on replacing the SGR with a sustainable payment system.

Sincerely,



Michael D. Maves, MD, MBA

cc: House Energy and Commerce Committee Members
Cecil B. Wilson, MD

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April 29, 2011

The Honorable Fred Upton
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Henry Waxman
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Ranking Member Waxman:

On behalf of the American Academy of Dermatology Association (AADA) which represents more than 12,000 dermatologists nationwide, I am writing in response to your letter dated March 28, 2011 welcoming our ideas on reforming the Medicare physician payment system. The AADA fully agrees that the current system threatens the long term viability of the Medicare program and access to care for our nation's seniors. We appreciate the Committee's recognition that the sustainable growth rate (SGR) is a fundamentally flawed basis for calculating physician payment. Together, we must reform Medicare's physician payment system to one that protects Medicare's beneficiaries, pays physicians fairly and improves quality and efficiency.

The AADA firmly believes the critical first step towards a new payment system is the permanent repeal of the SGR. When established nearly fifteen years ago, the purpose of the SGR and its expenditure target was well-intentioned; however it lacked the capacity to deal with technological advances, an aging population and the expansion of the Medicare program. Accordingly, since 2002, Congress has had to intercede twelve times to stave off draconian cuts to Medicare physician payment rates, currently scheduled to be cut by 29.5% on January 1, 2012.

The permanent repeal of the SGR would immediately stabilize the Medicare program and allow physicians to lead the effort to reform the payment system. As we work together to develop and transition towards a new Medicare physician payment system, the AADA recommends a five-year transition period. This second step requires statutory updates for the years 2012-2016; whereby physicians receive positive payment updates that accurately reflect the cost of providing medical services.

Most dermatologists are either solo practitioners (44% of our membership) or in small group practices. While we explore new ways to help physicians in these small practice settings work more collaboratively within the larger system, we must not unduly burden them with unproven or untested changes that might have unintended consequences or drive older physicians from practice, exacerbating our workforce shortage and hindering patient access to care. Time is necessary to adequately test and study those models to understand if they would actually result in improved care and coordination before they are considered for broad implementation. Indeed, several innovative models have been suggested that seek to align broadly shared goals of improved quality of care, better integrated care, and improved value. With over 85 percent of dermatologists treating Medicare patients, this transition period of time will protect patient access to quality dermatologic care.

The AADA appreciates the complexity of physician payment reform and is willing to work with you to develop the new matrix of innovative physician payment models. As physician practices vary greatly, there is no one-size-fits-all solution. Ultimately, different payment methods may need to be employed based on a variety of factors, e.g., location and size of practice, mix of patients and services, degree of integration. The key is employing incentives that encourage the delivery of the most appropriate and highest quality patient care. Any transition to new physician payment models should take into account the amount of time and resources necessary for physicians to develop the infrastructure and practice capabilities to succeed under a new payment system.

The AADA believes that systemic reform should encourage collaborative, patient-centered care that results in improved quality, accountability, and cost efficiencies throughout the system. The testing and development of a wide-range of alternative payment models such as bundled payments, capitation, pay for performance and accountable care organizations (ACOs) is critical prior to any implementation of such models.

During this five-year transition period, we encourage the development and study of shared savings programs, such as ACOs, on a voluntary basis and the potential for active participation, including decision-making authority, by dermatologists. The emphasis of any type of shared savings model should be on protecting beneficiary access to the full spectrum of medical care. Outside of a primary care environment or integrated organizations like Kaiser and Geisinger, there are still many unknowns about the practical application of such a model for specialists and we would support additional testing on how all of medicine would fit into such a system (*i.e.* the potential burden on solo practitioners and small group practices of having to enter into multiple contracts with different ACOs to maintain a sustainable patient base).

While we support the testing of models such as ACOs, regulations and guidance from entities like CMS need to look at all of medicine, not just hospitals and primary care, and consider how all providers can participate. With the recent

example of the proposed rule for ACOs, the role of specialists is largely ignored with the exception of stating that they have the option of contracting with multiple ACOs (as opposed to primary care physicians, who CMS is proposing may only participate in one ACO). While AADA would like to be able to provide some guidance to our membership when they ask us how they can participate in ACOs and what the impact will be on their practice, we have little to offer because the regulations simply do not address the small, independent specialty practice role in these integrated systems. The underlying concept for savings generation in ACOs is better coordination of care, which requires buy-in from all providers in the system. Until the role of specialist physicians like dermatologists in ACOs is better defined, organizations like ours will struggle with obtaining buy-in from and providing guidance to physicians who wish to engage and help generate the savings promised in the Affordable Care Act.

In the absence of information from CMS about how dermatologists can participate in ACOs, the AADA has established an ACO Workgroup of volunteer dermatologists working to determine how to actively engage in the ACO model. As a first step, they are seeking out dermatologists who work within the well-established integrated health systems (e.g. Billings Clinic, Sutter Health, Virginia Mason, etc.) and conducting interviews to get a sense of what it is like to practice dermatology within a system that likely reflects how some ACOs will operate. By hearing first-hand about the benefits and challenges associated with integrated practice, we can transform that information into resources for our members who will undoubtedly be struggling with the decision of whether to join an ACO.

The resounding message from our members is not one of resistance to all change, but a desire to understand how different payment reform scenarios will affect their ability to treat patients, retain employees, and maintain the viability of their practices. To that end, the AADA has also established a payment reform workgroup which is working to analyze how different payment reform scenarios that have been under discussion would affect dermatologists' payment and practice. As these other payment reform models have often been discussed at a high level but have yet to be laid out in regulatory text (episode groupers, bundling, etc.), such analyses require many assumptions and extrapolations of existing policy to get any sense of the impact.

Using internal resources and external health policy consultants, AADA is working to understand how these different scenarios might play out in the specialty and inform our members to help emphasize the message that the current payment system is unsustainable. While prevention of disease, including skin cancer, is ideal and should be a primary goal, dermatologists are best equipped to intervene when suspicious lesions and/or cancers are detected early to avoid costly treatment of undiagnosed disease. The development of appropriate use criteria for certain procedures may also prove beneficial to patient care as well as reduce costs. In addition, we believe it is necessary to provide further study on

the site of service as evidence suggests that outpatient care provides both improved quality of care and reduced costs to the health care delivery system.

The AADA supports efforts to improve quality of care and strongly encourages the Committee to include the physician community and specialty organizations in the process of developing those measures. Like many other specialties, dermatology is in the early stages of transforming the specialty through the use of data to measure, evaluate and improve the dermatologic care provided by its physicians. The science of measuring physician performance is in its infancy and dermatology, like many other specialties, struggles with the presence of confounding variables, non-existent risk-adjustment methodologies, and lack of a simple means to collect the necessary data in an ambulatory setting. Dermatology's practice demographics add to our specialty's struggle to find the best way to assess performance. In general, dermatology is practiced in mostly solo and small group practices, has few "hard" outcomes, and treats more than 3,000 different skin conditions. Many of these "orphan diseases" afflict a small number of patients making it difficult to collect sufficient data to appropriately measure performance.

The Academy is currently building capacity to identify our most costly disease states and develop evidence-based guidelines and quality measures. In addition, the AADA is considering building a practice-based research network and/or data registry that will help our specialty identify gaps in dermatologic care, measure them and issue practice improvement guidelines and tools. The network and registry would also support our numerous maintenance of certification (MOC) resources for practicing dermatologists seeking to keep their knowledge and skills up to date.

Where appropriate, the AADA supports virtual integration, namely through teledermatology, as one way to facilitate integrated care within a functioning ACO or some other payment model. Establishing telemedicine as an avenue for coordination of care would provide necessary access to dermatologists as well as other specialists who practice telemedicine, and give primary care providers options when they require consultations but do not have the expertise available in their community.

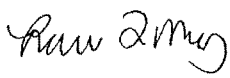
The visual nature of dermatology lends itself to this technology. The AADA has established a volunteer teledermatology program that serves the underserved population in various parts of the country. Though early in its development, there are demonstrated benefits of integrating primary care physicians with dermatologists via technology; access should increase and societal cost savings should be realized by reducing the need for in-office visits.

The challenges facing the overall Medicare program are complicated and carry significant fiscal implications as well as the potential for unintended consequences on access to care. The Academy believes it is incumbent upon

every physician and health care provider to commit to being a responsible steward of the nation's health care resources. We must find a balance between fiscal prudence, delivering high quality care and preserving the trusted physician-patient relationship. As we continue to understand the impact of changes on dermatology we will share our findings with you in hopes of achieving this balance.

We appreciate your leadership and look forward to working with you to secure a fair and equitable Medicare payment system. Please feel free to address any comments to John Hedstrom, AADA's Director of Legislative Policy & Political Affairs, at jhedstrom@aad.org or (202) 712-2601.

Sincerely,



Ron Moy, MD, FAAD
President
American Academy of Dermatology Association

cc: The Honorable Joe Barton, Chairman Emeritus, House Energy & Commerce Committee

The Honorable John Dingell, Chairman Emeritus, House Energy & Commerce Committee

The Honorable Joseph Pitts, Chairman, House Energy & Commerce Sub-Committee on Health

The Honorable Frank Pallone, Jr., Ranking Member, House Energy & Commerce Sub-Committee on Health

The Honorable Michael Burgess, Vice-Chairman, House Energy & Commerce Sub-Committee on Health

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April 27, 2011

Chairman Fred Upton
Ranking Member Henry Waxman
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Ranking Member Waxman:

The American Academy of Neurology (AAN), representing more than 24,000 neurologists and neuroscience professionals, is pleased to submit comments in response to the House Energy and Commerce Committees request for proposals to replace the current Medicare sustainable growth rate (SGR) formula.

Neurologists provide better quality care to patients with neurological disorders like dementia, Parkinson's, epilepsy, stroke, and migraine than other physicians. Where studied, care by a neurologist reduced costs and improved outcomes. Patients who receive care from neurologists often are discharged earlier from the hospital, receive more accurate diagnoses, and receive fewer unnecessary tests and procedures. For example, stroke patients have a lower mortality rate, and less disability when treated by a neurologist.

The Academy believes that without fundamental changes in payment policy, patient care will suffer, particularly for those with neurologic disease. Current policy has made cognitive specialties like neurology less attractive, leading to physician workforce shortfalls to treat this population, largely due to the economic pressure to emphasize procedures over direct patient care.

What is needed is a complete revision of the Medicare fee schedule, narrowing the payment gap between evaluation and management services and procedures.

Although the gap in median income between primary care physicians and specialists is well publicized, a recent review Medicare data demonstrates that the disparity is actually between procedural vs. non-procedural physicians. Health care policy discussions focused on this gap currently pit primary care physicians against all specialists. However, a number of specialists are also nonprocedural in that they derive the bulk of their income from evaluation and management. Nonprocedural specialties like neurology are experiencing the same economic disadvantages as primary care, with the resulting difficulty in attracting graduating US medical students into the specialty.

The Affordable Care Act (ACA), however, treats specialists as a monolithic group, ignoring the fact that several specialties spend the majority of their time in face-to-face patient care. The concept of primary care versus all specialties combined is both overly simplistic and inaccurate. The true dichotomy is between primary care and nonprocedural specialties taken together versus the procedural specialties. With this change in perspective, the current income gap has little medical rationale, and furthermore has unfortunate consequences on the quality and equitable allocation of patient care. This has led to misaligned financial incentives, leading to a procedure-centered instead of a patient-centered health care system.

We believe that steps could be taken to assure the availability of a balanced physician workforce, the availability of a full spectrum of expertise, and access of patients with chronic conditions to the appropriate physician. These solutions focus less on costly procedures and more on face-to face cognitive care that would provide higher quality, more appropriate care at lower cost to both Medicare and patients.

With the elimination of the consult codes in 2010 by CMS and lack of inclusion in the primary care incentive for 2011 and beyond, cognitive specialists like neurologists are now reimbursed less than primary care physicians for treating the same patients. Immediate steps are needed to ensure that the cognitive care work force remains viable in the near future.

Congress should immediately:

- Include specialists who routinely coordinate care and meet the 60% threshold for the primary care incentive as eligible.
- Reinstate payment for the consult codes eliminated by CMS starting in 2010.

Long-term shifts that move care from procedural to non-procedural care are essential for the long-term benefit of the Medicare program.

The current Medicare fee schedule is flawed in large part due to inherent biases that favor procedures and imaging services. These biases persist in spite of data showing inequity of provider reimbursement and the rapid growth of these services without a corresponding increase in medical need. Though recent legislation has been introduced to attempt to correct these biases by focusing on reform of the American Medical Association's Relative Value Update Committee (RUC), the Academy believes this approach will ultimately fall short of providing any basis for meaningful change. The problems associated with the devaluation of primary care services has more to do with the lack of goals put forth by CMS than with shortcoming of the RUC process. A more effective approach would be for Congress to give specific guidance to CMS to use RBRVS to create a new fee schedule that would favor primary and cognitive specialty care. Correction of the current undervaluation of primary care and cognitive physician work intensity would be one way to achieve this.

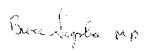
For the longer term Congress should:

- Change the misaligned financial incentives and close the income gap for both primary care and nonprocedural specialties.

- Support research to identify physician intensity of services to better show the parity of work from both procedural and non-procedural specialties.
- Pass meaningful malpractice reform that ensures that care provided by physicians is not subject to pressures that drive the use of high cost defensive medicine.
- Explore alternatives to the SGR such as:
    - Replace the SGR model which holds all providers accountable to the same target with one where services are grouped by service categories and held to separate growth targets. Categories should be based on service (not specialty) such as: primary care; cognitive specialty care (or other E/M); imaging and tests; major procedures; minor procedures; and anesthesia.
    - Support mechanisms for growth target (or SGR) exemptions for providers participating in alternative quality-based models such as accountable care organizations or patient-centered medical homes.
    - Cut the conversion factor to allow for substantial bonuses for primary care and other critical cognitive care specialties like neurology, rheumatology, and infectious disease.
    - Pay all physicians based on time, removing incentives to spend inadequate time with patients, read images too quickly, or focus on procedures that may be of marginal utility. This model would return the practice of medicine to a truly patient-centered focus by freeing physicians to meet their patients' needs. This model would allow reimbursement for the time physicians spend doing paperwork, telehealth activities, and more extensive care coordination. Providing more targeted care would likely decrease health care utilization, improve outcomes, and increase patient satisfaction. Hourly rates would still need to distinguish by service provided, however, these rates could be defined in terms of patient value instead of the relative value structure used in the current Medicare FFS model.

It is clear that these changes will not be welcomed by all physician groups, but in order to control costs and ensure an appropriate mix of physicians for all Medicare beneficiaries, fundamental changes in the health care delivery system must occur.

Sincerely,



Bruce Sigsbee, MD, FAAN
President, American Academy of Neurology

AMERICAN ACADEMY OF NURSE PRACTITIONERS

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April 29, 2011

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
United States House of Representatives
Washington DC 20515

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
U.S. House of Representative
Washington DC 20515

The Honorable Joseph Pitts
Chairman, Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
Washington D.C. 20515

The Honorable Frank Pallone, Jr
Ranking Member, Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
Washington D.C. 20515

Dear Chairmen Upton and Pitts and Ranking Members Waxman and Pallone,

Please accept these comments in behalf of the American Academy of Nurse Practitioners regarding the need for revisions to the current Medicare physician payment System. As the nation's largest nurse practitioner organization representing the nation's 140,000 nurse practitioners, we thank you for the invitation to express our views regarding potential changes to the Medicare payment system.

We recognize the necessity to discontinue the SGR formula for Part B reimbursement and agree with others that a gradual transition to revised reimbursement formulas will be necessary to maintain a stable reimbursement program for all beneficiaries and providers. As new formularies are developed, it will be important to have representation and input from nurse practitioners.

It has come to our attention that there are several recommendations for stepwise transitions to new models which we will be happy to review. If new frameworks for reimbursement are to be implemented, it is important that they be inclusive of all Part B providers, including nurse practitioners, and not limited to physicians and hospitals. It is also important that patients have a choice of providers and that classes of providers are not discriminated against in any new or revised payment formulations.

We feel strongly that reimbursement methodologies be based on services provided and outcomes of care. Likewise, it is important that patients have direct access to nurse practitioners as providers and that nurse practitioner led practices and clinics continue to be recognized as full and reasonable participants in reimbursement formulas, developed by and for the Medicare Program.

As you know, nurse practitioners have an outstanding record for consistently providing quality, cost effective care. It is crucial that they be included in the planning, development and implementation of reimbursement formulas that impact providers and their Medicare patients. We look forward to working with you on this issue in the coming months. Please contact us at any time.

Sincerely,

Jan Towers PhD, NP-C, CRNP, FAANP, FAAN
Director of Federal Health Policy and Professional Affairs

Penny Kaye Jensen, DNP, FAANP
President, American Academy of Nurse Practitioners

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Federal Affairs Department

May 2, 2011

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Mr. Chairman:

We are writing in response to your request for ideas and suggestions for a path to physician payment reform under Medicare. The American Academy of Ophthalmology represents over 32,000 physicians and surgeons, 18,000 of whom provide eye care in the United States. As you know, ophthalmology is a Medicare-focused medical specialty due to our serving an aged patient population. We applaud the Committee's effort to develop a long-term solution to the SGR and commitment to fair and stable reimbursement updates for Medicare providers. We agree with the position and time line that the American medical Association and the American College of Surgeons have proposed for repeal of the SGR and transition to a reformed payment system for Medicare.

Promoting quality medical care should be integral to reform. We have worked with AMA-Physicians Consortium for Performance Improvement (PCPI and Surgical Quality Alliance (SQA) to develop significant quality measures to ensure that Pay-for-Performance initiatives under the Medicare program are relevant to patient care and significant in impact. While we do not agree with the timing or speed at which penalties are scheduled for implementation, we are committed to working with CMS to improve the effectiveness of this evolving program. The ACA initiates significant reform of physician payment through the PQRS with as much as 7% of physician payment at risk for reduction by 2018 for failure to comply (see chart).

Many of the broad health system and hospital demonstrations either planned by CMS or actually underway do not immediately involve ophthalmology. AMA and ACS point out that a one-size-fits-all solution is not the best approach to ultimate reform of Medicare physician payment. We are analyzing the role that ophthalmology could have in various forms of payment bundling, particularly in defined episodes of care. We are participating in the discussion of Accountable Care Organization policy/rulemaking to ensure that ocular diseases are managed appropriately. Specialty adoption of EHRs will also be critical to a reformed system and the Academy is working with DHHS/ONC to ensure that future stages of Meaningful Use are flexible and relevant and engage specialty medicine with a product that improves care. Data derived from such instruments can be used to drive future performance improvement.

We support CMS efforts to continue allowing the migration of surgical and other procedures to the outpatient setting consistent with patient safety. This should reduce expenditures, improve quality and patient satisfaction and increase efficiencies in the health care system. Critical to this successful transition is maintenance of adequate reimbursement for this setting.

Finally, government recognition and support for specialty-generated care guidelines and decision-support tools will be critical to continued move to improving care for patients and population. These would reduce some of the waste within the current system. Medicare physician payment reform initiatives must recognize the role specialty societies can play in moving changes forward.

Thanks again for your commitment.

Sincerely,

Michael Repka, MD
Medical Director for Governmental Affairs

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AMERICAN ACADEMY OF OPHTHALMOLOGY

Value Based Purchasing

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*Beginning in 2015, physicians can earn up to $44,000 to adjust their Medicare payments under a new reporting system.
**Reports of your Medicare revenue for the year.

AAOS
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AMERICAN ASSOCIATION OF ORTHOPAEDIC SURGEONS

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April 26, 2011

The Honorable Fred Upton
Chairman
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Members of the Committee:

Thank you very much for the opportunity to provide our comments and view points to the House Energy and Commerce Committee on the Sustainable Growth Rate (SGR) formula. I am writing to you as President of the American Academy of Orthopaedic Surgeons, which represents over 18,000 board-certified Orthopaedic Surgeons. We appreciate the committee's willingness to pursue a permanent fix and replacement of the SGR formula. As you have noted, the SGR formula, which was promulgated into law by the Balanced Budget Act (BBA) of 1997, has failed to curb the growth of Medicare expenditures for the past decade. As a result, Congress annually devotes significant portions of every Congressional session to passing short-term "fixes" which avoid imposing severe payment cuts to health care providers mandated under the SGR formula. This approach is a legislative nightmare and a major impediment to meaningful payment reform. We applaud your commitment to finding solutions for the budgetary hole of $300 billion and a physician fee schedule that is fair and rewards quality rather than quantity.

The AAOS has long been committed to the replacement of the SGR formula and has created numerous position statements addressing Medicare programs and payment reform. In December of 2010 the AAOS adopted a "Principles of Payment Reform" which outlines the AAOS' recommendations for a reformed payment system.

Our recommendations to your committee are grouped into different categories: Payment Models, Cost Reduction, Market-based Innovations, Transparency, and Regulatory Reform. These areas of emphasis provide a roadmap for how our country could restructure the current system so as to emphasize higher quality, lower costs, and encourage innovation by providers by incorporating meaningful and fair cost controls, promoting coordination of care, and encouraging consumer and patient education and direct involvement in cost and quality.

Payment Reform Models

- **Congress should make "quality of care" the primary focus of payment reform**
  Our current payment system offers few financial incentives to providers to provide higher quality care to patients. Instead, it pays the same amount for a given treatment intervention regardless of the quality of care delivered and the outcome of the intervention. This does not serve our patients or our healthcare system well and is contrary to a market-driven approach to payment. A market-driven approach would provide incentives for higher quality (rather than higher quantity) care, and would thus encourage providers to improve the quality and value of the care they provide.

  The AAOS believes payment reform must provide financial incentives that reward higher quality care based on appropriately risk-adjusted, patient-centric measures of health outcome. This system must be risk adjusted so as to account for the medical, social, and personal co-morbidities that are beyond a provider's control. These would include factors such as obesity, diminished mobility, chronic disease states, noncompliance with treatment recommendations, poor nutrition, tobacco and alcohol use and many other factors which are beyond the control of health care providers.

  We believe a tiered payment system can be built upon evidence-based guidelines, appropriate use criteria, risk-adjusted performance measures, and mandatory participation in national registries. In the last ten years, many registries have been created and disseminated by specialty societies and these deserve legislative, payor, purchaser, hospital, and health care provider support. We now have a foundation of quality measures and evolving evidence in virtually every area of medical practice. These are the best resources for a quality-focused payment system. We also have a sufficient foundation of outcomes research to begin to determine what constitutes a high quality outcome compared to a low quality outcome. These types of quality measures should be the foundation of a new physician payment model that does not rely on the current fee-for-service payment mechanisms.

- **Congress should continue to explore payment reforms such as bundled payments under the leadership of physicians**
  Physicians have the best knowledge and the most direct interest in their patient care. In collaboration with other stakeholders, physicians should be responsible for determining rates at which bundled and shared savings programs are reimbursed. Specialty societies should be at the forefront of developing measurements for quality and payment models that will provide the best incentives for particular groups of providers.

- **Congress should avoid relying on a one-size-fits-all approach to payment reform**
  Within orthopaedics, all of the following types of payment systems could work for different types of orthopaedic care: capitation with warranties and floors, episode-of-care, and traditional fee-for-service. Capitation with warranties, for instance, might work well for treatment of chronic musculoskeletal conditions, while episode-of-care models might work well for joint-replacement care, and fee-for-service might work for non-patternable multi-system trauma services where episode-of-care and other approaches might not be applicable due to its high variability. A new payment model should create incentives both by offering higher reimbursement for quality and shared savings, but it should also create incentives by shifting some burden of financial risk to providers as well. The current system has zero financial risk for providers and by providing both positive and negative financial incentives for higher quality, a new model could move care in a new direction of better patient care with greater physician involvement in decision making.

- **Congress should continue to explore the creation and facilitation of Accountable Care Organizations (ACOs)**
  ACOs represent an attractive alternative payment model. In recent years, several initiatives have been introduced to either control costs or improve quality: pay-for-performance, gainsharing, value-based purchasing. In theory, ACOs could combine all of the above. However, ACOs have not initiated operations within the Medicare system and therefore they will need to be adapted and altered based on direct experience and input from participating stakeholders. The AAOS believes ACOs cannot be relied upon as the sole alternative delivery model, but must be blended with other approaches, particularly in the early stages of ACO development and maturation.

Regulatory Reform

- **Congress should eliminate the Independent Payment Advisory Board (IPAB) and create a mechanism for review of Medicare payment rules and regulations that will focus on all aspects of health care payment, not just on physician payment rates**
  Any such review body must be accountable to Congress and should not be an independent body with statutory powers. The majority of members of such an advisory council must be physicians and non-physician medical providers like nurses or nurse practitioners. Physicians and medical providers are the best judges of the potential impacts of any physician payment model on the quality of care delivered to patients.

- **Congress should ensure fiscal solvency of federal programs**
  The current approach to physician payment has many drawbacks. It stifles payment, discourages innovation, and still manages to threaten the fiscal solvency

of the federal government. Any physician payment reform needs to balance equitable payment with a commitment to the long-term solvency of federal health care programs.

- **Congress should consider basing any new payment model on the prospective payment systems such as the one used for Part A Medicare services that include annual market basket updates to payment rates**
  This approach is far more rational than the current SGR system used for Part B Medicare Services which bases updates on target expenditure rates rather than market basket updates. A prospective payment system must also recognize costs under the control of the provider and not include items beyond a provider's control. Until 2010, Medicare Part B included the costs of drugs provided in physician offices even though physicians had no control over these costs. CMS eventually changed this, but not before it had contributed significantly to the SGR "hole". A new model must ensure no such misattributions occur from the beginning.

- **Congress should look for savings from other Medicare programs besides Part B**
  Part B expenditures are only a small percentage of total Medicare expenditures and any Congressional efforts toward cost savings in Medicare should look at Part A-hospital payments, Part C-Medicare advantage and Part D-drug payments in addition to Part B. Congress could achieve dramatic and immediate savings in parts C & D in particular.

Market-based Innovations

- **Congress should encourage medical innovation not stifle it**
  Payment systems should reward physicians for developing medically innovative treatments that are better for our patients by increasing quality and by reducing health care costs. This will keep patients healthier and out of hospitals, thereby increasing their productivity and GDP. Orthopaedics has long been a driver of medical innovation such as arthroscopic treatments for conditions which formerly required open surgery and inpatient hospital stays. These types of innovative technological advances have saved employers, patients, Medicare, and other payers billions of dollars a year in reduced costs, principally though reductions in hospital stays and post operative days of patient morbidity. Yet, our current system, with its perverse incentives, pays more for procedures with longer procedure times and more hospital patient
  visits. This is economically irrational and must be corrected in future payment reform. By tying payment to quality and to savings generated by medical innovation, Medicare can reduce overall costs and drive innovation.

- **Congress should encourage and facilitate reinsurance for providers**
  Reinsurance is a common method for corporations to insure themselves for catastrophic or unusual outcomes that are not typically covered in standard insurance contracts. These types of reinsurance provide corporations with stability in the face of outlier episodes. Physicians should also have the ability to carry reinsurance and payment reform should specifically include access to reinsurance for Medicare providers which would allow them to take on greater risk when warranted.

- **Congress should adopt multiple approaches to payment reform since not all physician services will fit one model**
  Our current healthcare system is diverse, with organizational models ranging from solo practitioners to comprehensive, fully-integrated systems of care. What works well in one practice setting may not work for all patient disorders, for all physicians or in other practice environments. Yet our current payment system operates on the assumption that all physician practices are the same. More flexibility will reduce inefficiency and properly price physician services provided in the multiple settings that exist today. Payment reform must acknowledge this diversity and accommodate the need for flexibility.

- **Congress should encourage public and private sector collaboration**
  New payment models should be transferrable to and usable for commercial and 3rd party health provider reimbursement and new payment models need to align with private sector approaches. The public and private sectors should be brought together to collaborate and share approaches that reward outcomes and value and reduce administrative demands.

- **Congress should stimulate private contracting between patients and providers**
  The ban on the ability of providers to enter into private contracts with Medicare patients has further impacted the ability of providers to cover the widening gap between inadequate Medicare payments and the cost of providing services. Federal rules capping private contracting between patients and providers should be repealed in the absence of a reasonable long-term solution to inadequate payments to providers by CMS. Also, insurers should be forbidden from including such provisions in physician-insurer contracts. The AAOS believes this action will help providers close the gap between inadequate Medicare payments and the cost of providing services to seniors and other members of society.

- **Congress should enable Medicare beneficiaries to assume greater responsibility by cost-sharing for the Medicare program, with protections for low income beneficiaries, in order to preserve their access to quality care**
  There are a broad range of options that policy makers could consider for enhancing beneficiary cost-sharing, among them are:

- Indexing Part B premiums to gradually raise the overall beneficiary cost-share of Part B increases above 25%.
- Further reducing the subsidy for Medicare Part B premiums for high-income beneficiaries so that they assume a greater share of program costs.
- Increasing Part B deductibles and indexing them to better reflect the cost growth in the program.
- Replacing the complex set of cost-sharing arrangements with a single standardized coinsurance rate.
- Restructuring Part A financing, including a Part A premium.
- Establishing a co-payment for home health, clinical laboratory, pathology and skilled nursing facility services.
- Raising the eligibility age for Medicare beneficiaries to be consistent with the Social Security program.
- Eliminating the costs generated by the increased utilization of services due to Medigap first dollar coverage.
- Enacting liability reform to lower the costs of liability insurance and the practice of defensive medicine.
- Establishing a basic benefit package for every Medicare patient, the projected cost of which is within the budget, that would be expected to cover all basic health care needs. The program should then allow supplemental insurance by private companies to enhance an individual's coverage if he or she chooses.

- **Payment reform should account not just for costs but also benefits provided by specific procedures and types of care**
  Care that reduces business and government cost by returning and keeping employees at work (as opposed to on worker's compensation, unemployment insurance, or simply not working at all) should be recognized as more valuable than care that contributes little to societal well-being. For instance, patient quality of life, typically captured by QALYs (Quality Adjusted Life Years) and DALYs (Disability Adjusted Life Years) should be accounted for in the form of greater payment for procedures and providers that increase QALY and DALY scores for patients.

Cost Reduction and Fraud Prevention

- **Congress should pass federal medical malpractice liability reform**
  The current combination of increased risk of malpractice litigation and a fee-for-service system with no mechanism for annual updates has created incentives for potential over-utilization of medical services because physicians fear litigation. Payment reform must consider mechanisms for limiting real over-utilization, rather than focusing solely on cutting reimbursement of so-called over utilized procedures. This could be done through two positive incentives-- paying for quality outcomes which will encourage greater utilization of services that provide true quality, and by reducing or offsetting the risk of medical malpractice lawsuits which will free providers from defensively ordering extra tests and services. Reducing payment rates for discrete services probably will not curb the utilization problems, and, in fact, would likely create incentives for higher utilization; in contrast, meaningful medical malpractice liability reform will likely lead to lower utilization rates which will benefit patients and reduce costs.

- **Congress should work toward eliminating real Medicare fraud where it exists**
  It is impossible to accurately account for the percentage of total Federal spending on physician services paid for fraudulent services, but it is reasonable to assume it is a significant and could be reduced through fair and thorough auditing. Any efforts to eliminate Medicare fraud must focus on true Medicare fraud and not become a mechanism for charges against honest providers of services. Congress should encourage the Centers for Medicare and Medicaid Services to work closely with specialty societies to identify Medicare utilization patterns that run counter to specialty society guidelines, appropriate use criteria and on best coding and billing practices. This collaborative effort could generate millions of dollars of savings without punishing honest physicians who constitute the vast majority of physicians in the United States.

Transparency

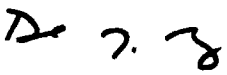
- **Congress should adopt and facilitate physician feedback**
  Our current system makes meaningful interaction between physicians and policy makers difficult and rare. This is a disservice to our patients, our regulators and to taxpayers. Feedback mechanisms must be developed that will accurately assess how physicians are responding to new models and incentives. Local and federal "innovation zones" are one strategy to speed learning and dissemination of best practices in varied circumstances.

- **Payment reform should provide meaningful incentives for adoption of Electronic Medical Record (EMR) systems, meaningful use of EMR systems, and participation in registries**
  In order for quality to become the lynchpin of any new payment models, it is essential that physicians report outcomes, performance measures and information in a secure environment. Physicians should be rewarded for contributing their data to large data repositories and Congress should allocate funds toward supporting the development of registries and depositories.

Any payment system is, by its nature, going to be complex and as the past 14 years of experience under the SGR formula has taught practitioners and legislatures alike, payment systems are fraught with unintended consequences and perverse incentives. That is why it is so important to create a payment system that rewards quality practitioners, and encourages constant improvement in the care of Medicare patients. The AAOS is committed to working with your committee and all of Congress to achieve this goal.

Thank you again for the opportunity to provide comments and ideas. We look forward to continuing to work further with all of you over the coming months.

Sincerely,



Daniel J. Berry, MD
AAOS President

cc: Karen L. Hackett, FACHE, CAE, AAOS Chief Executive Officer
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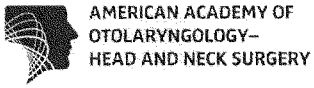

April 27, 2011

John O'Shea, MD
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

J. Timothy Gronniger
U.S House of Representatives
2322A Rayburn House Office Building
Washington, DC 20515

Tiffany Guarascio
U.S. House of Representatives
237 Cannon House Office Building
Washington, DC 20515

Dear Dr. O'Shea:

On behalf of the 12,000 members of the American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS), I appreciate the opportunity to provide input regarding the concurrent efforts to permanently repeal the flawed Sustainable Growth Rate (SGR) formula and develop a new Medicare physician payment system that will provide neeessary stability for physicians and ensure access to quality care for the nation's senior population.

The AAO-HNS is the national medical association of physicians dedicated to the care of patients with disorders of the ears, nose, throat (ENT), and related structures of the head and neck. We are commonly referred to as ENT surgeons.

The existing Medicare physician payment system, driven by the SGR formula, is broken beyond repair. For years, physicians across the House of Medicine have struggled in a system that fails to differentiate by provider or specialty and lacks the tools necessary for recognizing quality and/or efficiency in regards to the delivery of care. The strict budgetary focus and inherent instability of the current payment system have resulted in large negative annual updates that threaten providers' willingness and ability to care for beneficiaries. In addition, it has become increasingly difficult for physicians to make fiscally responsible, and necessary, practice management decisions. Because of these and other contributing factors, the AAO-HNS strongly believes that no more time should be wasted on efforts to mend the current system.

Eliminating the SGR is the cornerstone to an evolved payment system that improves quality, lowers costs, and better integrates the delivery of care across all patient care settings. Moving forward, any new payment model must, by design, include mechanisms to better inform policy-makers of spending growth trends, while simultaneously facilitating appropriate expenditure controls. Modern-day healthcare is dynamic and any payment mechanism should reflect the ongoing evolution of care.

More specifically, using a target growth rate system by carving out a small number of service categories may help to track and correct for volume growth (service categories growth rate, SCGR). Two categories of service types that could be used for this payment model are evaluation and management codes (E&M), and all others. This would provide physicians with the autonomy to provide care that addresses each patient's unique medical needs.

The AAO-HNS also wants to emphasize the importance of maintaining the current AMA Relative Value Update Committee (RUC) to value current physician services and those that may be bundled together in the future. We encourage you to continue to rely upon its expertise in

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AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
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valuing MFFS physician services. The key strength of the RUC is that it is convened by and comprised of physicians, with additional representation by non-physician healthcare practitioners. No other entity has the expertise to determine the appropriate complexity, intensity, and associated risk of a procedure than the collective, deliberative panel of the RUC.

While it is of paramount importance to develop and implement an updated physician payment mechanism, we urge Congress to refrain from viewing the problems associated with physician payment in a "vacuum." Payment reforms impacting other healthcare providers should be considered and may be necessary to ensure a fair, stable Medicare system emerges from your efforts. In addition, recent reforms very much support tying compensation to outcomes and quality. The ability of physicians to meet many of the tenets of Meaningful Use and the requirements for Accountable Care Organizations (ACOs) will obviously affect physician reimbursement, and therefore should be considered in your deliberations regarding physician payment reform. Unfortunately, it may be too early to determine how these programs will fully impact the delivery of care.

Further, the notion of "healthcare reform" must also extend to beneficiaries. Attempts must be made to better educate patients/beneficiaries about the costs associated with healthcare services and resources. Without increased patient education and accountability, a large piece of the healthcare reform puzzle will be missing.

In the next few months, the AAO-HNS looks forward to working with Congress to build upon last year's bipartisan effort to permanently replace the SGR formula with a workable system that rewards quality and efficiency, while still keeping pace with rising practice costs. And, to help demonstrate our commitment to ensuring patients have access to the highest quality healthcare available, we recently convened an Advisory Council on Quality. This Council is comprised of internal and external subject matter experts to provide expertise to the AAO-HNS quality agenda, including the development of a specialty-specific data registry. We will keep Congress apprised of this new initiative and any impact it may have on your future discussions.

Again, thank you for the opportunity to provide input on your efforts to permanently reform the Medicare physician payment system. This will undoubtedly be a daunting, yet necessary, undertaking, but the AAO-HNS and others in the physician community stand ready to assist in any way possible. If you have questions regarding the AAO-HNS positions stated above, please contact Megan Marcinko, Senior Manager for Congressional and Political Affairs, at 703-535-3796 or mmarcinko@entnet.org.

Sincerely,

David R. Nielsen MD

David R. Nielsen, MD
Executive Vice President and CEO

American Academy of Pediatrics

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May 5, 2011

The Honorable Fred Upton
Chairman
US House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Upton:

On behalf of the American Academy of Pediatrics (AAP), a non-profit professional organization of 60,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, thank you for the opportunity to provide input regarding new Medicare payment structures that will avoid the problems created by the Sustainable Growth Rate (SGR) adjuster contained in current law. In considering any proposals to reform the Medicare physician fee formula, we urge you to do no harm to children.

Even though only around 14,000 children are enrolled in Medicare due to their end stage renal disease diagnosis, the down-stream impacts of the Medicare physician fee schedule impact almost all US children. The majority of third-party payers, including a growing number of Medicaid programs and commercial payers, use variations of the Medicare RBRVS as their basis for physician payment. Many group practices have also adopted this system to benchmark physician productivity and determine variable compensation and bonus payments. Because pediatric care is underrepresented in any Medicare-based payment system analysis, unique aspects of physician work and practice expense may not be accurately reflected in the total relative value units (RVUs) for certain pediatric services. Despite this potential limitation, the American Academy of Pediatrics supports the use of *Current Procedural Terminology* (CPT) codes to report unique physician work and the RBRVS physician fee schedule as a uniform payment system.

The Academy is an active participant and founding member of the Patient Centered Primary Care Collaborative. A document reflecting that group's thoughts on payment reform is available at http://www.pcpcc.net/content/payment-reform. Along with children and youth with special health care needs, the Academy laid the groundwork for current discussions regarding the medical home and urges your close consideration of this model. Principles for financing the medical home are at http://www.medicalhomeinfo.org/downloads/pdfs/MHfinanceprin.pdf.

In any new Medicare payment system, payment reform should correct existing imbalances and distortions in physician payment and take into account value created. Payment by measures of value created should help redress the gross underpayment for primary care and raise primary physician payments. Thank you for you attention to the thoughts of the American Academy of Pediatrics.

Sincerely,

O. Marion Burton MD

O. Marion Burton, MD, FAAP
President

OMB: rh

From: Lawrence W. Jones
To: O"Shea, John;
Subject: SGR Urology
Date: Tuesday, April 12, 2011 3:41:14 PM

I met with you on Tuesday, March 29 with the American Urological Association and the American Association of clinical Urologists. I have no new ideas for you with regard to the bipartisan letter on the SGR fix, but I want you to know that I will be looking out for your input and applaud your patience and your efforts.

Lawrence W. Jones, MD
Huntington Medical Research Institutes
Huntington Hospital
Pasadena California

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House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115

Majority (202) 225–2927
Minority (202) 225–3641

March 28, 2011

Ralph Brindis, M.D., M.P.H., President
American College of Cardiology:
2400 N Street, N.W.
Washington, D.C. 20037

Dear Dr. Brindis:

The current payment system for physician services in Medicare is a major threat to the integrity of the program and the ability of America's seniors to access quality health care. Enacted in 1997 as part of the Balanced Budget Act (BBA), the Sustainable Growth Rate (SGR) system threatens providers with a 29 percent payment reduction in 2012 and will cost $300 billion to abandon.

In an attempt to preserve access to care for Medicare beneficiaries, Congress has found it necessary to override scheduled cuts to provider fees. This has been done annually since 2002 and several times in 2010. Obviously, these short-term "fixes" are not a solution to the problem and have only added to the physician insecurity and general instability in the health care system.

The House Energy and Commerce Committee is determined to achieve a permanent, sustainable solution to the Medicare physician payment problem this year. Toward that end, the Committee would welcome specific ideas and proposals from physician organizations and the provider community on how to reform the physician payment system and move to a system that reduces spending, pays providers fairly, and pays for services according to their value to the beneficiary. These ideas and suggestions should be in a form that can be translated into legislative proposals.

The problems preventing reform of the payment system are twofold: a budgetary hole of $300 billion, and a lack of consensus among experts and stakeholders about what kind of payment system should replace the Medicare physician fee schedule. It is the latter question on which we invite your comment.

The Committee plans to hold a hearing on the issue in early May of this year. We would request that you submit ideas to the Committee by the end of April. Unless we begin the process

of developing a long-term solution, we will once again be faced with the unwanted choice of extending a fundamentally broken payment system or jeopardizing access to care for Medicare beneficiaries. We cannot let either happen.

The Committee appreciates your efforts in providing care to America's seniors and looks forward to working with you to resolve this complicated problem. Please submit your responses and suggestions to John O'Shea with the Majority staff and Tim Gronniger and Tiffany Guarascio with the Minority staff. If you have any questions, please contact Dr. O'Shea, Ryan Long, or Howard Cohen at (202) 225-2927.

Sincerely,

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April 6, 2011

The Honorable Fred Upton
Chairman

The Honorable Joe Barton
Chairman Emeritus

The Honorable Joseph Pitts
Chairman
Subcommittee on Health

The Honorable Michael Burgess
Vice Chairman
Subcommittee on Health

The Honorable Henry Waxman
Ranking Member

The Honorable John Dingell
Chairman Emeritus

The Honorable Frank Pallone, Jr.
Ranking Member
Subcommittee on Health

C/o Dr. John O'Shea, Majority Staff
Tim Gronniger & Tiffany Guarascio, Minority Staff
Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Esteemed Congressmen,

The American College of Cardiology (ACC) is delighted to have received your correspondence of March 28 challenging us to offer specific ideas and proposals on reforming the physician payment system in Medicare toward reducing unnecessary spending, promoting fair payment, and aligning payment incentives with improved quality, lower costs, and increased patient satisfaction. There is no doubt that the sustainable growth rate (SGR) formula is an ongoing disaster that must be remedied, and new payment models must be proposed, tested, and implemented to truly bend the cost curve and improve value in health care. We applaud your determination to achieve a permanent and sustainable solution to the SGR.

The ACC over the past decade has invested many millions of dollars in developing sophisticated registries for hospitals and physician practices to measure quality of care through the degree to which the best scientific evidence is consistently delivered at the point of care and in measuring health care outcomes in cardiovascular disease for hospitals and large practices. The National Cardiovascular Data Registries (NCDR) are operational in 2500 US hospitals, accumulating more than 11 million patient records and generating sophisticated outpatient reports on the treatment of heart attack, including the use of

of cardiac catheterization, angioplasty, stents, implantable defibrillators and pacers, carotid artery procedures, congenital heart disease procedures and care, and other cardiovascular services. Our new PINNACLE outpatient registry already has 1.5 million patient records across many outpatient practices, and is growing rapidly. The College has for 25 years worked with the American Heart Association and others in continuously translating clinical science into guidelines, performance measures, and appropriate use criteria. The registries allow us to measure the extent to which such evidence and patient centered care is actually being delivered, including an ability to evaluate the overuse, misuse, or underuse of precious health care resources. As such, we're in an excellent position to consider and propose payment reforms which can improve care and outcomes while reducing unnecessary spending. Over the past five years, the application of these tools across hospitals and practices everywhere in America has reduced the average length of stay for the most serious form of heart attack from 5 to less than 3 days, with a cost reduction averaging more than 30%, while improving survival and outcomes for heart attack victims. There have been no payment rewards attached to these achievements!

We are broadly testing our new "appropriate use" criteria tools to reduce unnecessary imaging costs in cardiovascular medicine, and we have a new and similar tool designed to improve the efficiency and appropriateness of the use of bypass surgery, angioplasty and stents, and other heart attack treatments. And through our Hospital to Home (H2H) Program we are working with cardiologists, nurses and more than 1,000 major hospitals to reduce heart failure hospital readmissions, one of the most costly elements of Medicare spending. There are many other innovations we could share whereby we are reducing costs of heart disease and stroke through prevention, better chronic disease management, and more effective hospital care.

We are very excited about working with you to improve heart health and simultaneously lower health care costs, noting that cardiovascular disease accounts for more than 43% of Medicare costs. We will set meetings up with Mr. John O'Shea and with Mr. Tim Gronninger and Ms. Tiffany Guarascio to discuss possible proposals, and to offer our services to potentially testify at the proposed May hearing of the Energy and Commerce Committee on Payment Reform. We have been working for many years to prepare for this important element of health care reform—namely payment reform—and believe we are well positioned to assist you, the nation, and our profession to achieve tangible results. Without payment reform that incentivizes quality, appropriateness, shared decision making with patients, and measurement of clinical quality standards across inpatient and outpatient care we will not achieve these desired results.

Very Truly Yours,

David R. Holmes, Jr., MD, FACC
President

Jack Lewin, MD
Chief Executive Officer

Cc: Jim Fasules, MD, FACC, SVP, Advocacy
Janet Wright, MD, FACC, SVP, Science & Quality

AMERICAN COLLEGE of CARDIOLOGY

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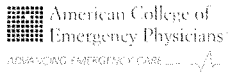

April 28, 2011

The Honorable Fred Upton
Chairman
Committee on Energy & Commerce
2125 Rayburn House Office Building
US House of Representatives
Washington, DC 20515

Dear Chairman Upton:

On behalf of the American College of Emergency Physicians (ACEP), I am pleased to respond to your letter of March 28, co-signed by Representatives Waxman, Barton, Dingell, Pitts, Pallone and Burgess, seeking specific ideas and proposals on how to reform the physician payment system. ACEP is a national emergency medical specialty society with more than 29,000 members. ACEP is committed to improving the quality of emergency care through continuing education, research, and public education. We appreciate the opportunity to provide comments to you on this important initiative.

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For nearly 10 years, the SGR formula and resulting fee schedule reductions have negatively affected emergency physicians disproportionately. While physicians in other types of practice can limit their financial losses in ways considerably more subtle than dropping participation in the Medicare program, emergency physicians continue to see everyone who comes to the emergency department, regardless of their ability to pay. As you know, the unfunded EMTALA mandate has now been in place for nearly 25 years, creating such financial strains on hospitals in certain areas that ERs and sometimes entire hospitals (e.g. Los Angeles, New York City) have closed. This has occurred several hundred times in the past several years, in spite of hospitals receiving positive annual update payments and disproportionate share payments to compensate for low income and uninsured patients. For emergency physicians, there is no offset payment for uncompensated care. In a recent study that CMS used for the 2009 Medicare Physician Fee Schedule, uncompensated care for emergency physicians was estimated at $139,000 per physician per year. As part of its consideration of changes to the funding formula for physician payments, we urge Congress to fund the EMTALA mandate.

We believe that Congress must take into consideration the unique form of care provided by emergency physicians. Emergency physicians provide care 24 hours per day, 7 days a week. They are medical specialists who are prepared to care for every type of medical emergency—and do so in a high risk environment--often with little or no information about their patients. Emergency physicians treat patients of all ages and incomes. According to the American Medical Association, emergency physicians provide four to 10 times as much charity care as any other physician specialist. For these reasons, we do not believe any new payment methodologies should penalize emergency physicians who may readmit sick patients.

Unlike other medical providers, emergency physicians never turn patients away. The health reform law (PPACA) will greatly expand insurance coverage starting in 2014, and many of the provisions in the law are designed to shift patients to primary care physicians who will coordinate their care. This is a laudable goal, but current demand for primary care already outstrips the supply. The volume of emergency visits is showing no signs of

diminishing. Even in states like Massachusetts where 97 percent of the population has coverage, ER visits continue to grow. According to the Centers for Disease Control and Prevention (CDC), emergency visits in 2008 grew to 124 million, the highest level ever reported. In addition, we believe that when the estimated 16 million individuals are added to Medicaid, the volume of ER visits will sharply increase as the supply and willingness of physicians in the community to add more low paying Medicaid patients to their practices falls short. A recent Center for Disease Control report shows that the percentage of emergency patients seeking care for nonurgent medical conditions dropped to less than 8 percent (in 2007) and has been dropping since 2005 when it was 13.9 percent. The CDC defines "nonurgent" as "needing care in 2-24 hours." With the anticipated increase in demand for medical services from highly trained physicians and other professionals, it is imperative that the Sustainable Growth Rate (SGR) formula be repealed. The formula is fundamentally flawed in that it fails to take into consideration the cost of caring for Medicare beneficiaries, a cost that has outstripped the gross domestic product (GDP). Additionally, the measure used to determine target spending is based on 1997 projections and fails to recognize, as previously discussed, the level of uncompensated care many physicians, emergency physicians in particular, bear in the current system.

On more than 12 separate occasions, Congress has acted to prevent dramatic cuts from being imposed under the SGR formula. But those interventions, added to one another, have cost nearly $300 billion without addressing the underlying problem. With a projected reduction of 29.5 percent due in January, 2012, there can be no alternative but to repeal the SGR.

We encourage the Committee and Congress to carefully assess the many models currently being demonstrated or piloted in Medicare and in the private sector. As well, a thorough analysis of the many quality initiatives now being implemented, and those called for in the Affordable Care Act, should reveal the promise of savings from higher quality care. A period of stability in physician payments is critical to those savings and the longevity of the Medicare program.

Congress can take demonstrable steps to help reduce health care costs. According to the PricewaterhouseCoopers Health Research Institute, the top three areas of waste in the health care system are (1) defensive medicine (estimated at $210 billion annually), (2) inefficient claims processing (up to $210 billion annually), and (3) care spent on preventable conditions related to obesity ($200 billion annually). Clearly, medical liability reform and the establishment of health courts would help cut costs by reducing the amount of defensive medicine practiced by emergency physicians and other physicians treating patients in emergency departments.

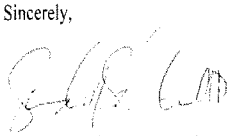
As the Committee addresses these issues, we encourage the Committee to recognize the value of care provided in emergency departments and to avoid misconceptions about the "cost of unnecessary care" provided in "inefficient emergency rooms." According to U.S. government statistics, emergency care represents less than 2 percent (1.9 percent) of the $2.4 trillion spent on health care.

Emergency physicians and their departments are essential to the nation's health care delivery system. They are truly America's health care safety net. A stable and fair reimbursement system, combined with reasoned system reforms, can help us meet the rising demand for care just as new innovations and solutions unfold. Health information technology (HIT) is a critical piece of the transition to coordinated care in communities.

Care coordination between primary care physicians, hospitals and emergency departments can only be effective if a meaningful electronic health record adopted by all providers is implemented in the near term.

We look forward to working with the Committee on Energy and Commerce as it addresses the flawed SGR formula.

Sincerely,



Sandra Schneider, MD, FACEP
President

CC: Rep. Henry Waxman (CA)
Rep. Joe Barton (TX)
Rep. John Dingell (MI)
Rep. Joseph Pitts (PA)
Rep. Frank Pallone, Jr. (NJ)
Rep. Michael Burgess (TX)

House Energy and Commerce Committee Members

April 26, 2011

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Joe Barton
Chairman Emeritus
Energy and Commerce Committee
U.S. House of Representatives
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The Honorable John Dingell
Chairman Emeritus
Energy and Commerce Committee
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The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
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The Honorable Frank Pallone, Jr.
Ranking Member
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Michael C. Burgess
Vice Chairman
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Upton and Pitts, Chairs Emeritus Barton and Dingell, Ranking Members Waxman and Pallone and Dr. Burgess:

On behalf of the 130,000 internal medicine specialist and medical student members of the American College of Physicians (ACP), I wish to express my deep appreciation for your bipartisan request for ideas on how to move to a new Medicare payment system that reduces spending, pays physicians fairly, and pays for services according to their value to the patient. ACP is the largest medical specialty society and second largest physician membership organization in the United States, representing internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults and medical students who are

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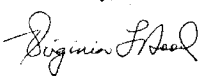
considering a career in internal medicine. As you requested, attached is the College's proposal for stabilizing, improving, and innovating Medicare payment policies leading to broad adoption of new value-based payment models.

We propose a two-stage process. During the first stage, Medicare would stabilize and improve payments under the current Medicare fee schedule for the next five years by eliminating the sustainable growth rate (SGR) as a factor in establishing annual updates and by ensuring higher payments and protection from budget neutrality cuts for undervalued evaluation and management services. Also, during this stage, physicians who voluntarily participate in specific, designated Physician Payment Innovation Initiatives—including Patient-Centered Medical Homes, Accountable Care Organizations, and other models that meet suggested criteria for value to patients—could qualify for appropriately higher payments. Then, during stage 2, physicians would be given a set timetable to transition their practices to the models that Congress and the Department of Health & Human Services (HHS) has determined to be most effective based on experience with the payment initiatives evaluated during stage 1, leading to permanent replacements to the existing Medicare payment system. A distinguishing feature of the ACP proposal is that 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 College looks forward to continued discussion on how our ideas might be incorporated into legislation that meets the Energy and Commerce Committee's bipartisan objective "to begin the process of developing a long-term solution" instead of "the unwanted choice of extending a fundamentally broken payment system or jeopardizing access to care for Medicare beneficiaries."

Yours truly,



Virginia Hood, MBBS, MPH, FACP
President

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April 29, 2011

The Honorable Fred Upton,
Chairman
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Henry Waxman
Ranking Member
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Upton and Ranking Member Waxman:

The American College of Rheumatology representing over 5500 rheumatologists appreciates the Energy & Commerce Committee's bipartisan effort to repeal the current Medicare sustainable growth rate formula and determine a new physician payment system.

Rheumatologists are specialists who provide expert care to over 7 million adults and children in the US who have chronic, complex rheumatic and musculoskeletal conditions such as rheumatoid arthritis, psoriatic arthritis, lupus, and ankylosing spondylitis Rheumatologists are a unique specialty of physicians that perform "detective work" by conversing at length with patients seen previously (and treated unsuccessfully) by a number of other physicians, and reviewing voluminous charts to make a correct diagnosis. It is significant to note that unlike other internal medicine subspecialists, rheumatologists do not perform invasive procedures regularly and visit the hospital rarely.

Given the types of diseases we treat, and the adults and children who rely on our specialized care, rheumatologists do not fit into common payment molds. The ACR appreciates the opportunity to provide suggestions on physician payment reform.

Discard the Flawed SGR Formula
Everyone agrees the flawed SGR formula must be repealed. The flawed formula forces physicians to worry year after year how they will be reimbursed. The retroactive "fixes" in 2010, although appreciated, forced rheumatologists to endure interruption in revenue, causing financial instability in the office and disruption in patient care. The SGR causes economic turmoil in the health care system and is tremendously detrimental to Medicare patients' access to care given its instability. Rather than belabor the point, the ACR is in agreement that the formula should be discarded for other payment mechanisms.

Create 5-year Transition Stability Plan
Stability, both for physicians and for beneficiaries, is essential as Congress determines the next steps in the physician payment system. Since modifications to the physician payment system will not happen immediately, Congress should consider establishing a set term of five years with incremental increases each year as new payment options are piloted, adjusted, and implemented. This will give physicians and beneficiaries much-needed confidence that physicians will be available for care, and will be reimbursed for their care.

Balance the Payment System
During the five year transition, Congress should appropriately balance the currently skewed reimbursement model between proceduralists (physicians that perform procedures) and cognitive

specialists (physicians that primarily perform evaluation and management services.) Not only does the current system devalue spending time with a patient – a crucial 'cognitive procedure' in a field like rheumatology – it establishes considerable pay inequities among physicians. The repercussions of these policies result in fewer numbers of young physicians going into such specialties, and patients unable to access proper, effective care. Inevitably the delay in proper diagnosis and treatment results in needless suffering among patients and increased health care costs.

Evaluation and Management Services

Face-to-face time spent with a patient to make a diagnosis is referred to as evaluation and management. Prior to 2010, physician specialists were reimbursed for a consultation service. A consultation is when one physician has requested the education and experience of another physician to see the patient and review the chart to determine a diagnosis. The elimination of consultation codes in 2010, combined with inadequate payment for high level E&M consultative services, sent a strong message that CMS fails to recognize the advanced training and expertise in "cognitive specialty" care. Congress should require CMS to reinstate consultation codes to ensure specialists are appropriately recognized for advanced training and expertise, and that patients with complex chronic conditions have access to specialty physicians.

The Accountable Care Act made a step in the right direction when it provided primary care physicians with a 10% bonus in recognition of the current unbalanced system. Unfortunately, the "fix" only helped a single group of physicians who perform significant evaluation and management services. Rheumatologists, neurologists, infectious disease physicians, endocrinologists, and other physicians also spend significant time performing evaluation and management services. Congress should provide an increase to all physicians that spend a majority of their time performing crucial evaluation and management services.

A concept discussed a few years ago is deserving of reconsideration today. The target system, which would establish five separate targets for various procedures, could potentially create a more level field if designed with appropriate safeguards in place. With any new model, one concern is that it's new and untested. Additionally, smaller specialties are concerned larger specialties with more lobbying power could increase their reimbursement target at the expense of other specialties. However, this concept should not be abandoned without further discussion.

Multiple Models

Numerous payment models have been suggested throughout the years. A constant refrain, though, is that some of the models work for some physicians, but no model works for all physicians. Accountable care organization regulations were recently released, and require a base of 5000 beneficiaries with primary care physicians being central in the ACO. Rheumatologists are both curious and concerned about ACOs. ACOs are set-up to encourage physicians to find ways to reduce costs while providing quality care. Rheumatologists treat patients with chronic debilitating diseases and use expensive biologic medication treatments to stop disease progression. We are concerned that ACOs may shun rheumatologists and rheumatology patients because of the expensive treatment options. At the same time, requesting or requiring rheumatologists join ACOs could reduce the availability throughout the US, requiring patients to drive longer distances to see a qualified rheumatologist. While rheumatologists are as interested as other physicians in reducing costs while providing quality care, rural and underserved community providers cannot abandon their patients.

Patient centered medical homes have been discussed in great detail both through the ACA and through the press. Rheumatologists agree that patients should be the center of all care, and that physicians be

responsible for coordinating care. However, rheumatologists went to school to diagnose and treat patients for rheumatic diseases. Rheumatologists do not want to be responsible for monitoring if patients have done routine preventative examinations and immunizations. Primary care specialties have been working on a neighbor concept to the home but reimbursement models have not been released. The PCMH is limited in utility beyond the primary care physicians and until an appropriate reimbursement model is provided for specialists that need to fill out additional paperwork without the benefit of consultation reimbursement, the model seems prone to failure.

Another concept is bundled payments for specific diseases or conditions. We understand the concept, but are concerned how it could be implemented. Patients with multiple diseases see a variety of specialists, and the diagnostic bundled code would need to be split among the physicians in a fair and equitable manner. If patients live in one place and see the same physician, perhaps one fee could be paid on an established length of time, but it's not clear how a bundled payment system would work for Americans who regularly move or switch physicians. For rheumatologists, it's also difficult to understand how they would be reimbursed for patients with complex chronic diseases such as rheumatoid arthritis. For example, at the beginning of diagnosis or during a flare the patient may be seen frequently, but may go a few months without seeing a physician when the disease is well-controlled. Conceptually a bundled payment system seems worth pursuing, but realistically, it is hard to envision how a bundled payment would work except for a small number of beneficiaries.

Moving Forward

The flawed SGR formula should be eliminated and new payment reform options implemented. These options need to take into account the diverse set of physician specialties and practices, and one model will not fit all. Payment reform must acknowledge the work performed by cognitive specialists to ensure the patients receive optimum care by trained specialists. This can only happen by ensuring appropriate balanced reimbursement to cognitive specialists so that medical students will feel comfortable choosing careers based on talent and interest rather than income potential.

The ACR is intrigued by the Centers for Medicare and Medicaid Innovation dedicated to support innovative payment and delivery models. We are currently working on developing options for cognitive specialists such as rheumatologists. Therefore, the five-year transition period would be appreciated.

Payment reform is a complicated mission and it's challenging to satisfy all physician sectors. We commend the Energy & Commerce Committee's dedication to develop a more stable, fair and appropriate system that will ensure patients have access to necessary care.

The ACR welcomes the opportunity to be a resource on the complexity of our specialty and our patients' conditions. Please feel free to contact Aiken Hackett, ACR director of government affairs at ahackett@rheumatology.org or (404) 929 4811 for additional information.

Sincerely,

David Borenstein, MD
President
American College of Rheumatology

American College of Surgeons

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April 28, 2011

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Upton:

On behalf of the more than 75,000 members of the American College of Surgeons (ACS), I am writing in response to your letter dated March 28, 2011 requesting suggestions for developing a long-term solution to the Medicare physician payment system. The ACS appreciates the Committee's recognition that the sustainable growth rate (SGR) is a failed system for calculating Medicare reimbursement for physician services and strongly supports the effort to find more innovative models of physician payment.

The current payment system for Medicare is unsustainable for patients, physicians, and for our health care system as a whole. The first step towards reforming it must be to immediately eliminate the SGR and include a realistic budget baseline for future Medicare payment updates, which accurately reflects the anticipated costs of providing physicians with positive updates under a new update system in lieu of SGR-related cuts, into the federal budget. Following the elimination of the SGR, we believe it is essential to provide a transition period of up to five years that would allow for the testing, development and future implementation of a wide range of alternative payment models aimed at improving quality and improving the integration of care.

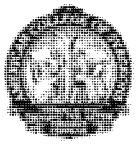
During the transition period, we propose that Congress replace the SGR with a system of separate service category growth rates (SCGR) that recognizes the unique nature of the various types of services that physicians provide to their patients, while providing additional dollars for primary care. Unlike the SGR, which bases reimbursement on the overall spending on all physician services, the SCGR would establish a system that determines reimbursement based on the spending and volume growth among like services. ACS believes that the SCGR would have distinct advantages as a transition model to more innovative reforms. First of all, it recognizes that all physician services are not alike, and lower growth services, such as primary care and surgery, would no longer simply be subject to the blunt cuts of the SGR. Second, under the SCGR, efforts to promote specific services, such as primary care, would be greatly simplified, and the proposal would promote increased payments for primary care without requiring corresponding Medicare cuts for other services. Most importantly, the SCGR would support efforts to promote improved quality and better value by recognizing that these goals will look different and will be achieved in different ways for different services. Also, as various payment models are tested, the SCGR could enable Congress and CMS to study and better understand how these physician quality improvement efforts affect spending for hospitals, skilled nursing, home health and other service areas in the Medicare program.

The ACS strongly believes that a new delivery system must focus on promoting quality care, improving patient access, and, ultimately, reducing cost. A partnership among patients, physicians, hospitals, and payers is essential to develop a successful delivery system. The testing, development, and future implementation of a wide-range of alternative payment models such as accountable care organizations (ACOs) and the bundling of payments for care received from various providers for a particular condition over a set period of time is critical to reaching these goals. We believe that in order for any alternative payment model to be successful, they should achieve the following:

- Ensure that quality and safety are the highest priorities for patient care;
- Require that specific quality metrics are achieved before any savings can be shared among any payers or providers;
- Align payment models with proven quality improvement programs;
- Account appropriately for risk factors and variability that may impact cost of care or treatment, including age, health status, and other factors;
- Maintain primacy of physician-leadership within a highly qualified team of health care professionals to work with patients in determining evidence-based courses of clinical care;
- Acknowledge that surgical care is delivered in a variety of geographical locations and facilities and that innovative responses may be required to address patient needs in urgent or unique situations;
- Preserve the ability of a surgeon to recommend the surgical treatment plan that best meets the patient's needs as guided by best practices and evidence-based medicine;
- Ensure clearly-defined mechanisms for appropriate distribution of shared risk and savings among patients, physicians, and health care team members.

The ACS is currently analyzing the role of surgery in bundled payments. The primary goal of bundled payment is to improve the quality and coordination of patient care through the alignment of financial incentives of surgeons and hospitals. One approach to bundled payment combines the payments of surgeons and hospitals for a defined episode of inpatient surgery into one single fee. Instead of being paid for each visit or procedure, surgeons and hospitals would be paid for all services provided to a patient related to a particular condition, depending on how the episode is structured. In order for a bundled payment model to be successful, certain safeguards must be included. The quality of patient care must be ensured and physicians must be involved in decisions about how and to who bundled payments are distributed. The ACS is supportive of efforts to coordinate patient care, improve quality and reduce adverse events. We view bundled payment as a potential opportunity to further these goals.

Finally, and most importantly, the ACS strongly believes that improving quality 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. The ACS has proven physician-led models of care, such as the National Surgical Quality Improvement Program (NSQIP) that measure and improves quality, increase the value of health care services and reduce costs.



The Honorable Fred Upton
April 28, 2011
Page 3

The ACS is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment and we appreciate your dedication to the challenges facing America's physicians and the patients that our members serve. The ACS looks forward to working with you to find a meaningful and sustainable solution to Medicare's current payment system that improves the quality and value of the care our physicians provide.

Sincerely,

L.D. Britt, MD, MPH, FACS
President, American College of Surgeons

ACOG
THE AMERICAN CONGRESS
OF OBSTETRICIANS
AND GYNECOLOGISTS

Office of the President
Richard N. Waldman, MD, FACOG
770 James St.
Syracuse, NY 13203-2117

April 28, 2011

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Mr. Chairman:

Thank you for the opportunity to provide you with guidance on needed reforms to the Medicare physician payment system. We very much appreciate your leadership and acknowledgement that the Medicare Sustainable Growth Rate (SGR) formula has long outlived its usefulness. We pledge to do everything we can to work with you to develop a better system that will ensure Medicare beneficiaries speedy access to high quality needed care. As part of the transition to a new payment system, it is imperative that Congress act this year to permanently repeal the SGR.

92% of ob-gyns participate in the Medicare program and 63% accept all Medicare patients, reflective of ob-gyn training and commitment to serve as lifelong principal care physicians for women, including women with disabilities. 56% of all Medicare beneficiaries are women. With the baby boomer generation transitioning to Medicare and primary care physician shortages, it is likely that ob-gyns will become more involved in delivering health care for this population. Medicare physician payments matter to ob-gyns beyond the Medicare program, too, as TRICARE and private payers often follow Medicare payment and coverage policies. Clearly, we all have much at stake in ensuring a stable Medicare system for years to come, starting with an improved physician payment system.

We urge you to ensure that a better system adheres to the following six principles:

1) The global ob-gyn package Medicare currently uses to reimburse for physician services works well, and may be a model for global payment options for care provided by other physician types. The global obstetric care payment includes the 10 months of care, from the first antepartum visit through the final post-delivery office visit. Global payments allow the provider to manage costs and care for a patient's course of treatment, rather for a patient's individual encounters with the physician. **We encourage you to retain the global approach that currently exists for ob-gyn care and to consider extending this approach to other specialties.**

2) **Medicare payments should fairly and accurately reflect the cost of care.** In the final 2011 Medicare physician fee schedule, CMS is proposing to reduce the physician work value for ob-gyn care to women by 11% below what is paid to other physicians for similar men's services - exactly the opposite of what should be done to encourage good care coordination and in direct contradiction to recommendations by the Resource Based Relative Value Scale Update Committee (RUC). Medicare payments to obstetricians are already well below the cost of maternity care; no further cuts should be allowed for this care.

In this area, we urge you to:

- **deny CMS' proposal to overrule the RUC recommendation**
- **continue to rely on review and recommendations by the RUC, and**
- **ensure that a new payment system fairly and accurately reimburses physicians for the cost of care.**

3) **A new payment system should be as simple, coordinated, and transparent as possible, and recognize that there is no one-size-fits-all model.** A new Medicare system should coordinate closely with non-governmental and other-governmental programs, to ensure information technology is interoperable, that quality measurement relies on high-quality, risk-adjusted data, and to guard against new and special systems that apply to only one program or may only be workable for one type of specialty or only certain types of diseases and conditions. Ob-gyns often see relatively few Medicare patients, and unique Medicare requirements can pose significant administrative challenges and inefficiencies to ob-gyn participation.

4) **Congress should remove barriers to, and in fact encourage, ob-gyn and physician development of ACOs, medical homes for women, and other innovative care models.** The current proposed rules on the Medicare Share Savings Program allowing for expedited antitrust review should be extended to ACOs and other physician-led models of care that do not participate in the Medicare Shared Savings Program. These models should also recognize the dual role ob-gyns may play, both as primary care providers and specialty care providers.

5) **Congress should repeal the Independent Medicare Payment Advisory Board (IPAB).** We recognize the importance of improving the value of health care. However, the IPAB is not a suitable mechanism to achieve this goal. Leaving Medicare payment decisions in the hands of an unelected, unaccountable body with minimal congressional oversight will negatively affect timely access to quality health care. The arbitrary reduction of Medicare physician payments would undermine the progress of testing and implementing more innovative care delivery and payment systems.

6) **We urge Congress to enact meaningful liability reform such as that in H.R. 5, the HEALTH Act, or alternatives such as health care courts and early disclosure and compensation offers.** The Congressional Budget Office (CBO) has recognized the steep cost of our current liability system in scoring approximately $40 billion in savings from comprehensive medical liability reform. The current system for compensating injured patients drives defensive medicine practices in health care and increases health care costs.

Thank you again for your leadership and for your interest in reaching out to ACOG and others in the physician community. We appreciate the opportunity to work with you to address this major issue. We share your commitment to the Medicare program and stand ready to assist you in every way we can. Please contact me or ACOG Government Relations Manager Nevena Minor at nminor@acog.org or 202-314-2322, if we can be of any assistance.

Sincerely,

Richard N. Waldman, MD, FACOG
President

cc:

The Honorable Henry Waxman
The Honorable Joe Barton
The Honorable John Dingell
The Honorable Joe Pitts
The Honorable Frank Pallone
The Honorable Michael Burgess, MD

THE AMERICAN GERIATRICS SOCIETY

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JENNIE CHIN HANSEN
Chief Executive Officer

April 25, 2011

The Honorable Frederick Upton
Chairman, Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

The Honorable Henry Waxman
Ranking Member, Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

The Honorable Joe Barton
Chairman Emeritus, Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

The Honorable John Dingell
Chairman Emeritus, Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 2051S

The Honorable Joseph Pitts
Chairman, Energy and Commerce Health Subcommittee
United States House of Representatives
Washington, D.C. 20515

The Honorable Frank Pallone, Jr.
Ranking Member, Energy and Commerce Health Subcommittee
United States House of Representatives
Washington, D.C. 20515

The Honorable Michael Burgess
Vice Chairman, Energy and Commerce Health Subcommittee
United States House of Representatives
Washington, D.C. 20515

RE: American Geriatrics Society Recommendations on SGR Reform

Dear Sirs:

On behalf of the 6,000 multidisciplinary geriatrics health professionals that comprise the American Geriatrics Society (AGS), we thank you for the opportunity to submit our comments and recommendations regarding a new payment framework that will replace the unworkable Sustainable Growth Rate (SGR) system.

AGS members are the geriatricians and other health professionals specializing in the care of the elderly, including advanced practice nurses and physician assistants, who are responsible for furnishing and directing care for our nation's growing number of elderly patients with multiple and complex conditions. The population of Americans aged 65 and older is expected to nearly double, to more than 70 million, by 2030. Of added significance is the phenomenal growth of the population of adults aged 85 and over. This segment is growing at four times the rate of the rest of the population and encounters greater overall disability, as well as need for medical and other support services. In fact, frail elders and those with multiple chronic conditions account for the highest percent of Medicare expenditures.

We believe it is imperative that a new payment system recognizes that these frail elderly with multiple conditions are the patients who will benefit the most from transformation of Medicare into a patient-centered system focused on primary geriatric care, chronic care management and coordination of care across settings.

A new payment framework should incorporate the following principles:

- Define "sustainable growth" in terms of total health care expenditures.
- Support and properly value primary care services, geriatrics expertise and care coordination.
- Replace volume-based payment structure with a value-based payment model that rewards quality and takes into account differences in the complexity of patients' health care needs.
- Use payment mechanisms to promote optimal use of clinicians and support staff, promote the efficacy of care transitions between settings and reduce preventable hospital readmissions.
- Establish stable and predictable updates that accurately reflect increases in provider expenses.

Background

The current Medicare program with its "siloed" payment systems, has contributed to fragmented care delivery, resulting in health care that is provider-centric, not patient-centric.

The SGR formula relies upon national spending patterns across many different provider types. It creates a budget with accountability enforced by updates, yet completely fails to create or foster organizational capacity to manage expenditures. The current system has incentivized increasing the volume of care rather than improving outcomes. If anything, the SGR rewards excessive utilization as providers seek to take what they can before cuts are imposed. But the imposition of penalties is indiscriminate with respect to current efficiency.

It also significantly under-pays primary care physicians, especially geriatricians, because it does not take into account the needs of older adults with multiple illnesses or the cost of providing coordinated patient-centric care. In June 2008, the Medicare Payment Advisory Commission (MedPAC) noted that nonprocedural "evaluation and management (E&M) services - the hallmark of primary care - are undervalued, potentially creating an imbalance relative to procedurally-based services." This disproportionately affects geriatrics health care professionals -- physicians, advanced practice nurses, and physician assistants alike -- because the vast majority of their patients are Medicare beneficiaries. According to the report, 65% of geriatricians' payments are derived from nonprocedural primary care services, and this percentage was the highest among all primary care specialties.

Also, MedPAC recently assessed the current physician payment system and the current SGR formula for updating payments annually (which penalizes all physicians when aggregate spending exceeds a spending target in a given year) and determined that the current system does not differentiate by provider. While the SGR formula was designed to constrain growth, MedPAC described it as "strictly budgetary" with no tools for improving quality or efficiency, such as care coordination. Certainly, some growth is necessary and to be expected; but Congress should consider approaches to change the current system in order to constrain the growth of health care costs to a level that is fundamentally sound from

an economic standpoint. Such an approach (or potentially multiple approaches) should consider total costs of health care (*e.g.*, including lost productivity for caregivers) and not just the costs associated with health care delivery.

A new payment system needs to fully recognize the importance of geriatrics in the care of the sickest Medicare patients - the patients who cost the system the most money. The kind of high-quality care provided by geriatricians and the interdisciplinary geriatrics care team requires that Medicare changes how it pays for services. We need innovative models for financing care that pays for value, not volume. These innovative models should create systems that incent and provide coordinated, patient-centered care -- the kind of care which is most likely to result in savings or, at minimum, reduced growth. This means properly compensating geriatricians and other geriatrics health professionals for the type of care provided and for the value added by improving functional outcomes and reducing the number of hospitalizations and unnecessary tests and procedures that are performed on patients. It also means increasing Medicare's investment in the development of performance standards, metrics and measurement methodologies as well as establishing additional incentives to use electronic health records and data collection tools.

Also, without a focus on the importance of geriatric care, younger physicians will continue to pursue training in more financially rewarding interventional medical specialties rather than in geriatric medicine. This could further exacerbate the fragmentation of care and increase health care costs that could be avoided, or at least mitigated, through the type of care provided by health professionals with skills and training to meet the needs of older, frail adults. Our nation already faces a shortage of geriatrics health professionals across disciplines. For example, in 2010, there were 7,029 certified geriatricians -- one geriatrician for every 2,699 Americans 75 or older. Due to the projected increase in the number of older Americans, this ratio is expected to drop to one geriatrician for every 5,549 older Americans in 2030 unless the payment system is reformed to correct long-standing payment inequities for primary care services delivered by geriatrics providers and other primary care professionals.

Recommendations for Payment Reform

We recommend a process involving steps that will achieve comprehensive payment reform that reduces costs, pays providers fairly, and rewards value and quality care delivered to Medicare beneficiaries. While the SGR must be repealed and permanently replaced with a new payment model, such fundamental reform may not be feasible before the end of 2011.

The first objective should be to stabilize current payment for the short-term so as to ensure continued physician participation in Medicare. In the long term, we believe that the system should provide options (in the most expeditious manner) for providers to voluntarily choose to be paid under other newly created payment systems. This will support migration away from the physician-fee-schedule by clinicians. The transition could be done in a way that reduces total spending while actually increasing reimbursement to physicians who provide high quality cost effective care in these other payment systems.

Short-Term: Concrete Steps to Phase Out the SGR

If Congress must adopt an interim approach, it should be one that begins the transition by modifying the current physician payment formula as a prelude to replacing it with a permanent solution. In the short-term, improvements in primary care payments are needed (1) to stabilize the current payment environment under the SGR; and (2) to attract and retain primary care clinicians.

As a first step toward value based purchasing, and to concurrently identify how money is being spent on physician services, we propose considering replacing the single update for all physicians with separate updates for different types of services and or specialties. Congress could consider establishing five separate updates for: (1) evaluation and management (*i.e.*, office visit) services furnished by primary care and geriatrics physicians; (2) evaluation and management services furnished by other specialties; (3) diagnostic/imaging services; (4) minor surgical services; and (5) major surgical services, each with a different conversion factor based on utilization, growth and other factors.

Based on past analysis, it is likely that primary care/geriatrics services would receive higher annual updates than diagnostic or imaging services. Such a system would create incentives for primary care and geriatrics providers in the short term, and the existence of five "pools of money" would facilitate the migration of physicians away from the current payment system. This would allow Congress to accurately score the cost of that migration because it could allow an accurate reduction of the money in each pool as physicians begin to provide services under other payment systems while also identifying the savings provided by that migration. We believe it is likely that this approach will reduce the "cost" of eliminating the SGR system because the dollars being moved would be vastly more cost-effective in the other systems and those savings could be recognized.

During this time period, the primary care provider bonus for primary care clinicians should remain in place, or be extended for a number of years past its current 2015 expiration date. An extension would help create a more stable environment and provide an incentive for new physicians, advanced practice nurses and physician assistants to enter and stay in primary care, including geriatrics. Moreover, creation of a specific pool and update for primary care evaluation and management services will allow the continuation of the 10% primary care bonus beyond 2015 in a targeted, cost effective way because it will be easy to define both the services and providers who are eligible for the bonus.

We understand that creating a system with separate updates and conversion factors is a complex undertaking. In developing a new or revised system to begin transitioning away from the current SGR system, it is important that the old formula is not replaced with a similar flawed formula. Significant and meaningful discussion will have to take place regarding spending targets and growth rate formulas to ensure that the goals of promoting primary care, inclusive of geriatrics, are achieved. Again, these are complex issues that will require a great deal of serious thought and discussion.

Long-Term

At the same time that Congress establishes short-term revisions to the SGR system, it should further facilitate the phase-out of the physician-fee-schedule by enacting new payment systems into which physicians and other providers could opt in a budget neutral way with respect to the current fee schedule (*i.e.*, as physicians migrate to other payment systems, money is moved from the physician-fee-schedule into the new systems).

These new payment systems could include bundled payment (*e.g.*, for all items and services furnished over defined episodes of care); partial, risk adjusted capitation; and shared savings options. All options would incent care coordination and the provision of high quality, evidence-based medical care. This would mean higher payments for providers, including physicians and hospitals, that furnish the most effective and efficient care. Under the direction of Congress, the Centers for Medicare & Medicaid Services (CMS) has tested and even begun implementing some of these concepts, such as bundling, gainsharing, medical homes, and beginning in January of 2012, accountable care organizations (ACOs). The new Center for Medicare and Medicaid Innovation will soon begin testing a variety of new and

innovative health care delivery and payment models that promote care coordination and cost efficiency, which, if successful, could swiftly be expanded to the broader Medicare program. Additionally, Congress could enact new programs or direct CMS to test other promising models.

The challenge will be to define sustainable growth in a way that is economically feasible and promotes high quality care. Importantly, while physician services make up a relatively small portion of total health care costs, physicians (and other professionals) direct or influence a greater portion of costs by admitting patients to the hospital, writing prescriptions, ordering services, *etc.* In the long-term, physician payment should recognize this and provide incentives for managing high quality, cost-effective, well-coordinated patient care.

The biggest question is not what needs to be done, but how best to get there. As an organization that represents health care professionals who specialize in the care of the oldest and most frail members of society, we understand the complex issues that face Congress as it works to reform SGR. We are ready to work closely with Congress on specific approaches that can be implemented now and in the future to improve health care payment and delivery, and to make the growth of health care spending sustainable over the long-term.

We look forward to working with you. Please do not hesitate to contact Alanna Goldstein, Assistant Director of Public Affairs and Advocacy, at agoldstein@americangeriatrics.org or 212-308-1414, should you have any additional questions.

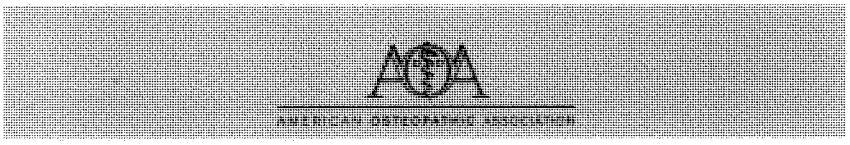
Best Regards,

Sharon A. Brangman, MD

Jennie Chin Hansen

Sharon A. Brangman, MD
President

Jennie Chin Hansen, RN, MS, FAAN
Chief Executive Officer



1090 Vermont Avenue NW, Suite 510, Washington D.C. 20005 ☎ 202 414.0140 | 800 962 9008

April 28, 2011

The Honorable Fred Upton
Chairman
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Henry Waxman
Ranking Member
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Joseph Pitts
Chairman, Subcommittee on Health
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member, Subcommittee on Health
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Upton and Pitts and Ranking Members Waxman and Pallone:

On behalf of the American Osteopathic Association (AOA) and the more than 70,000 osteopathic physicians we represent, thank you for the opportunity to submit comments on policies that would establish an equitable payment methodology for physicians participating in the Medicare program. The AOA appreciates the Committee's recognition that current Medicare physician payment models are inconsistent with the delivery of coordinated, quality, and efficient health care. In fact, the current payment models advance fragmentation in delivery and is prohibitive to the establishment of coordinated delivery models.

We applaud your bipartisan and thoughtful approach to seeking and analyzing proposals that will move us away from the challenges of the past decade and toward a Medicare payment system that promotes the highest levels of access, quality, and efficiency. Most importantly, the AOA supports the creation and implementation of a payment system that focuses on Medicare patients and promotes delivery models that enhance their overall care and experience in the Medicare program. While we firmly believe that all physicians and other health care providers strive, each day to provide the highest quality care to Medicare beneficiaries, the current payment model has created an environment that is unsustainable and inequitable. Additionally, it contributes to increasing access issues for millions of beneficiaries.

The AOA recognizes that health care is provided effectively in a variety of settings by dedicated physicians. In our opinion, the current philosophy of using a single payment model for all services is not appropriate. We approached your request from the point-of-view that we first should determine what are the most appropriate delivery models that can be used in the Medicare program and then develop payment models that promote selected delivery models. These delivery models should foster innovation and secure higher quality outcomes for beneficiaries, while being fiscally responsible to the Medicare program as a whole. We do not believe every physician should be

subject to the same payment model. Instead, we propose the use of a variety of payment models that are acutely focused on the various types of care and the settings in which care is provided.

Additionally, we believe that Medicare must be evaluated as a comprehensive health care program, not a collection of four distinct programs. As designed, Medicare is a fragmented program with four individual benefits. This fragmentation ignores the impact each individual component has on the others and limits our ability to analyze how changes or improvements in one area of the program impact others. Specifically, we believe that it is important that the barriers between Parts A and B be terminated. The flow of health care dollars should not be limited to individual segments of the program. In fact, we believe that the removal of barriers between Parts A & B is one of the most important steps Congress can and should take when establishing new delivery and payment models.

The AOA does not believe we should pursue legislation that "fixes" or extends the use of the sustainable growth rate (SGR) in the Medicare program on a permanent basis. It is our opinion that this policy is severely flawed and inequitable. Furthermore, we believe it further advances fragmentation in our health care system. The AOA believes that we should transition to new payment models that advance and support proven delivery models and provide a more consistent and equitable payment structure for physicians. However, a rapid transition away from the current payment methodology potentially creates confusion for physicians and patients, thus compounding growing access to care issues in the program. Since a number of existing policies are closely aligned with the current Medicare payment formula, an immediate transition to a new payment model would undermine the investment made in these important programs. These programs include the Physician Quality Reporting System, the Electronic Health Records Incentive program, the Electronic Prescribing program, and the primary care and general surgery bonus payment programs, among others. Immediate implementation of a new payment formula would jeopardize the success of these programs and the financial incentives they provide for participating physicians. Based upon these concerns we are proposing a three-phase approach that is built around a period of stability and innovation, transitioning to new payment models within the next decade.

Phase I – Stability

The sustainable growth rate (SGR) should be terminated as a factor in establishing annual payment updates and the annual conversion factor (CF), in statute effective December 31, 2015. We believe it is imperative that Congress establish a clear termination date for the SGR. Failure to define a termination date of the SGR will impede the identification and adoption of new delivery and payment models, further promulgating our current challenges for years to come.

During the time period between January 1, 2012 and December 31, 2015, all physicians participating in the Medicare program should be protected against reductions in their annual payment rates and ideally receive annual payment updates equal to increases in practice costs. We suggest that the annual payment update for evaluation and management (E&M) services be set at 2% per year for the time period 2012-2015. The payment update for all non-E&M services should be set at 1% during the same time period.

To further accelerate growth in primary care specialties, we recommend that any increases in the Relative Value Units (RVUs) for E&M services not be subject to budget neutrality requirements. In addition, we urge the Centers for Medicare and Medicaid Services (CMS) to work closely with the American Medical Association's (AMA) Relative Value Update Committee (RUC) to identify potentially misvalued and overvalued codes, with an emphasis on increasing payment rates for E&M services. While recommendations have been made by MedPAC and others that CMS establish an independent panel of experts to assist in this effort, we believe that the current expertise of the RUC is better positioned to make these necessary changes. If the RUC, in the opinion of Congress and CMS, fails to accept and meet this recommendation over the next 4 years, then the AOA would support the establishment of an independent expert panel.

Additionally, all existing incentive payment programs such as the primary care and general surgery bonus, electronic health records, physician quality reporting system, and others should continue through December 31, 2015. We also recommend that the "work GPCI" be made 1.0 for all localities during this transition period.

Phase II – Innovation and New Payment Models

The AOA encourages Congress to work with multiple entities, including physician organizations and practices, to identify, develop, and test new payment models during the 2012-2015 time period. The AOA is a strong supporter of the Center for Medicare and Medicaid Innovation (CMMI), which was established as part of the Patient Protection and Affordable Care Act (Public Law 111-148). The CMMI is authorized to develop and test innovative delivery and payment models in the Medicare program. More importantly, the CMMI is unencumbered by the historic budget neutrality provisions that have hampered past Medicare demonstrations and pilots. Instead, the CMMI has new resources at its disposal that can be used to test and evaluate new models of care and supporting payment models in a manner that allows for a thorough evaluation of their impact on the Medicare program – not just Part B services. The CMMI is a key component to identifying new delivery and payment models that will allow the Medicare program to move away from its current fragmented models towards a more integrated and coordinated health care system. We urge the Committee and Congress to support the CMMI and work with them to identify and test new delivery and payment models.

Additionally, we recommend that Congress seek the expert opinions of the Medicare Payment Advisory Commission (MedPAC). Over the past decade, MedPAC has put forth numerous recommendations on how the Medicare program could improve care delivery, payment of services, and quality. The AOA appreciates the expertise offered by MedPAC and believes that they should be a vital part of our efforts moving forward.

Finally, we believe that the input and recommendations of physicians and their professional organizations are essential to our collective efforts. Physician organizations have enormous resources and expertise available and are a key component in the collection of information from practicing physicians on the impact of various proposed and implemented policies.

Our recommendations on new delivery payment models that should be studied include the following:

Patient-Centered Medical Home

The AOA believes that a health care delivery system with a sound foundation in primary care is best positioned to meet our joint goals of increasing the quality of care provided to beneficiaries and better aligning resources. Numerous studies have demonstrated that continuous and comprehensive primary care increases the quality of care and reduces Medicare costs through reductions in hospitalizations and readmissions to hospitals. Based upon these findings, the AOA proposes the broad and immediate implementation of the patient-centered medical home in the Medicare program.

To further promote continuous and comprehensive primary care services, the AOA believes that the current primary care incentive program should be made permanent and, beginning January 1, 2016, be allocated in a manner that promotes the wide-spread adoption of the patient-centered medical home. To accomplish this, we propose that all primary care practices recognized at the top level by current patient-centered medical home recognition programs be eligible for a PCMH care management payment equal to 20 percent of the physician's allowable primary care Medicare charges. Practices recognized as patient-centered medical homes at any level should be eligible for a payment equal to 10 percent of their allowable primary care Medicare charges. We believe that the definition of "allowable primary care Medicare charges" for the PCMH payment be based upon criteria established in the Affordable Care Act for the purposes of the primary care bonus.

To support this, we recommend two payment models, either of which in our opinion will provide the foundation for its implementation.

PCMH Payment Option 1 – Blended Payments

The AOA proposes the establishment of a blended payment model for primary care practices. This payment model would be based on a new methodology that incorporates all Medicare Part B historical spending on a per beneficiary basis, with the appropriate annual risk-adjustments that incorporates beneficiary characteristics that contribute to increases in annual spending. Primary care practices would be eligible for the PCMH care management payments as outlined above.

PCMH Payment Option 2 – Global Payments

The AOA proposes the establishment of a global payment model for primary care practices. This payment model would be based on a new methodology that incorporates all Medicare Parts A and B historical spending on a per beneficiary basis, with appropriate annual risk-adjustments that incorporate beneficiary characteristics that contribute to increases in annual spending. To protect against any suggestions that there are incentives to withhold care as a means of meeting the benchmark, only practices that are recognized as patient-centered medical homes would be eligible to participate in the global payment model and would receive the 20% PCMH care management payment.

Beneficiary Assignment to Primary Care Practices

While we appreciate and support a beneficiary's ability to seek and receive care based upon their individual needs, we believe that the lack of shared-responsibility between beneficiaries and the Medicare program advances fragmentation in delivery and drives utilization. To address this issue, we propose that all Medicare beneficiaries, beginning in 2016, be required to identify a primary care physician. Eligible primary care physicians would be DOs or MDs with a primary practice designation of family medicine, internal medicine, pediatrics, or geriatrics. To support this new policy, we propose that the current cost-sharing arrangements be adjusted to promote this policy recommendation. Consistent with our previous recommendation that Medicare Parts A & B be blended, we would welcome proposals that would create a combined premium and co-pay. The AOA is receptive to provisions that would allow certain beneficiaries to claim two primary care physicians based upon the fact that beneficiaries often reside in two primary localities over the course of a year.

Accountable Care Organizations

The AOA believes that Congress should support the continued evolution of accountable care organizations (ACOs). While we have significant concerns with the rules and regulations under development, we strongly support the concept of integrated delivery models as a means of improving the quality and efficiency of health care. We recommend that ACOs be better designed to allow for the virtual versus contractual alignment of physician practices as a means of achieving integration.

Bundled Payments for Non-Primary Care Ambulatory Services

The AOA recognizes that a large percentage of health care services provided to Medicare beneficiaries are provided by non-primary care physicians in an ambulatory setting. We also recognize that many of these services are episodic in nature and are not conducive to a global payment. In fact, these services are more conducive to the current fee-for-service payment structure. However, we do believe that a bundled payment for such services is achievable. To this end we propose that a bundled payment model for all non-primary care ambulatory services be established and studied. We further recommend that this payment be "all-inclusive" so that fragmentation of services and payments are eliminated.

Bundled Payments for Physician Services Provided in Hospital or Institutional Settings

The AOA proposes the establishment of a bundled payment model for acute-care physician services provided in hospital or other institutional settings. This payment would reflect both the costs

associated with physician and institutional services. We recommend that the payment flow through the physician.

Private Contracting for Beneficiaries and Physicians
The AOA recognizes that all physicians are not willing to accept new payment models, but may wish to retain their ability to provide services to Medicare beneficiaries. We support the creation of policies that allow all physicians to privately contract with Medicare beneficiaries for health care services.

Imaging Services
The value of imaging services to beneficiaries and the Medicare program are well documented. However, the payment structure for such services has been a source of continuous policy debates over the past decade. We urge the development of clear and sustainable coverage and payment policies that promote access to imaging services. Any future coverage and payment policies should promote quality and be based on appropriateness criteria established by physician organizations, but not restrict access to imaging services. Specifically, we do not support coverage and payment policies for imaging services that would limit the ability of all physicians, as appropriate and justified by clinical guidelines, to provide such services to their patients in a timely manner.

Laboratory Benefit
Currently, the laboratory fee schedule is the only Medicare benefit that has a payment structure independent of a beneficiary cost-sharing arrangement. For this reason we propose the establishment of a defined laboratory benefit that includes a beneficiary cost-sharing arrangement as suggested by the Congressional Budget Office (CBO) and others.

Education and Training
One of the keys to fostering the adoption of new delivery and payment models is ensuring that future generations of physicians have the appropriate training experiences. We urge Congress and CMS to use their inherent ability as the primary financer of graduate medical education to promote new delivery models, specifically those focused on primary care, through the GME system. All too often, the experiences garnered during the training years will influence the practice style of a physician throughout their career. To better prepare the next generation of physicians, we believe modifications in the GME system are warranted.

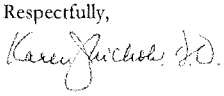
Phase III – Implementation of New Payment Models

Starting January 1, 2016, physicians and physician practices would be eligible to select from a list of payment models based on the needs of their patients and practice setting. Physicians participating in innovative delivery and payment models during the years 2012-2015 would retain their ability to opt-out of one model for another, free of penalty. Beginning in 2016, all physicians would be required to select a new payment model suitable for their practice specialty and location.

The AOA recognizes that not all physicians are positioned to participate in new payment models, or may simply oppose doing so based upon specific factors for their practice or career. Regardless of reason, we do not believe that prohibiting physicians from participating in the Medicare program based upon their reluctance to participate in new payment models is justified. In fact, we feel that this would be counterproductive and further exacerbate access to care issues for beneficiaries. We propose that the current fee-for-service (FFS) system be maintained for 10 years – 2016 to 2026 – and that payments be gradually reduced by 1% per year as a means of encouraging transitions to new delivery and payment models. After 2026, physicians would no longer have the option of participating in the FFS payment system and would be required to enter into a new payment model as a means of participating in the Medicare program.

The AOA and our members appreciate the opportunity to share these thoughts, views, and recommendations with the Committee. Again, we applaud your thoughtful and bipartisan approach to addressing this critical issue and stand ready to work with you, collectively, to identify and implement new delivery and payment models that promote quality and efficient care for all patients.

Respectfully,



Karen J. Nichols, DO
President

C: The Honorable John Boehner, Speaker
The Honorable Eric Cantor, Majority Leader
The Honorable Nancy Pelosi, Minority Leader
The Honorable Kevin McCarthy, Majority Whip
The Honorable Steny Hoyer, Minority Whip
Members, Energy & Commerce Committee
Members, Ways & Means Committee

April 30, 2011

The Honorable Fred Upton, Chairman
Congress of the United States
House of Representatives
Committee on Energy and Commerce
2155 Rayburn House Office Building
Washington DC 20515-6115

The Honorable Henry A. Waxman, Ranking Member
Congress of the United States
House of Representatives
Committee on Energy and Commerce
2155 Rayburn House Office Building
Washington DC 20515-6115

Dear Chairman Upton and Ranking Member Waxman:

On behalf of the American Physical Therapy Association (APTA) and its 78,000 members, I want to thank you for the opportunity to provide our perspective on reforming payment under the Medicare physician fee schedule. APTA appreciates your bipartisan effort to address this issue in 2011. Physical therapists are significantly impacted by the Medicare Physician Fee Schedule and its payment policies. In 2008, outpatient therapy services under Medicare Part B resulted in $4.8 billion (2.6%) in program expenditures for services provided to 4.5 million beneficiaries (10.5%) at an average per patient cost of $1,057. Outpatient physical therapy (PT) services accounted for 73.5% of the outpatient therapy expenditures followed by occupational therapy (OT) services at 19.5% and speech language pathology (SLP) services at 7.0%. Specifically, outpatient physical therapy services accounted for almost $3.5 billion in program expenditures for services provided to 3.9 million beneficiaries at an average cost of $884 per patient.

Physical therapists provide critical health care services to beneficiaries under Medicare Part B to assist individuals remain in their homes, communities and society at their highest potential functional level. The Medicare Physician Fee Schedule is used in claims to report outpatient physical therapy services and therefore, physical therapists are acutely aware of the pending 29% reduction, the cost to repeal this flawed sustainable growth rate (SGR) formula and its impact on beneficiaries' access to health care providers.

APTA believes a strong Medicare Part B program is essential to provide cost-effective, accessible and high quality health care to our nation's seniors and individuals with disabilities. The payment policies established under the Medicare program dramatically impact payment policies established by private payers, Medicaid, workers compensation, and others payers. The opportunity to address these fundamental policy problems under Medicare Part B is vital to move towards a sustainable delivery system that is supported by sound payment policies.

APTA would like to focus its comments on three areas of potential reforms for the Energy and Commerce Committee to consider in its reform of payment policies under the Medicare physician fee schedule.

A) Replacement of the Sustainable Growth Rate with an annual index of health care inflation. APTA believes that off-setting the cost of repealing the SGR should be done through reforms to payment policies under the Medicare program that ensure high quality health care is delivered by professionals licensed and qualified to provide those services thereby reducing fraud and abuse. APTA would welcome the opportunity to provide the Committee with a list of policies it believes would strengthen Medicare Part B and provide savings towards the cost of repealing of the SGR. APTA strongly supports the expansion of quality reporting, value based purchasing, and use of electronic medical records under Medicare Part B as part of this reform. APTA requests the Committee consider policy changes needed to ensure that all providers that are eligible in the statute to participate in quality reporting can do so. Currently, only physical therapists in private practice (PTPPs) can participate in the Physician Quality Reporting System due to issues with the claims form for other Part B settings in which physical therapists practice, such as rehabilitation agencies and skilled nursing facilities. In addition, APTA would encourage the expansion of the Medicare and Medicaid incentive program for the adoption of health information technologies that meet the meaningful use criteria to all eligible Medicare Part B providers and suppliers. Improving quality of care while also decreasing costs will require participation by all providers, including broad adoption of health information technology. Expansion of the health information technology incentive program to include other qualified health providers would facilitate the goals of health care reform to improve quality. As it exists, the capacity is limited in its ability to provide a truly integrated system across critical transitions of care across providers and settings.

B) Repeal of the therapy cap on outpatient physical therapy services. Similar to the SGR policy, the therapy caps were authorized as part of the Balanced Budget Act of 1997. Since their scheduled implementation date of January 1, 1999, Congress has intervened numerous times to place a moratorium on therapy caps or, since 2005, extended a broad-based exceptions process. The therapy caps were designed to be a temporary measure until the Centers for Medicare and Medicaid Services (CMS) provided an alternative payment methodology for therapy services for Congress' consideration. Without significant development in this alternative, APTA proposes that Congress extend a limited exceptions process for 2012, 2013, and 2014 and instruct the Centers for Medicare and Medicaid Services to develop a per visit payment system for outpatient therapy services that controls the growth of therapy utilization for implementation by January 1, 2015. Limiting the exceptions process is only meant to provide some temporary reductions in spending while providing a bridge to a long-term solution. APTA has begun work to provide a reformed payment system for outpatient physical

therapy services that could be implemented as early as 2014 and stands ready to work with the Committee to solve this issue in the 112th Congress.

C) Policies that would improve the integrity of services paid for by the Medicare program. Currently under Medicare Part B there are various ways to bill for services. We believe that in regards to physical therapy services, modification to the Stark II in-office ancillary services exception to the self-referral law as well as changes to "incident to" billing could provide potential cost-savings and improve the integrity of the services delivered and paid for by the Medicare program. Specifically, APTA recommends the elimination of physical therapy services from the in-office ancillary services exception to the physician self referral law and reforms to the incident to requirements for physical therapy services. The Office of the Inspector General of the United States Department of Health and Human Services has continued to identify a high rate (78% to 93%) of inappropriate billing of physical therapy services billed incident to a physician's professional services. Elimination of these practices must be addressed in an effort to provide a sustainable payment system for providers that serve the Medicare Part B program and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

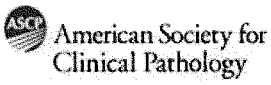
Thank you for your attention to this pressing health and payment policy issue under the Medicare Part B program. APTA stands ready to assist the committee and is happy to provide more specifics on the three areas of reform listed above including legislative language for your consideration. Please feel free to contact Justin Moore at 703-706-3172 or justinmoore@apta.org with any questions or if you need additional information.

Sincerely,

R. Scott Ward, PT, PhD

RSW:jdm

Cc: The Honorable Joe Barton, Chairman Emeritus
The Honorable John D. Dingell, Chairman Emeritus
The Honorable Joseph R. Pitts, Chairman, Subcommittee on Health
The Honorable Frank Pallone, Jr., Subcommittee on Health
The Honorable Michael C. Burgess, Vice Chairman, Subcommittee on Health



American Society for Clinical Pathology

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April 29, 2011

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Mr. Chairman:

The American Society for Clinical Pathology (ASCP) is pleased to respond to the Committee on Energy and Commerce's bipartisan letter of March 28, 2011 regarding ideas on how to reform the physician payment system. ASCP is committed to working with the Congress and the Administration to move to a system that enhances patient care and simultaneously reduces spending, and pays providers fairly.

ASCP acknowledges the Committee's sustained efforts to address the short-term and long-term physician payment predicament, most recently the Committee's bipartisan effort last December to prevent the 25 percent cut under the current sustainable growth rate (SGR) formula under Medicare from taking effect for one year, thereby allowing the necessary time to work on this complex issue.

This letter endorses many ideas of organized medicine as outlined by the American Medical Association and other specialty societies and also addresses the issue of **closing various loopholes associated with physician self-referral which costs Medicare enormous sums of money with no benefit to patient care.**

ASCP endorses the following ideas in reforming the physician payment system:

- repeal the SGR;
- implement a five-year period of stable payments;
- transition to an array of new payment models such as ACO's, etc.; and
- amend title XVIII of the Social Security Act to protect taxpayers, Medicare beneficiaries and the Medicare program from abusive self-referral arrangements.

Repeal the Flawed SGR Formula under Medicare

The SGR formula, as adopted in 1997, was intended to function by reducing Medicare Part B payment updates to offset the growth in utilization of physician services exceeding gross domestic product (GDP) growth. Under the formula actual growth in spending on physician services is compared to a cumulative target growth rate linked to GDP, using 1996 as the base year. When actual growth exceeds the cumulative target, payment updates are reduced and will be less than practice cost growth. Unfortunately, this formula is fundamentally flawed for a

whole variety of reasons including the fact that the growth in the cost of caring for Medicare beneficiaries has historically grown faster than the GDP due to technological advances in care, an aging population, expansion of the Medicare program and other factors.

ASCP agrees with the AMA that it was not appropriate for policymakers in 1997 to define what health care spending should be in 2011 or any other year. Additionally, the concept of a global target affecting the actions of individual physicians is flawed in that there is no individual incentive to reduce spending.

The Committee and its distinguished members know the history of Congressional intervention with the SGR well. Since 2002, the SGR formula has annually required reductions in Medicare reimbursements. Payments were cut by 5 percent for 2002. ASCP very much appreciates the fact that Congress has intervened on 12 separate occasions since then to prevent additional cuts from being imposed. We also are well aware that the current Congress is challenged by the prospect of even steeper cuts to the physician payment system.

Unfortunately the 10-year cost of a long-term solution has grown from about $48 billion in 2005 to nearly $300 billion today, and physician payments are scheduled to be cut by 29.5 percent on January 1, 2012, and those cuts continue for many years to come.

To permanently reform the physician payment system ASCP believes it is necessary to repeal the SGR. Medical technology, Medicare coverage and benefits, and the cost of running a medical practice have all changed drastically since 1996 yet the SGR has failed to adequately recognize those changes. Repeal of the SGR would also provide stability to patients covered by other payers that tie their rates to Medicare including military members, their families, and retirees in TRICARE, retired Federal employees, and those enrolled in state Medicaid programs.

Period of Stable Payments

The fiscal uncertainty caused by the SGR and the pending cuts to physician payment have caused disruptions within our health care system that are unnecessary. ASCP agrees with organized medicine that for the period 2012-2016, physicians be provided with a positive Medicare physician payment updates that keep pace with the growth in medical practice costs. ASCP agrees with the following language adopted from the American Medical Association's letter to the committee:

Providing statutory updates for five years will provide predictability and fiscal stability for physician practices at a time in which they will also be making significant investments in health information technology and quality improvement initiatives. A replacement for the SGR should not be another one-size-fits-all formula. Rather, replacing the SGR should involve transitioning to a new generation of payment models that reward physicians and hospitals for keeping patients healthy, managing chronic conditions in a way that avoids hospitalizations, and, when acute care episodes occur, delivering high quality care with efficient use of resources. We envision physicians choosing from a menu of payment models, selecting those that best address their patients' needs, specialty, practice type, capabilities and community. We believe that statutory

payment updates for five years will allow time for demonstrations and pilots of new Medicare and private sector payment models to take place. During this time, evidence should be available on how to properly structure and implement those models with the most promise, while addressing issues such as risk adjustment and attribution. We believe this process should be dynamic, enabling physicians to transition into those models as they become available.

Further, we believe this period will provide Congress the opportunity to act on legislation to create a new Medicare physician payment system that incorporates those models by September 30, 2015. The bill establishing five years of statutory updates could include provisions requiring congressional action by such date and provide for congressional "fast-track" procedures to ensure consideration of such legislation. The Centers for Medicare and Medicaid Services (CMS) would begin implementation of the new payment system, adopted by Congress, through the proposed and final 2016 Medicare Physician Payment Rule, which would become effective on January 1, 2017.

Transition to New Models of Care Coordination

ASCP believes that the administrative and clinical structures of Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs) hold a great amount of promise to the future of medicine. ACOs and PCMHs are two of the many health care reforms contained in the Patient Protection and Affordable Coverage Act (PPACA). Both of these models for the delivery of patient care are relatively new to the realm of health policy. These models appear to present a fresh opportunity to improve patient care, control patient health care costs, and improve the patient care experience for Medicare and Medicaid beneficiaries.

The ASCP believes that to improve costs savings, quality of care, and the patient care experience these patient care delivery models should fully utilize and incorporate into their administrative structure pathologists and advanced certified laboratory professionals to identify inappropriate, unnecessary, and/or duplicative testing. These efforts should be recognized by ACOs and PCMHs when allocating shared savings and/other financial incentives/benefits. To improve and document quality, these models should utilize nationally-recognized quality measures—but should not penalize physician specialties when adequate specialty-specific metrics are absent—and should allow ACOs and PCMHs to use or develop other quality indicators to reflect the quality of services provided. Moreover, Medicare laws should be strengthened to prevent physician self referral and other schemes that result in the overutilization of physician-provided medical services.

There are also a number of other pilots and demonstrations that are expected over the next several years. This diversity is important because there is no one-size-fits-all payment model that will achieve physicians' and policymakers' objectives for improved care and affordability. These pilot projects are an important means for policymakers and physicians to learn how new models work, how best to structure them, their savings potential, the capabilities practices need to be able to implement these changes, and which models work best for different specialties, communities and practice types before more widespread application.

Additionally, it is important to test transitional approaches to reform that will give physicians sufficient time and resources to develop the infrastructure and care management capabilities that will be needed to succeed under a different payment system.

Amend Title XVIII of the Social Security Act

Physician group practices are increasingly providing additional medical services designed to take advantage of the Stark law's in-office ancillary services (IOAS) loophole. Not surprisingly, study after study is showing that these self referral medical services are increasing costs, not just due to the cost of initial medical service also for those related downstream medical services, many of which may also be self referred.

ASCP believes that removing advanced diagnostic imaging, anatomic pathology, physical therapy and radiation therapy from the Stark law' IOAS exception, while preserving the ability of robust, integrated multi-specialty group practices to offer these services, would help offset the cost of repealing the sustainable growth rate formula.

Georgetown University Economist Jean Mitchell has estimated that Medicare costs could be reduced by approximately 25% if self-referral was eliminated or better monitored. Not only would removing these services help reduce Medicare costs, such an initiative could also be used to promote the formation of accountable care organizations, integrated delivery systems, and other health care delivery models that can better coordinate or reduce the cost of patient care. This could be accomplished by amending title XVIII of the Social Security Act.

Conclusion

While replacing the SGR is critical, it must be done correctly. ASCP believes this proposed framework, and timeline, are critical to developing the evidence-base necessary to ensure a reformed Medicare physician payment system meets our mutual goal of improving the Medicare program while ensuring beneficiaries' continued access to care.

ASCP looks forward to continuing to work with members of Congress on both sides of the aisle on repealing the SGR and transitioning to a system that incorporates new payment models designed to enhance care coordination, quality, appropriateness and cost. Again, thank you for the opportunity to provide comments on replacing the SGR with a sustainable payment system.

Sincerely,

John E. Tomaszewski, MD, FASCP
President, ASCP

cc: House Energy and Commerce Committee Members

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***Gastrointestinal Endoscopy* - Editor**
GLENN M. EISEN, MD, MPH, FASGE
Portland, Oregon

Executive Director
PATRICIA V. BLAKE, CAE
Oak Brook, Illinois

April 27, 2011

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Upton and Ranking Member Waxman:

On behalf of the American Society for Gastrointestinal Endoscopy (ASGE), I thank you for seeking input and ideas from the physician community on how to reform the Medicare physician payment formula. The ASGE is an 11,000-member, professional medical society whose mission is to advance patient care and digestive health by promoting excellence in gastrointestinal endoscopy.

I understand that you are requesting ideas and suggestions in a form that can be translated into legislative proposals. ASGE is pleased that the committee will be holding a hearing on the topic of physician payment in the near future and hopes it will yield a productive dialogue on feasible solutions. Because reforming the Medicare physician payment system is of great importance to ASGE's physician members, we offer you the following principles that we hope the committee will use as guideposts as it considers reform options.

Repeal of the SGR is Necessary
Each year that repeal of the sustainable growth rate (SGR) formula is postponed, the cost of repealing the SGR formula grows. In 2002, the SGR required an almost 5 percent reduction in physician fees, which Congress allowed to take effect. When a further cut was dictated in 2003, Congress overrode the cut with a small fee increase, establishing a precedent of congressional intervention to prevent cuts in physician payments every year since 2003. Each time that it has acted, Congress has specified that future updates should be calculated as if it had not acted. As a result, physicians face a 29 percent cut in reimbursement on Jan. 1, 2012. While ASGE physicians are deeply appreciative of past actions by Congress to prevent fee cuts, Congress should act this year to prevent the 29 percent cut and to abandon the SGR as it works to identify and implement a new approach(s) for paying physicians.

Stabilize Physician Payments
Frustration with the current SGR system is mounting among physicians. It is unacceptable that physicians were subjected to five short-term spending measures in 2010 and that on three occasions, Congress failed to act before cuts were implemented, causing disruptions in Medicare claims processing. Physicians and their patients deserve a predictable payment system. ASGE believes that repeal of the SGR should be accompanied by at least a five-year period of Medicare payment stability for physicians. During this period, physicians should receive positive payment updates. A sustained period of payment stability will allow physicians to make the proper investments in staff resources and technologies, including electronic health records, so they can prepare and transition to a new payment system.

Furthermore, and most importantly, this period of stability will allow the evidence to grow on new models of payment and care delivery before widespread implementation of a new payment system(s). The hope has always been that Congress would repeal the SGR and replace it with a new system(s). However, as discussed at a recent Medicare Payment Advisory Commission (MedPAC) meeting, there is the issue of mismatched timelines. As expressed by MedPAC Chairman Glen Hackbarth, time has run out on the SGR, yet the care delivery system needs to change and reorganize before receiving new payment mechanisms.

Additionally, ASGE asks that the committee refrain from instituting a more ambitious target for holding Medicare cost growth for the purpose of achieving offsetting savings through the Independent Payment Advisory Board (IPAB). In the Congressional Budget Office's (CBO) March 2011 10-year budget baseline, the rate of growth in Medicare spending per beneficiary is projected to remain below the levels at which the IPAB will be required to intervene to reduce Medicare spending.

Fund Innovation
ASGE believes that the $10 billion allocated under the Patient Protection and Affordable Care Act (ACA) to test and evaluate different payment structures and care delivery models should be preserved. ASGE hopes that as the Center for Medicare and Medicaid Innovation considers funding opportunities, it will place a priority on testing innovative physician payment models, including those related to payment bundling and payment capitation.

Specialty Care Must be Recognized and Appropriately Reimbursed
Payment reform and reorganized health care delivery must recognize the value that specialty physicians contribute to the health and well-being of Medicare patients. We do not dispute that primary care services should be appropriately valued, thereby providing incentives for future generations of medical students to pursue the primary care field. However, recent actions by CMS and Congress imply that the services provided by specialty physicians are over-valued. In addition to small or flat payment updates, physician specialists have experienced payment reductions with the loss of consultation codes while imaging payments have been cut drastically. ASGE believes that high-volume services are being arbitrarily targeted for payment reductions. We believe that perverse incentives in the Medicare system that reward for volume rather than value should be eliminated, and we support the accurate pricing of services. However, we oppose blunt-ax approaches that have been used in the past to curb high-volume services. These punitive, cost-cutting tactics may achieve short-term savings goals, but ignore the long-term impact on physicians and the health care system overall. One just needs to look at trends in hospital-owned physician practices as evidence. We hope that the committee will continue to seek the input of physician specialists and that any reformed system acknowledges the important contributions of physician specialists to the health care delivery system.

Physician Payments should be Value-Based
It is well recognized that one of the fundamental problems with the SGR is that it only rewards the provision of more services and more complicated services. This structural flaw has contributed significantly to scheduled payment reductions. ASGE believes that the SGR should be replaced with a system that aligns payment with quality and value.

The physician community has made tremendous progress over the past five years in the creation and adoption of quality metrics. Last year, ASGE and the American College of Gastroenterology launched the GI Quality Improvement Consortium (GIQuIC). GIQuIC designs, develops and utilizes various measurements of the endoscopic techniques of practicing gastroenterologists. This benchmarking initiative began with the collection of quality indicators for colonoscopy. GIQuIC has plans to launch modules to collect quality indicators for esophagogastroduodenoscopy, endoscopic retrograde cholangiopancreatography, and endoscopic ultrasonography. The clinical data being collected will provide a practical, objective method to grade performance of the most common endoscopic procedures, and it is our goal that the data will be used for clinical outcomes research, as well as for public and private payer quality improvement and payment initiatives.

ASGE believes that the ongoing work of CMS to implement the Resource Use Reporting Program and gradual transition to a value-based purchasing program for physicians will serve to inform payment and organizational redesign. We ask that Congress support policies that will continue to encourage organizations like ASGE to develop tools for physicians that will facilitate the delivery of the right care, for every patient, every time.

Offsets for Repealing the SGR Must Come from Outside Medicare
ASGE recognizes the enormous cost that is associated with repealing the SGR; however, we urge Congress to look outside the Medicare program for necessary offsets. ASGE would like to draw to your attention the following statement made by Mr. Hackbarth at the April 7, 2011 MedPAC meeting:

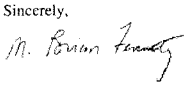
"I don't think there are, within the Medicare program, offsets for a $300 billion-plus budget score over 10 years, particularly on the heels of significant legislative changes [that] have happened as part of PPACA that cumulatively over 10 years are scored at $500 billion plus savings. So we would be talking about $300-plus billion beyond the $500 billion in PPACA, and I don't know where that kind of money is going to come from in Medicare."

Now is the Time for Real Reform

ASGE appreciates the opportunity to provide its views on reforming the Medicare physician payment system. We deeply appreciate your recognition that the current SGR system is a threat to the integrity of the Medicare program and to the ability of seniors to access needed health care services in a timely manner. We agree with you that the practice of short-term "fixes" to the SGR problem are not an appropriate solution and that the SGR should be replaced with a system that pays providers fairly and based on value, while reducing spending.

I thank you for your leadership on this important topic, and I hope that you will include ASGE in your ongoing physician payment reform dialogue. Please direct any questions and future communications to Camille Bonta, ASGE's Washington representative, at cbonta@summithealthconsulting.com or (202) 320-3658.

Sincerely,



M. Brian Fennerty, MD, FASGE
President

American Society of
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April 29, 2011

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Upton:

On behalf of the 46,000 physician members of the American Society of Anesthesiologists (ASA), I am writing to respond to your recent letter seeking suggestions and ideas to reform Medicare Part B payments to physicians.

As Congress and the country grapple with complex issues relating to the deficit and national spending priorities, including potential entitlement program reform, there are calls for and statutory provisions seeking to drive governmental payment for medical services even lower. This is especially ironic for anesthesiologists, long recognized as the leaders in patient safety, but unfairly paid through Medicare at the lowest rate among all health professionals at only 33 cents on the dollar, as compared to private payment rates.

Indeed, the current application of the Medicare sustainable growth rate (SGR) formula fails to distinguish high volume growth services, whether necessary or not, from medical services such as anesthesiology that are not contributing to the growth of the program. To this point, graphics in studies from the Congressional Budget Office (Dec 2008 CBO Report: Budget Options Vol 1: Health Care) show Medicare anesthesia cumulative spending decreasing and below the neutral line. Yet, as SGR reductions are calculated each year, anesthesiology is targeted with the same percentage cuts as all other eligible Part B professionals.

Moving forward, ASA supports reform and elimination of the onerous SGR formula, but if this is not fiscally possible, the unacceptably low Medicare payments to anesthesiology need to be exempt from SGR calculations or "held harmless." Our members are not driving volume or growth in Medicare spending to any significant degree, and, in fact, anesthesiology Medicare payments appear to be declining as a portion of the overall Medicare pie.

To make matters worse, starting in 2014, the non-elected Independent Payment Advisory Board (IPAB) created by the Patient Protection and Affordable Care Act will have unprecedented and sweeping powers to mandate added across-the-board or other targeted reductions in Part B payments on top of SGR cuts. ASA supports the bipartisan bill, H.R. 452, "Medicare Decisions Accountability Act of 2011," to repeal IPAB.

Given all of the above, unless the disparate quality and value-based purchasing requirements of the new health reform law are integrated and rationalized, anesthesiology Medicare payment could collapse and endanger safe access to care for millions of Americans. Innovative pilot program approaches to care delivery, such as the newly conceived perioperative or "surgical home" concept hold great promise to help hold down overall hospital costs and coordinate and improve quality care related to surgery. Anesthesiologists are the common medical denominator across surgical cases, and their unique training makes them natural team leaders in such an approach, just as primary care physicians now are doing through the medical home. Attached for your information, review and future discussion is an emerging ASA white paper for a "surgical home" demonstration project. We look forward to discussing it with you and the Committee in the near future.

Thank you for the opportunity to add ASA's voice to the many, many stakeholders calling for full SGR reform, repeal of IPAB and supporting innovative payment reforms. We trust that the "Surgical Home" concept will soon emerge in the form of innovative demonstration projects to advance needed reform, quality and care coordination, as well as achieved cost-savings.

Sincerely,

Mark A. Warner, MD

President
American Society of Anesthesiologists

Enclosure

April 29, 2011

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Joe Barton
Chairman Emeritus
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable John Dingell
Chairman Emeritus
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Michael C. Burgess
Vice Chairman
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Upton and Pitts, Chairs Emeritus Barton and Dingell, Ranking Members Waxman and Pallone and Dr. Burgess:

On behalf of the American Society of Cataract and Refractive Surgery (ASCRS), an international, educational, and scientific organization whose nearly 10,000 member ophthalmologists specialize in cataract and refractive surgery, I am pleased to respond to the Energy and Commerce Committee's bi-partisan request for input regarding the reform of the flawed Medicare physician payment system. I also want to express our thanks to you and the members of the committee for your continued commitment to comprehensive Medicare payment reform that provides fair and equitable reimbursement and ensures continued access to specialty care.

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Flawed Sustainable Growth Rate (SGR) Formula

As you are aware, the continued failure to provide a permanent solution to the flawed Sustainable Growth Rate (SGR) formula has resulted in years of temporary, short-term fixes that have exacerbated both the magnitude of the future pending reductions and the cost for replacing the system, in addition to jeopardizing access to medical care for our nation's elderly and disabled. As a result, physicians are now facing a 29.5% reduction in Medicare physician reimbursement effective January 1, 2012, with additional cuts pending despite the fact that Medicare reimbursement rates are already well below market rates. These deep cuts jeopardize the viability of many physicians' businesses and imperil Medicare beneficiaries' access to specialty care.

Last year, Congress was required to act five times to pass short-term reprieves to stop the cuts that were pending in 2010. In fact, some of those last-minute, temporary "fixes" occurred after cuts had already taken effect, which caused disruptions and instability in physician practices. Therefore, it is imperative that the system be repealed this year and replaced with a stable mechanism for updating Medicare physician payment fees to ensure continued beneficiary access to high-quality care and also to allow Medicare and the health-care system to move forward with important system delivery reform. In addition, while acknowledging the importance of ensuring the financial integrity of Medicare into the future, ASCRS believes that physician payment reform should recognize reasonable inflationary cost increases that lead to fair reimbursement for the services provided to Medicare beneficiaries. We also believe that any new system has to be flexible and recognize the myriad differences in physician practice type and size, including geographic location.

Clearly Defined Transition Period Based on Statutory Updates

ASCRS also urges the Congress to incorporate a clearly defined transition period to a new Medicare physician payment system that would provide a period of statutory updates that keep pace with the growth in practice costs while new payment models are being tested. This would provide the stability that is needed so physicians can make decisions about investments in their practices to improve the quality and efficiency of care they provide to Medicare beneficiaries.

Additional Policy Recommendations

Alternative Payment Options That Preserve Patient Choice

ASCRS strongly believes that Congress should empower patients to obtain medical services from the physician of their choice by adopting additional Medicare payment options in conjunction with a new physician payment system. As you are aware, under the current system, physicians must opt-out of Medicare for two years if they enter into a private contract with a patient. In addition, Medicare does not reimburse the patient. Under a new proposal, the "Medicare Patient Empowerment Act," a payment option would be established for patients and physicians to freely contract, without penalty, for Medicare fee-for-service services, while allowing Medicare beneficiaries to use their Medicare benefits and allowing physicians to bill the patient for all amounts not covered by Medicare.

This approach would provide patients with more choice of physicians, increase the number of physicians who will continue to accept Medicare patients, and help preserve the Medicare program.

Multiple Target Growth Rates

ASCRS has consistently supported the establishment of multiple target growth rates for Medicare Part B services as an alternative to the current unsustainable SGR formula, which is based on a national target. As you are aware, there are great variations in the volume increase across the various service categories, yet all are subjected to the same target and subsequent adjustments in reimbursement. Variations of this alternative have been included in several previous legislative proposals to address the Medicare physician payment crisis. We, therefore, urge Congress to, once again, consider this as part of a transition to a new payment system.

Repeal of the Independent Payment Advisory Board (IPAB)

ASCRS strongly opposes IPAB or any other board resulting in an inappropriate delegation of the oversight responsibilities of Congress and urges its repeal. Congress should retain proper oversight of the process that determines how services are provided under Medicare and not relegate it to another entity. If the goal of a new Advisory Board is to find new ways to eliminate spending in the Medicare program, the end result may well be detrimental to patient care for Medicare beneficiaries. With the establishment of this body, we are also concerned that care and services for Medicare beneficiaries will be rationed to cut costs without examining the clinical need and efficacy of treatments. Medicare reimbursement rates are already well below market rates for similar services, and it will likely get worse. The IPAB solution will arbitrarily ratchet down provider reimbursement, without sufficient oversight and without care taken to ensure that Medicare beneficiaries continue to receive the quality health care they need and deserve. Further, the Board does not have full authority over all aspects of the health-care system, but rather is required to selectively exempt certain providers from its purview – placing more pressure to cut Medicare in those areas under its jurisdiction – such as physician payment. We agree that we need to improve the Medicare program to make it sustainable well into the future; however, it cannot be "fixed" when we do not look at the entire program. Further, we do not support allowing important health-care decisions to be made by individuals with little or no clinical expertise, resources, or the oversight required to ensure that beneficiaries are not placed in jeopardy.

Improving the Quality of Patient Care

ASCRS supports efforts to improve the quality and effectiveness of health care for all Americans, and we are actively engaged in quality improvement efforts. We are involved in the process of developing evidence-based and clinically relevant quality measures and have established a joint data registry with the American Academy of Ophthalmology. We support positive incentives that assist specialty physicians with piloting, and eventually adopting, new workflows and technologies that will enable them to provide the highest quality and most

appropriate care for patients. However, we oppose financial penalties or untenable deadlines that do not promote, but rather hinder, our ability to improve quality.

Therefore, we urge the Congress to work with us to improve the quality of care for the patients we serve by preventing the implementation of the budget-neutral, value-based purchasing section of the Affordable Care Act before all the related demonstrations and accompanying reports have been completed. In addition, we believe that physicians who do not participate in the Physician Quality Reporting Initiative (PQRS) should not face financial penalties for failing to do so. We strongly believe that physician quality reporting should continue to be a voluntary, nonpunitive process.

Health Information Technology (HIT)

We urge Congress to amend the current HIT timelines that were included in the American Recovery and Reinvestment Act of 2009. Many specialty physicians will not be able to take advantage of the enhanced payments to purchase HIT because of the ambitious timelines. The majority of the current certified HIT systems have been developed for primary-care settings and have not yet been fully adapted for specialty care. The financial incentives and penalties are based on the adoption and "meaningful use" of certified HIT systems and will have a profound impact on our members and their ability to adopt and become meaningful users. Physicians are hesitant to make the considerable investment until certified systems that meet their unique needs are available.

Once again, we appreciate your commitment and willingness to work with the physician community on developing a solution to the flawed Medicare physician payment system. ASCRS remains committed to working with you to repeal and replace the SGR with a stable and reliable payment system that ensures continued access to quality health care for our patients. If you need additional information, please contact ASCRS Director of Government Relations Nancey McCann at nmccann@ascrs.org or 703-591-2220.

Sincerely,

Edward J. Holland, MD
President

American Society of Clinical Oncology

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April 27, 2011

Chairman Fred Upton
Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

Ranking Member Henry Waxman
Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

Chairman Joe Pitts
Energy and Commerce Subcommittee on Health
United States House of Representatives
Washington, D.C. 20515

Ranking Member Frank Pallone, Jr.
Energy and Commerce Subcommittee on Health
United States House of Representatives
Washington, D.C. 20515

Dear Chairmen Upton and Pitts and Ranking Members Waxman and Pallone:

The American Society of Clinical Oncology (ASCO) welcomed your letter of March 28, 2011 and appreciates the opportunity to contribute to the Committee's work developing solutions to the Sustainable Growth Rate (SGR) problem. ASCO is the national organization representing over 29,000 physicians and other health care professionals specializing in cancer research, treatment, diagnosis and prevention. ASCO's members are committed to conquering cancer by ensuring that all Americans have meaningful access to high-quality, evidence-based services for the prevention, diagnosis and treatment of cancer.

Our recommendations are detailed in the attached document. In summary, we urge the Committee to tie SGR reforms to the implementation of systems that promote and reward the practice of evidence-based medicine. If robust systems are used to measure adherence to evidence-based medicine, substantial savings in health care expenditures can be achieved along with improvements in the quality of care provided to Medicare beneficiaries. In the case of cancer, this effort should be based on use of the Quality Oncology Practice Initiative (QOPI), which is a robust quality assurance program with an extensive set of field-tested performance measures. Over 25 percent of outpatient oncology

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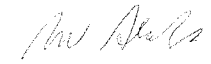
practices in the United States already actively participate in QOPI, and over 80 percent of oncology care is provided in the outpatient setting.

This year nearly 1.5 million people in the United States – more than half of them Medicare patients – will receive a cancer diagnosis, and nearly 500,000 Americans will die as a result of the disease. Cancer has a significant impact on the Medicare population, and it is therefore especially important that SGR reform include a meaningful quality measurement program for this complex group of more than 100 diseases. ASCO, working in cooperation with a number of dedicated oncologists, has committed years to developing QOPI into a comprehensive quality measurement program. A robust program like QOPI can reduce variation, minimize unnecessary or duplicative services and support patient-focused, coordinated care.

The current SGR system has created an uncertain and unstable environment—a situation that threatens the viability of practices and access to care for thousands of cancer patients across the country. We appreciate your efforts to solve this longstanding problem and look forward to working with you on this important payment reform.
Please do not hesitate to call on ASCO for further information or ideas by contacting Shelagh Foster at 571-483-1612 or shelagh.foster@asco.org.

Sincerely,



George Sledge, M.D.
President

Allen Lichter, M.D.
CEO

American Society of Clinical Oncology

Making a world of difference in cancer care

Congress Should Link SGR Reform to Robust Systems that Promote Evidence-Based Medicine

For Oncology, Congress Should Leverage an Existing Quality Assurance Program – the Quality Oncology Practice Initiative

Congress should link physician payment reform to the use of robust systems that promote and reward evidence-based medicine. To practice "evidence-based medicine" means that physicians adhere to recommended treatments and services that are based on an up-to-date understanding of the scientific literature. By participating in a quality improvement system that provides detailed, objective measures that compare individual performance against recommended treatment, virtually all physicians can improve the care they provide.

Evidence-based medicine is the most straightforward path to reducing variation in care and increasing successful delivery of high quality, high value care. It protects the best interests of patients, reduces exposure to unnecessary treatments and tests, minimizes the use of suboptimal treatment options, promotes the coordination of care and protects the Medicare program from costs associated with poor quality care.

Promoting Evidence-Based Medicine in Oncology under Medicare

A specific program that addresses evidence-based medicine in oncology is both warranted and necessary. Why?

- Medicare beneficiaries account for more than half of all new cancers diagnosed in the United States each year. Cancer treatment and prevention account for nearly 10 percent of expenditures in the inpatient and outpatient settings under fee-for-service Medicare.

- The nature of cancer care is complex, and the preferred treatment strategies change rapidly as science evolves. Cancer is comprised of more than 100 different diseases, requiring different health care strategies depending upon type, stage, presence of other diseases and patient/family preferences.

- Cancer care spans many specialties and types of health care providers. Developing meaningful measures of quality requires a mature program, multiple measures with adequate specificity, the ability to reach across a broad spectrum of care and treatment settings, and constant updating to reflect rapidly changing science.

- The complexity associated with cancer care is difficult to capture in a system designed to work across all medical specialties. Broad programs like the Physician Quality Reporting System (PQRS) do not fully capture important aspects of cancer care and do not address in a meaningful way areas vulnerable to underuse, overuse and ineffective care. There is an acute need for a separate system to promote evidence-based medicine that works in parallel to PQRS and that has more aggressive goals.

Congress Should Link QOPI Participation for Oncologists Directly to SGR Reform

The Quality Oncology Practice Initiative (QOPI) is the only sufficiently detailed quality measurement program to penetrate outpatient oncology offices, where more than 80% of cancer care occurs. ***We urge Congress to incorporate QOPI as the primary quality measurement and improvement system for oncology in any future reform of the sustainable growth rate (SGR) formula.***

The following characteristics make QOPI ideal for this purpose.

- **QOPI has a presence.** Approximately 25 to 30 percent of all outpatient oncology practices in the United States already voluntarily participate in QOPI. This reflects active participation by more than 700 oncology practices (representing more than 1,000 practice sites). Practicing oncologists, oncology nurses and quality experts developed QOPI and its measures with an emphasis on facilitating implementation within the operation of modern oncology practices. QOPI participants represent the full spectrum of practices. They include both small and large practices, urban and rural settings, community and academic sites, practices with advanced HIT and those still based largely in paper.

- **QOPI participation is free.** Access to QOPI and all related support services is free to oncology practices in the United States. From a technical standpoint, physician practices only require access to the Internet, and there are no hidden costs in the form of proprietary software or other required purchases. Costs to practices are limited to internal resources for chart abstraction and reporting and for internal quality improvement steps necessary to enhance performance under QOPI measures.

- **QOPI is already embraced by private insurers.** A growing number of private health insurance companies are adopting incentives for QOPI participation. These incentives include special recognition in provider directories, exemption from certain administrative requirements and financial incentives. As one example, Blue Cross Blue Shield of Michigan pays a fee to oncology practices that participate in QOPI.

- **QOPI provides a comprehensive set of robust, up-to-date performance measures.** QOPI includes nearly 90 evidence-based performance measures, which are updated rapidly to reflect the evolving understanding of cancer. New performance measures are field-tested and can be incorporated within six months after the publication of new scientific evidence.

- **QOPI is successful in promoting high quality, high value health care for cancer patients.** QOPI is designed to assist physicians in adhering to the widely accepted best practices defined by the scientific literature. It has demonstrated the ability to change clinical practices.

- **QOPI is valued by the cancer community.** Funding from Susan G. Komen for the Cure has made a critical difference in the trajectory of QOPI development and implementation. The National Cancer Institute has been an active participant and has brought the majority of National Community Cancer Center Program participants into QOPI. There also has been interest in QOPI participation from organizations in the international community. A number of cancer subspecialty organizations have reached out to explore possible partnerships in measure development and overall program participation.

- **QOPI can help address disparities.** By relying on a comprehensive set of objective measures designed to promote evidence-based medicine, QOPI is well-positioned to identify and address disparities in oncology care.

- **QOPI places value on physician-patient communication.** Though grounded in evidence-based practice, QOPI allows for flexibility in clinical decision making on a patient-by-patient basis and encourages oncologists to spend time explaining clinical options to their patients. Cancer patients should have the opportunity to play active roles in balancing the potential benefits and rewards of pursuing various clinical options, especially in light of the complex and high stakes decisions that arise in treating individuals with cancer. QOPI measure modules emphasize effective physician-patient communication, care coordination and the development of customized treatment plans.

- **QOPI is evolving.** ASCO continually evaluates and improves QOPI. ASCO is currently in the process of developing QOPI into the Rapid Learning Oncology Care System (RLOCS). The RLOCS will address the major cost drivers in oncology care: hospitalizations, imaging, and drug costs. By providing tools to monitor patient response and side effects in real-time, interventions can be instituted and problems can be resolved before they lead to emergency room visits or hospitalizations. This has been clearly demonstrated in a working model of the Oncology Patient Centered Medical Home. RLOCS will make this technology available to all QOPI participants. Appropriate use criteria will allow practices to conform their practice to national standards. Additionally the RLOCS can collect data in real time about whether or how the narrow trial results generalize to the broad spectrum of patients with cancer, for FDA approved drugs. This will inform physicians and patients so that care can optimized for their particular circumstances, reducing the utilization of therapies that are unlikely to work in specific sub-populations and saving unnecessary toxicity and cost.

* * * * *

QOPI is a valuable and challenging quality assurance program that has no equal in the field of oncology. QOPI is strongly supported by the full range of stakeholders in the cancer community, including oncology professionals and cancer patient advocacy groups. The promotion of evidence-based medicine through QOPI can address fundamental problems with the existing Medicare system. Over the past decade, voluntary participation in QOPI has grown to approximately 25 to 30 percent of outpatient oncology sites. The time has come for Congress to ensure that all Medicare beneficiaries receive high quality, high value cancer care from oncology practices participating in QOPI as a means for SGR reform.

A full description of QOPI is available at: http://qopi.asco.org.

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2011
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The Honorable Fred Upton
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The Honorable Henry A. Waxman
Ranking Minority Member
Energy & Commerce Committee
House of Representatives
2322A Rayburn House Office Building
Washington, DC 20515

Re: Proposals to Reform the SGR

April 28, 2011

Dear Chairman Upton and Ranking Minority Member Waxman:

The American Society of Hematology (ASH) appreciates the opportunity to offer our suggestions for changes to the Medicare Physician Fee Schedule. ASH represents more than 16,000 clinicians and scientists committed to the study and treatment of blood and blood-related diseases. ASH members include hematologists who regularly render services to Medicare beneficiaries.

It should go without saying that the threats of massive reductions to the conversion factor due to the flawed SGR system need to be eliminated. A system where each year physicians are faced with payment reductions of 20 to 30 percent only to be bailed out by last minute temporary fixes cannot be sustained. Physicians will increasingly look to minimize their exposure to Medicare by not taking new patients or by opting out of the program entirely.
The major problems ASH sees with the current physician fee schedule in addition to the SGR are:

- A need for a predictable and stable system for updating fees over time to fully and realistically account for the costs of operating a medical practice.

- A means to address the imbalance in payments for cognitive services compared to procedural services. This issue goes well beyond the need to attract and retain primary care physicians, which receives the most public and congressional attention. As important as primary care is to the nation's health care system, so too is access to medical specialists as well as adequate compensation of medical specialists who do not perform lucrative procedural services. Despite some efforts to modestly increase the relative values for evaluation and management services by CMS and the AMA Relative Value Update Committee (RUC), the payment scale is still substantially skewed in favor of physicians who perform surgical and other procedural services. This disparity can be seen whether one compares payments at a procedural level or compares the relative income of procedural and cognitive specialties.

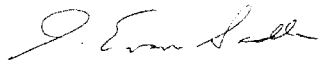
  These disparities might be addressed by establishing some process outside of the RUC to critically examine these issues and look to alternative methodologies for assigning relative payment rates. Alternatively, some shift in payment could be achieved by reducing procedural relative values by a certain percent and increase the relative values for visit and consultation services. Legislation would be needed to make this change.

- Recognition of specialty expertise under the fee schedule. Currently, the same payment is assigned to a service regardless of the expertise of the physician providing the service. For example, a family physician and a world renowned expert treating a complex blood disorder receive the same payment. We appreciate the complexity of establishing appropriate specialty adjustors; however, we cannot think of any other profession that functions in this manner.

The Society thanks you again for the for the opportunity to submit these comments and looks forward to working with you to find a permanent solution to the physician payment issue and prevent future disruption by stop-gap measures to correct the sustainable growth rate (SGR) formula.

We welcome the opportunity to meet with you to further discuss the Society's concerns. If you have any questions or would like additional information, please contact ASH Director of Government Relations and Practice Mila Becker at *mbekcer@hematology.org* or 202-776-0544.

Sincerely yours,



J. Evan Sadler, MD, PhD
President

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April 30, 2011

Honorable Fred Upton
Chairman, Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Upton:

On behalf of the American Society of Plastic Surgeons (ASPS), I write to respond to your request for input on the Medicare Physician Payment system. ASPS appreciates the opportunity to share our views, and thanks you and the other members of the committee for your focus on this important issue. The current Medicare physician payment system as a whole, and specifically the Sustainable Growth Rate (SGR), has increasingly resulted in severe instability for physician practices and less access to care for Medicare beneficiaries. Further, a series of patchwork "fixes" in recent years have delayed a permanent solution to this problem and introduced more distortions in the system. This situation has also resulted in vastly increasing the cost of a solution. We urge Congress to immediately address this problem to create a physician payment system that is stable, and to sustain the program for our nation's senior citizens.

Medicare Physician Payment System – Sustainable Growth Rate (SGR)

It need not be repeated here that the SGR is a failed payment model. The system is so broken that Congress had to intervene five times last year to stop draconian cuts in physician payments that would have severely hampered beneficiary access to care. It is imperative that Congress act this year to permanently repeal the SGR.

Further, we urge Congress to incorporate a five year period of statutory updates based on the medical economic index (MEI) as part of the transition to a new Medicare physician payment system. This transition is necessary to ensure that new payment models appropriately incorporate quality care parameters and information technology into the payment calculation, and that innovative payment methodologies are appropriately tested. Physician practices must be able to determine what is best for their patients as they incorporate new systems and processes into their business models.

However, there is no one size fits all model. Some practices have limitations on their ability to incorporate newer models due to patient population, geography or other demographic limitations. These new models of clinical integration also require data infrastructure, staff to collect data, staff skilled in analyzing data, and applying it for evidence based practice as well as the ability to share information and coordinate care.

Additionally, emerging shared savings models often require investments without initial rewards thus requiring significant cash reserves. Not all physician practices are prepared to quickly move to a new payment system that rewards these activities. For some practices, it may be necessary to remain in a traditional fee for service Medicare model. For others, accountable care organizations (ACOs) and other innovative practice models may work, but a transition period is needed so that these models may be appropriately tested across a broad variety of physician practice types. Finally, for many innovative payment models, existing antitrust and anti-kickback statutes must be amended to allow for appropriate coordination in local communities.

Recommendation

We urge Congress to ensure that any new system is based on flexibility to accommodate differences in practice types and capability, and to avoid application of one payment model to all physician practices. Additionally, Congress should enact a 5 year transition period to allow for proper testing of these models across the country, before a new system is incorporated into Medicare. During the transition, Congress should ensure statutory updates based on the MEI.

- **Service Category Growth Targets**

The SGR experiment has shown that a national target for reducing the rate of growth of Medicare Part B services is ineffective and unrealistic. ASPS believes that because different sectors of medicine grow at different rates, a more realistic payment system would include multiple growth targets for different service categories based on rate of growth analysis. For example, there has not been a substantial increase in the volume of surgical procedures in the Medicare program, yet the volume target for increased utilization applies to all physicians. We urge Congress to consider establishing a payment system with multiple growth targets to provide a bridge to future alternative payment models. Multiple targets will better allow fine tuning of efforts to identify and promote or slow the use of specific services. Such a system would also allow quality incentive programs to be more targeted, and better reflect differences in the way various types of services are provided.

- **Breaking Down Medicare Silos**

As the patient care system in our country has become more reliant on evidence based guidelines, and as technology has improved, many conditions that were previously dealt with in the hospital can now be handled in physician practices and Ambulatory Surgery Centers (ASCs). This has resulted in, and will continue to result in, savings to the system that are not currently accrued to Medicare Part B due to separate payment systems for different sectors of Medicare. We believe that the Medicare budget needs to be viewed on a more holistic basis and that breaking down the silos, particularly between Parts A and B, needs to be part of developing a new payment system for the future of Medicare.

- **Independent Medicare Payment Advisory Board (IPAB)**

ASPS strongly opposes the Independent Medicare Payment Advisory Board (IPAB). While the IPAB is not part of the current Medicare Payment system, our comments do not occur in a vacuum, and a body with the potential for such an enormous impact on the Medicare program can not be ignored.

Medicare payment policy requires a broad and thorough analysis of the affects on all providers and beneficiaries. The IPAB solution will arbitrarily ratchet down provider reimbursement, without sufficient oversight and without care taken to ensure that our seniors receive the quality health care that they need and deserve. As currently constructed, the Board does not have full authority over all aspects of the health care system, but rather is required to selectively exempt certain providers from its purview, placing more pressure to cut Medicare in those areas under its jurisdiction. We do not support allowing important health care decisions to be made by individuals with little or no clinical expertise, resources, oversight or the accountability required to ensure that seniors are not placed in jeopardy.

We recognize the importance of lowering health care costs and we are committed to improving the value of health care. However, the IPAB is not a suitable mechanism to achieve these goals. Leaving Medicare payment decisions in the hands of an unelected, unaccountable governmental body with minimal congressional oversight will negatively affect timely access to quality health care for our country's senior citizens and the disabled. The arbitrary reduction of Medicare physician payments under such a scenario carries the threat of undoing movement to more innovative payment systems, and could have a chilling effect on beneficiary access to care.

Preserving the Physician – Patient Relationship

Under the current Medicare program, patients do not have the right to contract with the physicians outside of Medicare. Physicians who enter even one agreement with a patient to provide services outside of Medicare are legally excluded from the Medicare program for two years. Additionally, the beneficiary gets no reimbursement from Medicare under such a scenario – even if the benefits would otherwise be a partially covered benefit.

ASPS plans to support new legislation to allow these arrangements without penalizing physicians, and to allow the beneficiary to recoup the portion of the payment Medicare would otherwise cover. The legislation will include appropriate and important beneficiary protections. We urge Congress to include these provisions in any new physician payment system.

Medical Liability Reform

The Congressional Budget Office (CBO) has recognized the steep cost of our current liability system in scoring approximately $40 billion in savings from comprehensive medical liability reform. The current system for compensating injured patients drives defensive medicine practices in health care and increases health care costs. Additionally, access to care for high risk procedures is increasingly compromised by lawsuit abuse. We urge Congress to enact meaningful liability reform such as that in H.R. 5, the HEALTH Act.

Quality Improvements

ASPS has undertaken multiple quality improvement initiatives in recent years, and supported enactment of comparative effectiveness research legislation. ASPS also maintains a clinical outcomes database, Tracking Outcomes in Plastic Surgery (TOPS), and has long supported data-driven approaches to quality care and incentives for achieving results. The Medicare program should foster acquisition and use of reliable outcomes and clinical effectiveness data, as well as developing a reimbursement system that rewards, rather than penalizes, physicians for improved outcomes.

Building true continuous quality improvement systems is dependent upon collection, analysis, and feedback to physicians of risk-adjusted clinical outcomes and utilization data. Subsequently, clinical data can then be linked with administrative data to track the cost of care over time and provide an assessment of clinical and cost effectiveness, including new technologies and devices. Only a clinical database with a sufficient volume of clinical records can be credibly risk-adjusted for case mix to yield accurate and comparable findings – focusing on costs alone is insufficient. Claims data, without requisite clinical information, is not a meaningful approach to assessing physician quality. To be meaningful, risk adjusted quality measures must be compared to resource utilization and feedback must be provided to physicians, including non-punitive strategies to improve utilization, effectiveness, and outcomes.

Physicians, in collaboration with their professional societies, are best positioned to define what constitutes high quality care. Additionally, it is well documented that physicians can best improve quality in a non-punitive environment. However, the PPACA does just the opposite by requiring physicians to participate in the Physician Quality Reporting System (formerly the Physician Quality Reporting Initiative) or face future Medicare cuts. In addition, the PPACA directs the Secretary of the Department of Health and Human Services (HHS) to develop a new budget-neutral payment modifier to the Medicare physician fee schedule, which would be based on the relative quality and cost of care delivered. This system will ostensibly be based on a composite of risk-adjusted measures of quality, although no such system now exists, nor will it be available anytime in the near future. Finally, the requirement on HHS to publicly report data on individual physician quality and resource use is premature, given the lack of reliable risk-adjusted clinical outcomes data.

We believe Congress should mandate that HHS incentivize development of specialty and/or condition-specific, outcomes-focused clinical data registries. Additionally, Congress should fully fund the Patient Centered Outcomes Research Institute (PCORI) which is the appropriate avenue for conducting

comparative effectiveness research as the charge of PCORI focuses on clinical research, rather than cost, in an open and transparent manner.
There are several provisions in current law that should be repealed or delayed to ensure an appropriate foundation is built for quality improvement and that physicians are incentivized appropriately rather than face a punitive system: **repeal penalties for quality reporting; defer electronic prescribing and HIT penalties; repeal the budget-neutral value-based payment modifier; and delay the public reporting of physician quality and resource use measures until valid risk-adjusted clinical outcomes data is available.** We look forward to working with Congress to ensure the Medicare payment system is built on a value based foundation that appropriately incentivizes physicians and delivers the best possible patient care.

Conclusion

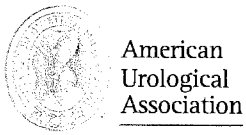
ASPS greatly appreciates your efforts to look seriously at the problems related to the current Medicare physician payment system, and to work to sustain access to the physician of their choice for Medicare beneficiaries. We look forward to working with you to repeal the SGR and to replace it with a more stable and rational payment system. If you need more information or any assistance from our Washington office, please contact Lori Shoaf, Director, Federal Government Affairs at 202-672-1518 or lshoaf@plasticsurgery.org.

Sincerely,

Phil Haeck, MD
President,
American Society of Plastic Surgeons

cc:

The Honorable Henry Waxman
The Honorable Joe Barton
The Honorable John Dingell
The Honorable Joe Pitts
The Honorable Frank Pallone
The Honorable Michael Burgess, MD



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April 28, 2011

The Honorable Fred Upton, Chair
Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Re: Sustainable Growth Rate

Dear Chairman Upton:

The American Urological Association (AUA), representing over 90 percent of the almost 10,000 practicing urologists in the U.S., welcomes the opportunity to respond to your request for ideas on how to replace the flawed Sustainable Growth Rate (SGR) payment system for physicians. Although a well intended approach, it is a flawed concept that should be abandoned.

Background

It is important to note some incontrovertible facts about the context within which we practice. These are often summarily dismissed or entirely omitted from national discussions about the practice of medicine and the cost of healthcare, particularly specialty care.

1) The American Medical Association (AMA) has provided solid evidence that practice costs have dramatically escalated over time while our revenue continues to decline.

2) Doctors' treatment decisions are where healthcare costs originate. Simply cutting physician reimbursement does not solve the problem – physicians if they are to practice appropriately will continue to order the tests, and do the procedures that have made medicine in the United States the envy of the world. Medicare Part B expenditures on physician services is now 18 percent, down from 22 percent.

Headquarters

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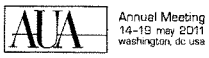

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3) No one has any incentive to rein in costs. This has been referred to as the "restaurant check scenario": when equally splitting the bill, each individual has no incentive to spend less. Each constituent is trying to maximize their own benefit by trying to survive without looking at the entire cost. As such, the system is currently getting the exact outcome it was designed to obtain as multiple factors lead to increased costs. These are a defined benefit for patients, explosion of new treatments and technologies, extension of lifespan, unrealistic patient expectations, liability driven test ordering which is ingrained in our healthcare culture and a lack of shared responsibility exhibited by all sectors of the healthcare system.

4) Hospital reimbursement is a major cost factor. Because it is not examined in juxtaposition to physician costs for similar procedures performed in the hospital setting, it contributes to a skewed view of physician work and expenses. In addition, current payment policies are causing more physicians to become employed in more costly healthcare practice environments. Since this transfers payments to more expensive hospital rates, the cost of providing Medicare services will only increase. These costs are seen in two common ways. First, commonly referred to as "provider based billing", an evaluation and management service (i.e. office visit) incurs a more expensive facility charge when the care moves to the hospital based clinic from the office. Similarly, increased facility costs for outpatient testing are incurred when a test is performed in a hospital compared to the office.

5) Continuing to cut physician reimbursement across the board, particularly for specialty care, is not the answer.

6) Any proposal to replace the SGR must be coupled with addressing Medicare expenditures across the entire spectrum of health care and should include hospitals, drugs, medical equipment, medical devices, supplies and home care.

7) "Relative values" for physician services (the RBRVS) have been dramatically altered over the past 19 years. They are generally deemed to be correct by the medical and surgical specialties that examine and change them at the AMA Relative Value Update Committee (RUC) – from Pediatricians to Urologists.

8) Many different practice environments exist today which respond to the geographic population diversity in this country; something which needs to be factored in to any new system.

9) Increasing regulation and administrative burden to practice, although may be necessary, should be more focused and viewed in its cumulative effect from prior initiatives and total burden.

10) There is a declining specialist workforce. In its December 2008 report, "The Complexities of Physician Supply and Demand: Projections Through 2025", the Association of American Medical Colleges (AAMC) documents that the impending workforce shortage is not limited to primary care but affects many specialties as well, including urology. Indeed, most studies show that physicians have increased the number of patients they see, and cannot accommodate more. Yet current reform plans include an influx of patients that urology cannot possibly accommodate in the near future. Some communities will be left without any urologists when their remaining specialists retire. Urology has undertaken its own workforce study and concluded that urology non-physician practitioners must be trained and recruited to serve the future increase in patients. However, there are currently few programs that do so.

Proposed Solutions to Replace the SGR

1) Make the 2011 Medicare Fee Schedule the "baseline" for going forward.

2) Couple the current "baseline" to the Medical Economic Index for the next 5 years (2012 – 2017), then re-examine in 2017.

3) Achieve reduction in healthcare expenditures from current practices through:

   a) Value based purchasing is an idea that must be pursued. However, our concern is that too much emphasis is being placed on an untested approach. Accountable Care Organizations (ACOs) may be an answer for large population areas, but are not a panacea for smaller communities and smaller physician practices. They are also complex to build which may limit their utility. Simpler approaches should be stressed. One example would be for CMS to accelerate the implementation of bundling payments around specific episodes rather than waiting until 2015. Evidence-informed episodes of care, in line with the *Prometheus* model, where such episodes can be reliably defined would be a model of how to start.

   b) Medical liability reform with provisions such as safe harbors for those who can document their conformance to the specialty's evidence-based clinical quality guidelines.

   c) Start a public service campaign: "Healthcare for the elderly is a right; its survival depends upon treating it as a privilege. We all have a stake in its survival." Although many authors focus on different successful systems across the globe, societal expectations of the system are an important concept that is often left out of discussions. Messaging examples: For patients, the campaign could stress medication compliance, healthy lifestyle interventions and appropriate follow up especially after hospital discharge. For physicians, the message could be to stress the importance of following evidence based care. For hospitals, the message could be to encourage more sharing of expensive technology to limit total cost for society.

d) Assist Congress in understanding the administrative burden and associated costs in providing healthcare services. Simplification and cost savings could be achieved by better coordination of overlapping legislative programs, providing adequate resources to HHS to achieve better implementation and perform more legislative oversight of the regulatory process to make sure the original legislative intent is achieved.

e) Legislating use of generic drugs in Medicare Part D.

f) Patient cost-sharing with a "co-pay" (not covered by Medicare supplement) for all Medicare patients for non-preventive services. As previously mentioned, part of the unsustainable nature of Medicare Part B is the "defined benefit" for patients. The number of patients promised these benefits have increased steadily since the inception of Medicare in 1965 and the associated costs have done the same. Part B beneficiaries must understand that the budget is not limitless. Whether it is a voucher system, a mandatory health savings account process or simply a means-tested out-of-pocket expense formula, beneficiaries must share in the increasing costs.

g) Re-examining the way hospitals are reimbursed by Medicare for drugs, devices and supplies and understand the cost of physician employment by hospitals (i.e. hospital facility charges for evaluation and management services as explained above).

h) Physicians should have the option to balance bill for services. The current Medicare Part B participation requirements are too rigid. Providers and beneficiaries are either all in or all out regardless of the health problem being solved. CMS could create a tiered system for balance billing where the most deserving conditions would have the highest proportion of funds devoted fully to supporting patient costs (i.e. preventive care or evidence based treatment). However, those ranking near the bottom of the list, while not denied, would bear the burden of the highest co-pays (or unlimited balance billing). We already have this with respect to treating those diseases not covered on most insurance plans (i.e. infertility, cosmetic procedures, etc). This would limit excessive utilization, give greater financial control to CMS and allow free market conditions in an area where there's little chance of putting patients in jeopardy.

Compensation for Indigent Care

At present, many physician practices provide uncompensated care at an increasing level. This is in addition to the decreasing levels of reimbursement received for both Medicare and Medicaid patients, putting an unbearable strain on the ever-shrinking resources of the private practice physician. Uncompensated care is absorbed by the physician practice – the costs are real and documented. A tax deduction or something similar would help offset this burden.

Independent Payment Advisory Board

Finally, the idea that the Independent Payment Advisory Board (IPAB), an integral part of the PPACA statute, can control system costs by simply cutting physician fees even further is unrealistic. We therefore support current legislation to repeal the IPAB, which if not eliminated, will perpetuate the same unfair, unrealistic, and unsustainable cost cutting measures upon physician practices of all types as the failed SGR.

In summary, we believe significant modifications can be made to our current fee for service system that would produce the cost savings and achieve the high quality care our nation seeks.

The AUA and its members are committed to working with the Committee as new approaches are considered. To date, fiddling with the old formula and repackaging old approaches have not solved this problem. We hope that at least some of our ideas will help contribute to a new approach.

We deeply appreciate the invitation from the House Energy and Commerce Committee to weigh in on this complex national problem, and firmly believe, as those trained and dedicated to the care of our country's patients, we have much to offer to any proposed solution. We respectfully ask that the Committee continue to include all physicians and particularly specialty physicians, in this critical dialogue. Urology is committed to helping our lawmakers to find an equitable and workable solution and we offer our services in any way that can advance this dialogue.

Sincerely,

Datta G. Wagle, MD
President
American Urological Association

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April 28, 2011

John O'Shea, M.D.
U.S. House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Dr. O'Shea,

The Arnold P. Gold Foundation for Humanism in Medicine offers the following thoughts in response to the request of the House Energy and Commerce Committee for suggestions for revising the Medicare physician payment system.

We strongly agree with the Committee that the current Medicare physician payment system "is a major threat ... to the ability of America's seniors to access quality health care." The current system is not only unsustainable but is also a barrier to the all-important goal of keeping the "care" in healthcare. The financial incentives inherent in the current payment system fail to reward healthcare professionals for providing the humanistic care highly desired by patients and strongly correlated with quality outcomes.

We believe that a payment system that improves access to preventive and primary care services would both lower overall healthcare costs and restore the flagging trust now threatening the doctor-patient relationship. As "fixes" are sought to the Medicare physician payment system, we urge all those committed to patient-centered care to keep the following in mind:

- Patients must have the opportunity to establish stable, long term relationships with their primary care providers.
- Emphasis must be placed on improving reimbursement for primary care services in order to attract more students into primary care. Cognitive work - the time doctors spend learning about and teaching about the factors that affect a patient's health status - must be recognized and properly reimbursed; the current skew that favors payment for procedures must be reversed.
- Physicians must be empowered to make diagnostic and treatment decisions for their patients, and when at odds with insurance company allowances, they must have access to swift and independent arbitration to avoid disruptions in care.
- Regulations that discourage the provision of comprehensive care at a single visit must be abolished.
- Payments must be adjusted to support the tenets of "Patient Centered Medical Home."

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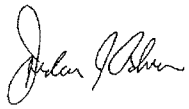
www.humanism-in-medicine.org

The committee will hear from many parties with varying degrees of self-interest. The Gold Foundation's primary interest is in supporting access to patient-centered care, which can only be established with trusting patient-physician relationships. This has been proven to improve healthcare outcomes by reducing the length of hospital stays, increasing patient compliance with treatment plans and diminishing the number of malpractice suits. A revised Medicare physician payment system can be a catalyst for such care.

Thank you,



Jordan J. Cohen, M.D.
Chair, Arnold P. Gold Foundation
President Emeritus, Association of American Medical Colleges

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Darrell G. Kirch, M.D.
President and Chief Executive Officer

April 28, 2011

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Henry Waxman
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Upton and Ranking Member Waxman:

On behalf of the Association of American Medical Colleges (AAMC), thank you for your bipartisan effort to seek input from the nation's medical schools, teaching hospitals and clinical faculty regarding how Congress might reform the Medicare physician payment system. The AAMC is a not-for-profit association representing all 134 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members, 75,000 medical students, and 106,000 resident physicians. The clinical practitioners at AAMC member medical schools account for one-sixth of all physicians in the Medicare system.

It is critical that the physician and broader provider community play an integral role in examining new proposals to replace the flawed Sustainable Growth Rate (SGR) formula with a permanent, sustainable solution. The AAMC supports your efforts, and looks forward to working with you to implement a system that preserves care access for Medicare beneficiaries, responsibly slows the Medicare growth rate, and pays physicians and all providers fairly. **However, I must stress that we cannot support any new payment system or extended patch that is financed by simply redirecting funds currently supporting other critical health care expenditures, including those that support the nation's teaching hospitals.**

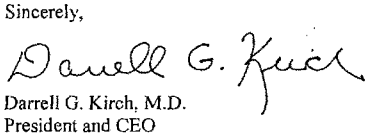
Although the method for physician payment must be changed, it also is important to acknowledge that the current system engenders large administrative costs—both for providers and the government—and that reducing these expenses is a sensible way to reduce Medicare spending. I am pleased that President Obama has ordered each federal agency to review its rules to determine those that can be eliminated, streamlined, or revised as this should result in large savings and reduced burden.

As you know, teaching physicians and hospitals play a critical role in providing care for Medicare beneficiaries. Adequate reimbursement for these clinical services is vital to sustain the education, training, safety net, and community service missions of academic clinical physicians. Teaching physicians and hospitals care for the sickest, most complex Medicare patients and provide primary care, as well as highly specialized services that may not be available elsewhere in the community. Additionally, academic physicians often serve as a resource for other health care providers in communities and across regions, providing consultations and care for Medicare patients who need their specialized expertise, while teaching the next generation of physicians. Without reliable, sufficient, and fair physician payments from Medicare, beneficiaries' access to many of these services could be placed in jeopardy.

The AAMC has long supported replacing the SGR formula with a payment system that, at a minimum, adequately compensates physicians based on such factors as the services provided, complexity of the patients served, and geographic area where the physician practices, while also accounting for increased costs due to inflation. As we continue to strive to create a health care system that improves patient care by providing appropriate, high quality care, we believe an appropriate case management fee in addition to Medicare payments for services may achieve this goal by ensuring and incentivizing coordinated care. Incorporating these preventive medicine incentives through case management payments could help meet the long-term goal of slowing the growth of Medicare expenditures. Finally, as Medicare moves to a new physician payment model, Congress should help ease this transition by enacting a period of stable and predictable physician payment updates. This will help ensure that beneficiaries continue to have adequate access and alleviate providers' concerns.

Again, thank you for your leadership in working to address this long-standing problem of replacing Medicare's physician payment system with a sustainable solution. The AAMC looks forward to working with you and Congressional leaders to address this important issue.

Sincerely,



Darrell G. Kirch, M.D.
President and CEO

cc: House Energy and Commerce Committee Members

Charles N. Kahn III
President and CEO

May 12, 2011

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Henry Waxman
Ranking Member
Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Ranking Member Waxman:

The Federation of Ameriean Hospitals (FAH) welcomes the opportunity to submit these comments in response to the Committee on Energy and Commerce's request for our suggestions on developing a pathway toward reforming the Medicare physician payment system. The FAH is the national representative of nearly 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, including inpatient rehabilitation, long-term acute care, cancer and psychiatric hospitals.

America's hospitals rely on the quality, quantity and professionalism of their medical staffs. The partnership we have long shared with physicians has ensured that seniors and patients in communities across America have access to the care they need when they need it. Going forward, we will need to strengthen this partnership to improve the performance of hospitals and the health system more generally to expand access and deliver higher quality care more efficiently – goals we all share. However, one of the greatest threats to this partnership, and the achievement of these goals, is the lack of fair and predictable Medicare payment for our mostly-volunteer physician staff.

That is why the FAH remains deeply concerned with the problems plaguing the current sustainable growth rate (SGR) formula. We applaud the Committee's interest in resolving the fundamental flaw in the SGR to prevent the 29 percent cut that is scheduled to take effect January 1, 2012, and to provide fair and predictable payment going forward.

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We agree with many in the physician community that an adequately funded SGR-based system may need to be continued while demonstrations and pilots are developed and tested in the search for a suitable, sustainable alternative payment system that improves quality and increases efficiency. Potential savings that might be generated through such payment reform could help mitigate short-term or long-term budgetary costs associated with an overhaul or outright repeal of the SGR.

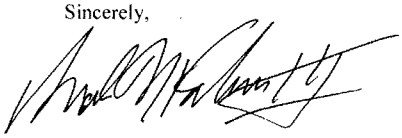
In the meantime, we respectfully urge the Committee to apply as an offset to these budgetary costs, the substantial savings attributable to passage of H.R. 5, the "Help Efficient, Accessible, Low Cost, Timely Healthcare (HEALTH) Act of 2011." Not only would this policy generate well over $50 billion in savings, but it would vastly improve the delivery of health care in our nation's hospitals and physicians offices.

Today, community hospitals face a challenging and increasingly difficult payment and cost environment. Medicare and Medicaid hospital reimbursement already falls far below the cost of care, and these payments are further pressured at the Federal and state level. At the same time, the underlying cost drivers of hospital care continue to climb. In addition, hospitals are preparing for a host of new policy initiatives in areas such as value based purchasing, readmissions, health information technology and patient safety. Few would argue that these reforms should not be put into place, but it should be recognized that their implementation imposes incrementally higher costs on hospitals, and could well result in lower payment.

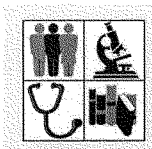
The fiscal policy problem with the SGR that we face today has been years in the making and results directly from actions taken, and not taken, by past Congresses. The policy flaw in the law as originally enacted by Congress surfaced many years ago. But rather than curing the problem at its source – the formula flaw-- past Congresses instead compounded the problem by treating only its symptom – a negative update. This annual action of postponing an effective permanent remedy had the effect of forward funding an escalating cost of an eventual solution.

It is unfair and unwise to expect the health care system, key elements of which, such as hospitals, already suffer from chronic Federal underfunding, to finance the cost of these past policy mistakes. Instead, we respectfully urge this Congress to explore new policies, such as comprehensive liability reform, that will not only help fund a fix, but strengthen the health care system more broadly.

Sincerely,



cc: House Energy and Commerce Committee Members



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May 10, 2011

Chairman Fred Upton
Ranking Member Henry Waxman
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Ranking Member Waxman:

The Infectious Diseases Society of America (IDSA) writes in response to the Committee on Energy and Commerce's bipartisan letter of March 28, 2011, requesting suggestions on developing a pathway toward reforming the Medicare physician payment system.

IDSA represents more than 9,300 physicians and scientists devoted to patient care, education, research, and community health planning in infectious diseases (ID). The Society's members focus on the epidemiology, diagnosis, investigation, prevention and treatment of infectious diseases in the United States and abroad. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, surgical infections, those with cancer or transplants who have life-threatening infections caused by unusual or drug-resistant microorganisms and new and emerging infections.

Medicare's fee-for-service payment system has historically disadvantaged cognitive physicians who provide primarily Evaluation and Management (E&M) services. This group is commonly understood to include primary care physicians. Less well known is that a number of subspecialties, such as ID physicians, endocrinologists, rheumatologists, and neurologists, also provide primarily E&M serviees. These cognitive specialties are experiencing the same economic disadvantages as primary care, with the resulting difficulty in attracting graduating US medical school seniors into the specialty.

Many cognitive specialists are now reimbursed less than primary care physicians for treating the same patients. This is due to Medicare's decision to eliminate payments for the consultation codes in 2010 combined with the Affordable Care Act's (ACA) inclusion of a +10 percent incentive payment for designated primary care specialties. Immediate steps are needed to ensure that the cognitive care work force remains viable in the near future.

Congress should immediately: Include specialists who routinely coordinate care and derive at least 60 percent of their allowed charges from the specified outpatient E&M service codes as eligible for the +10 percent primary care bonus. While many

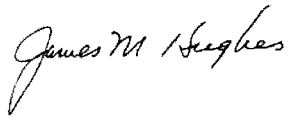
ID specialists will not be able to meet the 60 percent threshold, relaxing the specialty requirements would ensure that those who have a large HIV patient population might be able to qualify for the primary care bonus without changing their specialty designation.

The current Medicare fee schedule is flawed in large part due to inherent biases that favor procedures, imaging and laboratory services over cognitive services. These biases persist in spite of data showing the inequity of cognitive physician reimbursement and the rapid growth of procedures (in particular, minor procedures), imaging and laboratory services without a corresponding increase in medical need. Correction of the current undervaluation of cognitive physician work intensity would be one way to correct these biases. As such, for the longer term Congress should:

- Change the misaligned financial incentives and meaningfully close the income gap for cognitive physicians.
- Support research to identify physician intensity of services to better show the parity of work for procedural and cognitive physicians.
- Pass meaningful malpractice reform that ensures that care provided by physicians is not subject to pressures that drive high cost defensive medicine.
- Allow gainsharing arrangements between physicians and hospitals that are proven not to limit necessary care to patients. For example, ID physicians who serve as medical directors should be able to share in the savings for their role in reducing avoidable hospital-acquired infections or curbing unnecessary antibiotic use.
- Replace the Sustainable Growth Rate (SGR) payment formula, which holds all physicians' accountable to the same spending target, with one where services are grouped into different buckets and held to separate targets. Buckets should be based on service categories (not specialty) such as: E&M (cognitive services); imaging and diagnostic tests; major procedures; minor procedures; and anesthesia.

IDSA appreciates the Committee's consideration of our proposals to reform the Medicare physician payment system. If you have any questions, please feel free to contact Jason A. Scull, IDSA's Senior Program Officer of Practice and Payment Policy, at (703) 299-5146) or jscull@idsociety.org.

Sincerely,



James Hughes, MD, FIDSA
President, IDSA

April 28, 2011

Honorable Fred Upton
Chairman, Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

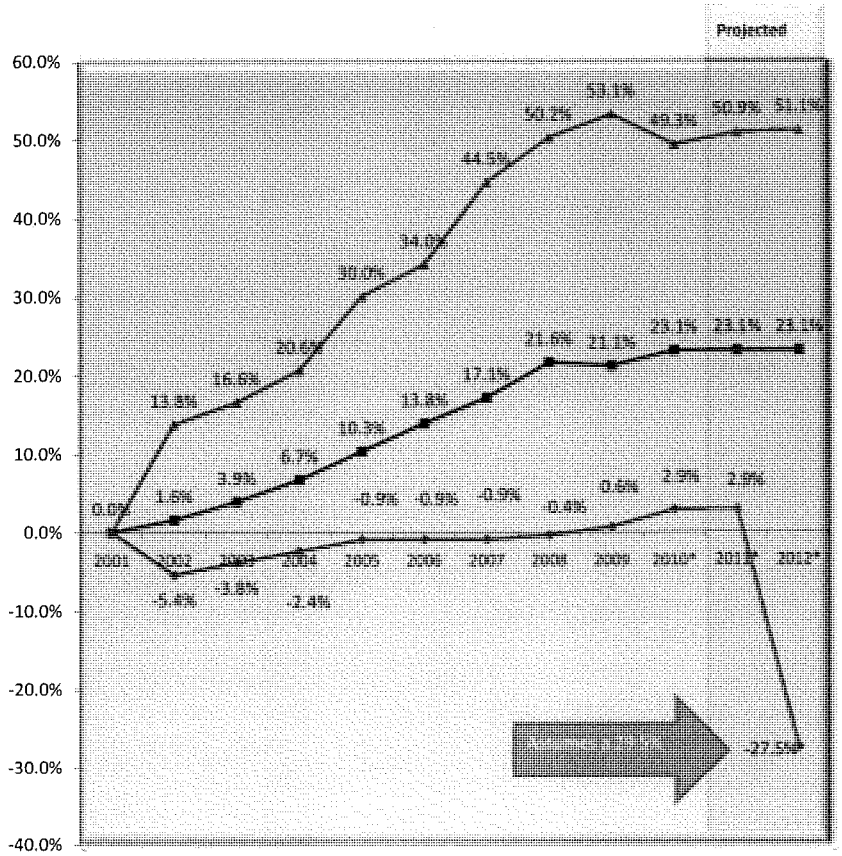
Dear Chairman Upton:

The Medical Group Management Association (MGMA) is pleased to respond to your request for input on the kind of payment system that should replace the Medicare physician fee schedule. As the nation's principal voice for medical group practices with 22,500 members who lead 13,600 organizations in which some 280,000 physicians provide more than 40 percent of the nation's health care services our members understand the challenges created by the current payment system. As you are painfully aware, under current law, Medicare physician payment will be reduced significantly in 2012 and further reductions are likely for several years. There is widespread agreement among experts and stakeholders that the existing physician payment system under the Medicare program is inadequate. Although Congress has repeatedly intervened to prevent rate cuts, it has never completed the task of finalizing change to the formula that dictates these cuts.

Medicare Physician Payment System Implications

It is clear that the sustainable growth rate (SGR) formula is flawed and does not adequately address growth in spending, as MGMA data shows below. For more than 50 years, MGMA has conducted annual surveys that focus on revenues, expenses, provider compensation and production, management compensation and group performance for medical and academic practices. The chart shows that the total operating cost per full time equivalent (FTE) physician has increased by 51 percent since 2001, while Medicare physician payments have remained relatively stagnant during that same time period with a sharp decrease forecasted for 2012. This widening gap will be insurmountable for many physician practices as it destabilizes business operations and decreases access to care for Medicare beneficiaries. In 2010, MGMA conducted a member survey that focused on the potential effect future reductions in Medicare physician payment would have on practices and the patients they serve. The study found that many medical practices were likely to limit the number of new Medicare patients they accept unless Congress takes action to halt pending Medicare reimbursement cuts. In addition to reducing the number of Medicare patients they see, practices stated they would take other steps to address decreased reimbursement, such as delaying the purchase of electronic health records.

Cumulative Percent Change Since 2001 for the Medicare Physician Payments, Not Hospital/IDS-Owned Multispecialty Group Operating Cost, and the Consumer Price Index



* 2010, 2011, and 2012 median operating cost values are three year moving average projections of previous years'data.
* 2010, 2011, and 2012 CPI figures are the July 2010 semiannual figure.
* Assumed reduction figure based upon CMS analysis (3/15/11 released).

Annual Medicare Update — CPI — Total Operating Cost per FTE Physician

Many stakeholders agree that the ultimate solution is to permanently replace the Sustainable Growth Rate (SGR) formula with a system that actually keeps pace with the cost of caring for our nation's seniors. Continuing the practice of enacting temporary patches serves no one. Medical practices are committed to taking the leadership role in developing Medicare payment reforms to replace the SGR once and for all, and we are counting on Congress to make permanent reform a reality.

Reports to Congress

We believe reevaluating past proposals to reform the SGR formula and incorporating some of these ideas into new initiatives will pave the way to an improved and equitable payment model.

In a 2005 report, the Government Accountability Office (GAO) categorized options for alternatives around two themes: (1) proposals that end the use of spending targets and separate fee updates from explicit efforts to moderate spending growth; and (2) proposals that retain spending targets but modify the current SGR system to address perceived shortcomings. The first approach emphasizes stable fee updates, while the second automatically adjusts fee updates if spending growth deviates from a predetermined target. GAO stated that "the choice between the two approaches may hinge on whether primary consideration should be given to stable fee increases or to the need for fiscal discipline within the Medicare program."[i] The second approach would end targets as an explicit measure for moderating spending growth. Updates would be based on cost increases with the possibility of specifically addressing high volume service categories such as medical imaging.

In its March 2007 report, the Medicare Payment Advisory Commission (MedPAC) described two possible paths: one path would eliminate the SGR and emphasize the development and adoption of approaches for improving incentives for physicians and other providers to furnish lower cost and higher quality care. The second path would add a new system of expenditure targets in addition to these approaches. However, MedPAC did not make any recommendations in favor of any single alternative to the SGR. MedPAC's report did stress that "a major investment should be made in Medicare's capability to develop, implement, and refine payment systems to reward quality and efficient use of resources while improving payment equity." Examples cited by MedPAC include pay-for-performance programs for quality, improving payment accuracy, and bundling payments to reduce overutilization.[ii]

Most recently, on April 15, MedPAC staff offered a brief assessment of the SGR and its current problems. The commission highlighted the system's failure to differentiate by provider and its strictly budgetary format. These problems do not encourage improving quality or efficiency, and temporary fixes to the payment system provide uncertainty in the Medicare program and reduce access for beneficiaries. The commissioners all favored repealing the SGR. A number of commissioners suggested that Congress should "write-off" the SGR fix; likewise, other commissioners proposed that money for the fix could come from reducing spending in other programs, though noted that spending outside of Medicare is beyond the scope of the commission. Regardless of the ultimate fix, commissioners were in agreement that any future temporary SGR fixes need to last for at least a year to provide stability to the program.

Recommendations and Transition to New Payment Models

In agreement with both reports, MGMA also urges Congress to repeal SGR and replace it with an update system that reflects increases in physicians' practice costs. We call on Congress to incorporate a five-year period of statuary updates based on the Medicare economic index (MEI) as part of a transition to a new Medicare physician payment system. The transition period would allow a phase out of the SGR formula over several years while instituting major payment reforms that move away from fee-for-service.

We advocate for Congress to establish such a transition pathway in order to provide stability to the Medicare system with positive funded updates over the next five years until a replacement takes effect. Uncertainty for

practices that continue to receive last minute Congressional patchwork fixes fails to foster either provider or patient confidence.

There are numerous proposals for payment changes that would promote integrated care delivery and encourage cost-effective medical treatment. Options include but are not limited to bundled payment, partial capitation, development of accountable care organizations, and breaking down the silos between separate payment systems for different sectors of Medicare (Part A and B).

These innovative financing and delivery systems need to be developed further. This transition pathway is necessary to ensure that new payment models appropriately incorporate quality care parameters and information technology implementation into the payment calculation and that innovative payment methodologies are tested and evaluated in a variety of practice settings. An ongoing evaluation process should be created to determine if a system is ready for wider implementation, requires further testing or proves ineffective.

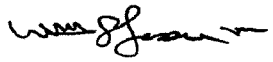
Given the diversity of medical practices, a single, one-size-fits-all approach must be avoided and physicians should have flexibility to adopt different approaches based on the composition and capabilities of their practice. These new models require data infrastructure and skilled staff to analyze data, as well as the ability to share information and coordinate care. Medicare should offer timely data sharing and positive financial incentives to assist medical practices that wish to experiment with alternative approaches to achieving savings as part of this transitional pathway.

Conclusion

In conclusion, it is clear that long-range savings and continued increased quality and accountable care will require other reforms to the current payment system. We urge Congress to base any new payment system on flexibility to accommodate different practice types. Innovative payment and delivery system models should not be incorporated into the Medicare system until they are properly tested.

We thank you for the opportunity to share our views on this vital topic. We are committed to working with you to repeal the SGR formula and replace it with a more equitable system. Should you have any questions regarding these comments, please contact Miranda Franco, MGMA Government Affairs Associate, at 202.293.3450 or mfranco@mgma.org.

Sincerely,



William F. Jessee, MD, FACMPE
President and Chief Executive Officer

cc:

The Honorable Henry Waxman
The Honorable Joe Barton
The Honorable John Dingell
The Honorable Joe Pitts
The Honorable Frank Pallone
The Honorable Michael Burgess, MD

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[i] U.S. Government Accountability Office, Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms, GAO-05-85, October 8, 2004.

[ii] Medicare Payment Advisory Commission, Assessing Alternatives to the Sustainable Growth Rate System, March 07

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April 30, 2011

Sent Via Electronic Mail

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Upton:

The North American Spine Society (NASS) is a multidisciplinary medical organization dedicated to fostering the highest quality, evidence-based and value-based, ethical spine care by promoting education, research and advocacy. NASS is comprised of more than 6,200 spine care providers from several disciplines including orthopedic surgery, neurosurgery, physiatry, neurology, radiology, anesthesiology, research and physical therapy. As patient and physician advocates, NASS welcomes the Energy and Commerce Committee's request for ideas and proposals to reform the physician payment system in a way that provides fair and value-based payment for physicians and at the same time reduces Medicare spending. NASS believes these are essential building blocks to establishing a truly sustainable system that accurately covers the costs of health care services delivered to Medicare patients while promoting access to high quality health care.

Executive Summary

The goal of any Medicare payment policy with physicians, hospitals, nursing homes, drug coverage and other providers is to obtain good value for the program's expenditures. This includes high-quality health care, efficient use of resources and maintaining continued beneficiary access to these high-quality services. A program that does not consider all of these aspects or the longer term implications of any policy changes may do a disservice to its beneficiaries and to the nation.

Broad consensus exists amongst the medical profession, Congress and various other stakeholders that the current Sustainable Growth Rate (SGR) formula used to determine annual physician payment updates is an unfeasible long-term solution that does not reflect the true costs of providing care to Medicare beneficiaries. Any system used to replace the flawed SGR formula should look into all aspects of Medicare outlays, including Medicare expenditures to non-physician providers such as hospitals, nursing homes, DME providers, Medicare Advantage as well as technical costs for imaging services. Disproportionate annual updates to various stakeholders within Medicare should be avoided. Identification of the value associated with specific elements of care is crucial, and stakeholders need to broaden the data infrastructure to optimize this process. In order to achieve meaningful incorporation of value parameters into the reimbursement system, a short-term (3-5 years) transitional system between the current SGR formula and a future value-based payment system, similar to other transitional systems that have been used in the physician fee schedule when a methodological change was made, may be necessary. Increasing the value and cost-efficiencies of health care delivery will require integration of efforts between multiple stakeholders, including the Centers for Medicare and Medicaid Services (CMS), clinicians and specialty societies.

We present our thoughts on a system that will allow us to continue to provide appropriate and patient-centered care for our patients in the following pages. The topics covered in the following pages include facts on Medicare expenditure growth, Part B expenditures, the current SGR formula and concepts that ought to be considered in any replacement system.

Topics Covered

- Medicare Expenditure Growth
- Physician Component of Part B Expenditures and Growth

- Physician Payments in the United States: Development of Fair Value for Codes
- Reducing National Health Care Expenditures: Bearing Our Share of the Load
- Broad Agreement of SGR Failure
- Options for Replacing the SGR
- Incorporating Value into Physician Payment Systems
- Specific Value-Based Model Proposals

Medicare Expenditure Growth

Total Medicare expenditures have increased by approximately 7.5 percent per year between 1997 and 2007.[1] In fiscal year 2010, overall Medicare spending accounted for 20 percent of national health expenditures and 15 percent of the federal budget. Medicare expenditures paid for more than 30 percent of the nation's total hospital spending, 24 percent of prescription drug costs and 20 percent of physician services covered under Medicare Part B. In addition to physician fees, Part B covers Medicare beneficiary charges for the following: hospital outpatient services, end-stage renal disease management, laboratory services, durable medical equipment and certain home health services.

Growth in spending can be attributed to both an increase in the fees Medicare pays for each service, which have risen by an average of about 2 percent annually since 2002, and the addition of covered services and increases in volume and intensity of services, which have risen by about 4.5 percent annually over this same time period.[2] An aging population, increasing life expectancy, advances in medical technology, advanced medical imaging and other changes in the practice of medicine have increased the average volume and intensity of the services provided to Medicare beneficiaries. Other policy changes, including the Part D prescription drug benefit added in 2006 and rising Medicare beneficiary enrollment into Medicare Advantage plans, have significantly contributed to overall Medicare expenditure and projections.

Medicare enrollment is expected to grow by more than 1.6 million beneficiaries annually between 2010 and 2030, expanding the number of people on Medicare from 47 million to 79 million.[3] Increased program enrollment from the "baby boom" generation will continue to act as a major driver of Medicare expenditures.

Physician Component of Part B Expenditures and Growth

Physician and other health professional services (including diagnostic imaging, laboratory testing, office-administered drugs and various other "high-ticket" items) are covered by Medicare Part B. Increases in combined Part B expenditures are often inaccurately used to imply higher physician expenditures. Physician payment within Part B is updated on an annual basis via the SGR formula. The conglomeration of services that constitute Medicare Part B is assigned an annual target, and if expenditures exceed this target, a formulaic decrease in the annual physician update is required. The combined Medicare Part B services have exceeded their spending target every year since 2002, and are projected to increase annually by 8 percent over the next decade.[4] Based on the SGR formula, physician payments were decreased by 4.8 percent in 2002.[5] The target-driven process has mandated further cuts in each subsequent year; however, these cuts have been averted by congressional intervention, creating an even greater difference between target and expenditures annually. Despite exceeding annual targets, combined Part B expenditures have not increased as a proportion of total Medicare spending, remaining steady at around 20 percent of overall Medicare expenditures since 2000.[6]

Increases in total Part B expenditures should not be attributed to increased payments for physician services. Medicare physician expenditures as a percentage of Medicare outlays have decreased significantly since 2008—from 12.9% in 2008 to 9.6% in 2011 (Figure 1). Medicare outlays for the professional component of Part B are currently in line with 2007 expenditures, which is the first year the Health and Human Services budget distinguished physicians alone (as opposed to

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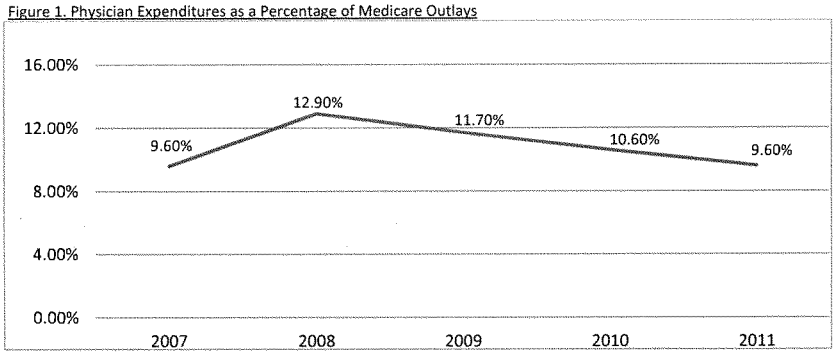
[1] Centers for Medicare and Medicaid Services. National Health Expenditure Data. www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf
[2] Medicare's Physician Payment Rates and the Sustainable Growth Rate. *CBO TESTIMONY Statement of Donald B. Marron, Acting Director.* July 25, 2006.
[3] Kaiser Family Foundation. Financing Medicare an Issue Brief. Prepared by Lisa Potetz, Health Policy Alternatives, Inc. January 2008.
[4] Id. at two.
[5] Id. at two.
[6] Id. at one.

combining physicians payments with other suppliers) as a separate service area within their budget documents.[7] The SGR formula, however, penalizes and holds physicians liable for costs over which they have no control.

Figure 1. Physician Expenditures as a Percentage of Medicare Outlays



Source: Department of Health and Human Services. Historical Medicare benefits by Service Data. CMS Budget in Brief Documents 2005-2011.

In its 2011 Report to Congress on Medicare Payment Policy, the Medicare Payment Advisory Commission (MedPAC) segregated services provided under Part B and highlighted volume growth patterns for each service category within Medicare Part B. The average growth rate for all services provided under Part B between 2000 and 2009 was approximately 4.4 percent. Physician evaluation and management services and physician payments for major procedures showed a modest 3.3 percent average annual volume growth rate, while the volume of imaging and test services grew by almost 9 percent on average annually.[8] Given faster rising costs for other components within Part B expenditures, the SGR formula will continue to project negative updates for physician payments despite decreasing expenditures on the professional component since 2007.

Physician Payments in the United States: Development of Fair Value for Codes

Health care in the United States has, for many decades, been a beacon to the rest of the world.
A substantial component of the United States' high-quality health care has been provided by specialists in their fields. Maintaining the excellence of that care by attracting individuals to specialty care must remain an integral part of health care policy as many surgical and specialty medicine disciplines have current or projected workforce shortfalls.

Physician payment in the United States is based on the submission of codes for services provided. Codes are valued through a process undertaken by the American Medicare Association (AMA) Relative Value Update Committee (RUC), which is a panel of 29 volunteer representatives from both primary and specialty care. The RUC has, in the last few years, recommended substantial increases to values for primary care services, preventive services, emergency services, home visits and nursing home visits while values for surgical procedures have decreased significantly. Between 1993 and 2002, Medicare payment for new office visits increased 73 percent and established visits increased 67 percent. During that same time period, payment for major procedures decreased an average of 8 percent, with some procedures such as cataract surgery, coronary artery bypass graft surgery and joint replacement surgery decreasing 43 percent.

While overall physician payment through Medicare has declined over the past few years, significant steps have been taken over this same time period to improve payment for primary care. In its March 2009 report, MedPAC noted that Medicare payments for primary care have increased 10.6 percent between 2006 and 2009, which can be attributed

[7] The Department of Health and Human Services. Historical Medicare benefits by Service Data. CMS Budget in Brief Documents 2005-2011.
[8] MedPAC. Report to Congress: Medicare Payment Policy. March 2011.

largely to the work of the physician community through the RUC process. The RUC's most recent five-year review (2007), approved by CMS, resulted in more than $4 billion in the fee schedule being shifted to evaluation and management codes from other services, including specialty care. Payment for many surgical services were cut again in 2008 because of an additional reduction in work values.

Specialists continue to lose ground in the fees they receive for serving Medicare beneficiaries while their practice costs steadily rise. Specialists go through longer training periods, accumulate more educational debt, experience more complex and higher stress of practice, work longer hours, and realize higher practice expense and liability costs. Further, several studies demonstrate looming workforce shortages for specialty care physicians, not dissimilar to that projected for primary care physicians. Any system attempting to replace or improve the current SGR should equally adjust payments for all physicians in an effort to maintain and promote access to high quality specialty care, accommodate the needs of all Medicare patients, and foster continued high quality care in the United States.[9]

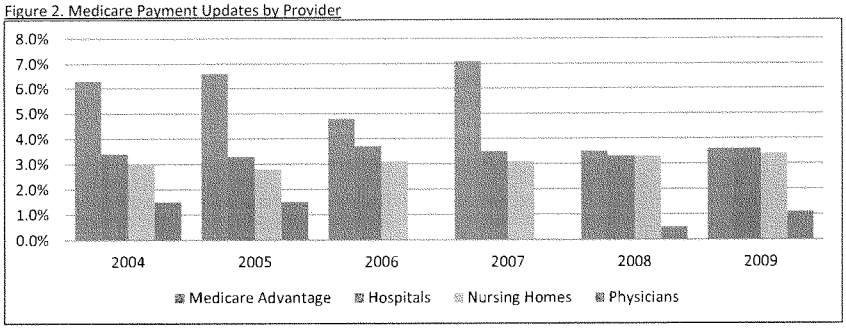
Reducing National Health Care Expenditures: Bearing Our Share of the Load

The patients' welfare is the primary driver of individuals who choose a career in medicine. Physicians are also cognizant of the current strains on the economy and wish to contribute to the effort in reducing national expenditures. It pains physicians to point out that Congress has, over the years, consistently provided significantly greater payment updates to Medicare Advantage plans, hospitals, and nursing homes than to those on the frontlines providing care to Medicare patients. On average, physician updates are less than half of those of other providers. These discrepancies have resulted in increasing payment inequities that negatively affect physicians' ability to continue providing high-quality services to Medicare beneficiaries.

From 2004-2009, physician updates averaged an annual 0.77% increase. Over the same time period, Medicare Advantage payments increased an average of 5.32%, while hospitals increased an average of 3.47% and nursing homes increased an average of 3.12%. In 2006 and 2007, when physicians received no payment update, Medicare Advantage plans, hospitals and nursing homes received updates of at least 3% per year (Figure 2). This lack of payment consistency across providers and settings is illogical, , inequitable and unsustainable.

Hospital spending constitutes approximately 33% of the total Medicare budget. Hospital payments have escaped the formulaic approach to payment, resulting in continued positive annual payment updates. Combined Part B Medicare expenditures constituted 13% of total Medicare expenditures in 2009. Any attempt at reducing health care expenditures should take into consideration all Medicare providers and in particular, identify expenditures that constitute higher proportions of overall expenditure and expenditures that have received generous updates.

Figure 2. Medicare Payment Updates by Provider



Source: American Medical Association. Analysis of Medicare Provider Payment Updates 2004-2009.

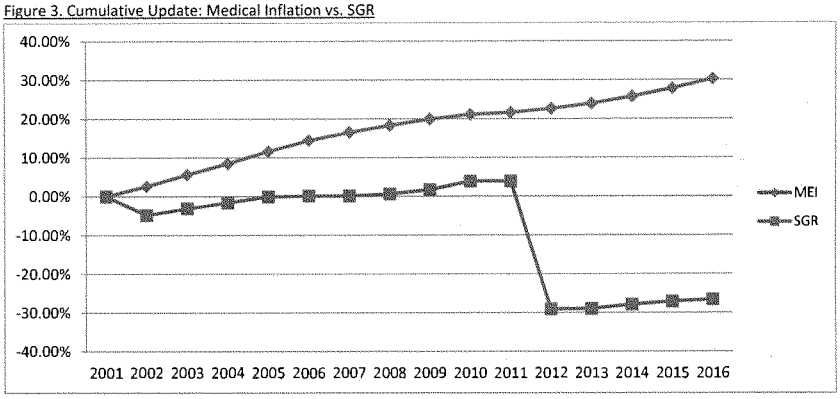
[9] Council on Graduate Medicare Education. New Paradigms for Physician Training for Improving Access to Health Care. September 2007.

Broad Agreement of SGR Failure

A general consensus among physician groups, policymakers and health care experts that Medicare's current physician payment formula is flawed. While this system attempts to monitor and stabilize Part B expenditures, it fails to accurately and fairly reimbursing physicians for the services they provide to Medicare beneficiaries. Expert analysis provided by physician groups, including the AMA and Alliance of Specialty Medicine, demonstrates that as Congress continues to provide temporary relief from payment cuts, the gap between the cost of services provided and their payment is increasing. The SGR formula requires a 29.5% cut to physician payments beginning January 1, 2012. According to the 2010 Medicare Trustees Report, further cuts of more than 20% will be mandated through 2016, while practice costs will increase more than 30% over the same period (Figure 3). Physicians cannot continue to treat Medicare patients if payments fail to even cover the costs associated with treating these patients.

MedPAC communicated its concerns with the SGR formula in its 2011 Report to Congress. The report highlights the disadvantages in the formula's across-the-board cuts to Medicare's physician fee schedule, the inability to reward or penalize individual providers who limit or contribute to unnecessary volume growth respectively, and its failure to provide a mechanism to counter the volume incentives inherent in a fee-for-service payment scheme.

Figure 3. Cumulative Update: Medical Inflation vs. SGR



Source: 2010 Medicare Trustees Report Updated to Reflect Medicare and Medicaid Extenders Act of 2010

Options for Replacing the SGR

NASS proposes that as Medicare physician payment transitions into a value-based system (3-5 years), the SGR formula be replaced by a formula based on the Medicare Economic Index (MEI). The CBO projects that the MEI will remain relatively stable from 2012 through 2019 and range from 1.0 to 2.7% (Figure 3). Replacing the SGR with a system that updates physician payments based on changes in costs as reflected by MEI would reimburse physicians in a manner that more accurately represents the cost of providing care. An alternate proposal would update physician payments based on changes in Gross Domestic Product (GDP), with the addition of a fixed percentage increase to ensure payment fairness. For example, President Obama recently proposed GDP plus 0.5% as a reasonable target for growth of total Medicare expenditure.

NASS also proposes that a target that uses combined Part B expenditures is too crude an instrument to develop any meaningful information on costs. This crude instrument precludes policymakers from accurately assessing the contributions of various expensive items with different annual growth rates within Medicare Part B, such as diagnostic imaging, laboratory and outpatient hospital expenditures. A combined target for all expenditures within Part B also eventually results in mandatory reductions in formulaic physician payment, without regard to the cause of increased expenditure within Part B. NASS proposes that if a target for expenditure were to be used, this target should be strictly limited to the immediate prior year professional physician payment expenditures. This more restricted target will provide a more accurate accounting of physician expenditures on an annual basis. Creating a set of more granular and increasingly sensitive targets may also lead to more careful analysis on various subgroups within the physician workforce when attempting to determine the best value for Medicare expenditures.

Incorporating Value into Physician Payment Systems

Despite vigorous efforts on the part of medical providers and researchers to develop an evidence-based approach to care, substantial gaps remain in quantifying the "value" of individual treatments, comparing the relative value of differing treatments, and the extrapolation of such values in the treatment of any individual patient. Therefore, attempting to develop a value-based system with the limited information currently available on what actually constitutes value is likely to result in an inaccurate and unsuccessful replacement of our current flawed system.

Identifying effective components of treatment and delivering high value care to Medicare beneficiaries will require an expanded pool of data. The development of registry databases, increased research on the effectiveness of treatments, the study of existing outcomes data through CMS or other organizations, and defining appropriate pathways of care will all allow for more reliable and consistent determinations regarding the value of specific services. Collaboration among specialty societies, CMS and other governmental agencies will be the most effective means of identifying crucial areas for study, appropriate individuals or groups to champion specific projects, and funding patterns that will facilitate the production of critical information necessary to transition to value-based payment. With government funding, specialty societies across medicine could develop a series of registries to track outcomes on important medical interventions.

Specific Value-Based Model Proposals

Developing integrated systems to deliver care in a manner that emphasizes value for the beneficiary and Medicare will require substantial cost outlays and risk assumptions. Identifying specific care pathways and components of delivery systems will be crucial to the success of these structures. In order to maintain a competitive balance that will allow for innovation, patient choice and economic efficiency, it is necessary to have a reimbursement environment that permits the development of smaller scale care groups that can maintain system viability. This will require some degree of economic protection or safety for groups that may be vulnerable to advancements of much larger groups which, if unopposed, may ultimately reduce patient choice and value. Additionally, there should be transparency in payment to ensure fair competition and to allow progress in cost containment to be shared. The parallel development of multiple delivery mechanisms will require the joint efforts of CMS, private payers, clinicians/specialty societies and patient advocates.

Value-based changes in care delivery that have been previously proposed include Accountable Care Organizations (ACOs), value-based payments and coordinated delivery of care. An ideal system may well involve a combination of these mechanisms of payment, particularly while transitioning from the current model. ACOs offer advantages by centralizing patient information and services, but have difficulties of scale, particularly for low population density areas, lower frequency treatments and highly complex patients requiring very specialized care. Ensuring adequate reimbursement for specialty care within these organizational structures is essential to reflect the high level of skill and training necessary to provide these services, to maintain an adequate specialty workforce, and to preserve the high quality of the nation's health care.

Value-based reimbursement could also be linked to the development of a value modifier for services provided. Transitioning to such a value-based payment system will require the development of specific outcomes information on various health care diagnoses. Registry databases, large scale clinical trials and appropriate care guidelines will be required to develop and refine this type of system. This form of payment would, however, allow for more independent forms of health care delivery than an ACO model, enabling clinicians to serve those who would be particularly difficult to treat in larger systems, such as those in rural areas. Coordinated delivery of episodes of care, or "bundling" of related

services, offers another potential delivery method. As with the other possibilities, identifying those components of care necessary to maintaining the value of the service is critical to the success of this model.

Because there are a variety of options without a clearly superior choice, Congressional support of demonstration projects may provide the best opportunity to explore and identify the best method or methods to achieve a successful transition to a payment system that focuses on value. For example, NASS includes primary care and specialty physicians, chiropractors and physical therapists who treat patients with spinal disorders. Neck and back disorders are a common malady representing a significant proportion of health care services. However, the care of patients with these common problems remains fragmented under our current delivery system, with inadequate and inefficient coordination among the various providers. Similar to the concept of the "medical home," which was evaluated with a CMS demonstration project, a model of interdisciplinary care that includes the integration and participation of a group of providers treating a disease process with a bundled payment reflective of the costs of managing the disease rather than costs reflecting each individual service would serve as an excellent demonstration project.

All of these alternative payment models offer the potential for increasing the quality of care while controlling costs. They also pose significant potential risks for Medicare beneficiaries while health care providers and systems try to deliver high quality care in a changing and uncertain marketplace. Financial safeguards for those developing these models will cultivate an innovative care environment and allow smaller provider groups to explore ways to improve value. Financial penalties associated with site-of-service or excessive documentation requirements will particularly disadvantage smaller groups and promote excessive consolidation of delivery by large hospital systems or coordinated groups, having a negative long-term effect on both cost and quality. Additionally, any value-based system developed should recognize efficiencies created by site-of-service changes and establish a mechanism to identify situations in which changing health care patterns result in cost shifting from Medicare Part A to Part B and vice versa. The implementation of this system should include policies to facilitate the movement of related funds across Medicare cost centers to improve budget and payment accuracy. Changes in the tort system that decrease the defensive practice of medicine and provide liability protection for physicians in these altered delivery environments will further enhance the capabilities of physicians to develop an effective value-based system.

As you consider the next steps for Medicare payment reform, NASS hopes that you will take into account these comments and concepts, as well as the unique role of specialty medicine. In closing, NASS would like to offer itself as a resource to the Energy and Commerce Committee as this discussion continues, and would be willing to provide expert testimony on any of the concepts offered. If you have any questions or comments please contact Nicholas A. Schilligo, MS, Director of Advocacy, at nschilligo@spine.org or (630) 230-3600. Thank you for your commitment to and leadership on this issue.

Sincerely,

Greg Przybylski, MD
President

cc: The Honorable Joe Barton, Chairman Emeritus
The Honorable Joseph R. Pitts, Chairman Subcommittee on Health
The Honorable Michael C. Burgess, MD, Vice Chairman Subcommittee on Health
The Honorable Henry A. Waxman, Ranking Member
The Honorable John D. Dingell, Chairman Emeritus
The Honorable Frank Pallone, Jr., Ranking Member Subcommittee on Health

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April 29, 2011

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Mr. Chairman:

The Society of Hospital Medicine (SHM), representing the nation's 34,000 hospitalists, appreciates the opportunity to provide suggestions on how to replace the flawed Sustainable Growth Rate (SGR) formula while improving the quality of U.S. health care. Practitioners of hospital medicine include physicians ("hospitalists") and non-physician providers who engage in clinical care, teaching, research, or leadership in the field of general hospital medicine. In addition to their core expertise managing the clinical problems of acutely ill, hospitalized patients, hospital medicine practitioners work to enhance the performance of hospitals and healthcare systems. SHM applauds the Committee's bipartisan effort to gather stakeholder input in developing a workable alternative that reduces spending, pays providers fairly, and pays for services according to their value to the beneficiary. SHM believes that Medicare's current physician payment system should be reformed to:

- Reimburse for quality rather than volume
- Promote and reward integrated, team-based care that fosters better coordination across settings of care
- Incentivize physicians and hospitals to improve transitions of care and post-discharge follow up
- Foster person and family-centered care
- Better align the priorities and financial incentives of hospitals and physicians

The problems with the current fee for service payment system are widely known. Most notably, performing more services increases pay for providers without an incentive to reduce unnecessary services or to improve quality. Nowhere is this problem more glaring than in the inpatient setting, which accounts for approximately 1/3 of health care dollars spent.

The current reimbursement system misaligns hospital and physician payments, resulting in spiraling costs associated with inpatient care and little incentive to implement initiatives that control those costs and improve quality. Although hospitals want to incentivize physicians to reduce costs through various gainsharing mechanisms, regulatory hurdles prohibit such arrangements.

An illustrative example of this fact can be seen with the success of hospitalist-led initiatives, such as SHM's Project BOOST, to reduce hospital readmissions. One in five hospitalized patients is readmitted to the hospital within a month of discharge, and these unplanned readmissions cost Medicare approximately $17.4 billion each year. Project BOOST decreased rehospitalizations by 17 percent in Piedmont Hospital near Atlanta, and, in a hospital near St. Louis, decreased unplanned 30-day

readmissions by more than 40 percent within three months. Project BOOST and similar initiatives have saved the Medicare program millions of dollars, yet they penalize hospitals and physicians by reducing billable services.

SHM believes that more physicians and hospitals will embrace quality improvement and cost containment initiatives if they are reasonably incentivized to do so. We support targeted gainsharing demonstration projects that would allow individual hospitals and physicians to share in savings accrued from successful implementation of programs such as Project BOOST, though not limited to a focus on reducing readmissions. To do this, legal gainsharing arrangements would need to be established, which could be accomplished by extending the safe harbors and waivers already slated for ACO applicants to demonstration project participants. Similar gainsharing waivers already exist within Medicare HMO programs. Program parameters would be very similar to relevant portions of the recently released proposed rule on ACOs, saving time and expense.

Limited demonstration projects such as these would be far less daunting to implement than full-scale ACOs because they would take place within a single institution, using well-established tools with proven track records for success. Programs such as these would likely offer quick return on investment and create momentum for hospitals and physicians to evolve to larger endeavors, such as full-scale ACOs.

In addition to this suggestion, SHM also supports the Medicare Payment Advisory Commission's recommendations for calculating growth-rate and payment targets for different service categories. This could be done through creating a new system that would provide a growth target of GDP plus two percent for evaluation and management services and preventive services and a growth target of GDP plus one percent for all other services, a plan that has been supported previously in the House of Representatives. We also support exempting ACA-created accountable care organizations from the SGR payment system.

SHM appreciates the opportunity to work with you in fixing the flawed SGR payment system. If we may be of further assistance or provide any additional information, please do not hesitate to contact Laura Allendorf, Senior Advisor, Advocacy and Government Affairs, at 703-242-6273 or LAllendorf@hospitalmedicine.org.

Sincerely,

Jeffrey Wiese, MD, SFHM
President

April 29, 2011

The Honorable Fred Upton, Chairman
Congress of the United States
House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

The Honorable Henry A. Waxman, Ranking Member
Congress of the United States
House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Representatives:

We are writing to you in response to your letter dated March 28, 2011 regarding proposals to reform the Medicare physician payment system. The Society of Nuclear Medicine (SNM) is an international scientific and professional organization that promotes the science, technology and practical application of nuclear medicine. We represent 16,000 physicians, technologists and scientists specializing in research and the practice of nuclear medicine.

More than 20 million men, women and children have noninvasive molecular imaging procedures annually. These safe, cost-effective procedures include positron emission tomography (PET) scans to diagnose and monitor the treatment of cancer, cardiac stress tests to assess coronary artery disease, bone scans for orthopedic injuries, and lung scans to detect blood clots. The advances in imaging technology have significantly reduced the need for exploratory surgery and have changed how physicians diagnose and treat many of our most serious diseases.

Since 2003, use of the Sustainable Growth Rate (SGR) formula has threatened to result in significant reductions in physician reimbursement. These year-by-year fluctuations contribute to the instability of the Medicare program, and threaten the willingness of providers to continue to treat Medicare beneficiaries. The SGR system does not improve quality or efficiency of Medicare provider services.

SNM strongly favors repeal of the SGR formula and opposes further across-the-board cuts to reimbursement rates for imaging services. Congress should pursue solutions that ensure accountability and quality in the provision of these services. We believe the following steps are critical to the appropriate utilization of imaging services, which will reduce costs and improve quality of care:

1. *Maintain Accountability for Physician Services:* The creation of separate payment categories or buckets for physician services has been discussed by Congress as one option for moving away from the flawed SGR physician payment system. Part of the rationale for separate payment categories is to influence physicians on the volume growth within their respective service areas. We believe the costs associated with imaging services should not be solely attributable to the imaging category merely because imaging services were ordered. We believe all of medicine is responsible for the appropriate use and growth of imaging utilization. CMS and Congress should pursue a payment method that states when a physician orders imaging services the reimbursement costs associated with the imaging procedure would be attributable to

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the specialty bucket to which that physician belongs. For example, imaging done by a neurologist in his or her own facility would be attributed to the neurology bucket. Whereas, imaging performed on an order by imaging specialists, like nuclear medicine, would be attributed to the imaging bucket.

2. *Accreditation and Certification:* The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires providers of advanced imaging services to meet comprehensive accreditation standards by 2010. Accreditation will help attest to the quality of practice and image outputs at a given facility. Requiring minimum standards for all providers, including technologists, allows for consistency and accountability within the field of advanced imaging. With improved accountability comes improved quality of care and cost savings by reducing the need for repeat procedures. The SNM supports the accreditation requirement under MIPPA and encourages Congress to pass the Consistency, Accuracy, Responsibility and Excellence in Medical Imaging and Radiation Therapy (CARE) Bill. The CARE Bill will establish education and certification standards for technical personnel who plan and deliver nuclear medicine procedures.

3. *Establish Methodologies to Assess Imaging Effectiveness:* Despite its best efforts, the imaging community has not been able to devise a methodology to measure the impact on the outcome of the patient. Imaging physicians need to develop and institute a robust body of clinical evidence that accurately assesses both the cost and clinical effectiveness of imaging procedures. To do this properly, funding should be allocated for a new program structure to help stakeholders develop a meaningful, substantive body of clinical evidence using a transparent process that minimizes the administrative burden. Establishing these core principles will allow more accurate, clinical-based data to guide clinical decision making in the future and reduce costs from inappropriate imaging procedures.

SNM appreciates the opportunity to provide input on how to reform the Medicare physician payment system. Should you have any questions, please contact Sue Bunning, Director of Health Policy and Regulatory Affairs via email, sbunning@snm.org, or via telephone (703) 326-1182.

Sincerely,

Dominique Delbeke, MD, PhD
President, SNM

CC: George Segall, MD
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Michael Graham, MD, PhD
Virginia Pappas, CAE
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May 2, 2011

Honorable Fred Upton, Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Upton:

On behalf of The Society of Thoracic Surgeons (STS), the largest organization representing cardiothoracic surgeons in the United States and the world, I am writing in response to the House Committee on Energy and Commerce request for input on the Medicare physician payment system. Founded in 1964, STS is a not-for-profit organization representing more than 6,100 surgeons, researchers, and allied health care professionals who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lung, and esophagus, as well as other surgical procedures within the chest. Thank you for the opportunity to share our comments with the Committee as it focuses on this most important issue.

SGR Reform

The volatility of the Medicare payment system is threatening Medicare beneficiaries' access to surgical care. Continued payment cuts, rising practice costs, and ongoing uncertainties about the Medicare payment system make treating Medicare patients more difficult for both community-based and academic surgical practices. Over the past decade, STS has repeatedly advocated for the reform and redesign of the unstable and unsustainable Medicare physician payment formula. Congress' reluctance to reform a flawed payment system has caused instability and uncertainty that undermine surgeons' abilities to plan for the future and has created a substantial impediment to continuing efforts toward improvements in the quality and efficiency of patient care.

STS believes it is the professional responsibility of all physicians to use health care resources effectively and efficiently so that the quality and value of health care are maximized. Existing payment systems reward providers only for delivering more care and more complex care rather than better care. Moving to a quality-based payment system must start with redesign of the Medicare physician payment formula. The current Sustainable Growth Rate (SGR) formula is fatally flawed and must be replaced.

In conceptual terms, the current SGR formula places overall responsibility for physician expenditures on the medical profession as a whole; but in practice, SGR experience has clearly demonstrated that setting a reduced growth rate target for Medicare Part B services is ineffective and unrealistic. A major shortcoming of the SGR formula is that there are no organizational mechanisms by which the profession can influence the growth rate of physician services and payments; there is actually a disincentive to self-regulate. Any modernization of the physician payment system should address this shortcoming of the

SGR formula with increased responsibility at the medical specialty level, where organizational infrastructures already exist. Professional responsibility for physician expenditures can then occur based on real data concerning what is most effective and most appropriate for the patient. The system should focus on methods that reward improved outcomes and efficiency rather than volume.

Different sectors of medicine grow at different rates; therefore a more realistic payment system would include multiple growth targets for different service categories based on rate of growth analysis. Unlike other areas in medicine, cardiothoracic surgery and other surgical specialties have *not* seen a substantial increase in the volume of specialty procedures, yet the volume target for increased utilization applies to all physicians. STS has analyzed this further, and data show that Medicare expenditures between 2000 and 2009 exceeded the growth rate of the Medicare beneficiary population in 41 specialties. In that same time period, expenditures were less than the growth rate of the Medicare beneficiary population in 10 specialties, including cardiothoracic surgery and other surgical specialties. Because most physicians in the U.S. belong to specialty and subspecialty organizations with their professional peers, and because such organizations increasingly are developing clinical registries to help physician members improve their practices, this organizational infrastructure could serve as a more realistic basis for control of physician expenditures.

Recommendations
STS recommends repealing the current SGR formula in favor of a system that aligns payment with quality and value.

STS recommends a system of multiple conversion factors that rewards professional accountability and encourages physicians to assess the effectiveness of treatments and services. At a minimum, STS supports a separate conversion factor for major surgical procedures and believes that separate conversion factors for each specialty should be strongly considered. Such a system would be administratively simple to implement and would provide a disincentive to "over spend" and exceed established targets. This approach would also allow quality incentive programs to be more targeted, requiring specialty-level self-regulation. Combining specialty conversion factors based on disease management could easily be adopted (cardiovascular disease, for example) and could rely on common outcomes databases. As the STS National Database and registries of other specialties have demonstrated, sharing outcomes data effectively motivates physicians to change their practice patterns, which can result in more efficient care delivery and increased patient value.

Investing in Proven Quality Improvement Initiatives
STS also believes that there is a need to improve the *value* of health care. In order to achieve this goal, there must be a reimbursement system in place that recognizes and rewards physicians who improve the quality and value of care. Such a system should reinforce meaningful quality improvement initiatives, including the acquisition and use of risk-adjusted reliable outcomes and clinical effectiveness data, and reward physicians for improved outcomes. STS has been the leader in developing physician-led quality improvement initiatives – initiatives that have resulted in improved outcomes and lower costs. Those initiatives have been possible because STS maintains a robust, externally audited, and world-renowned National Database of more than 4 million patient records, each detailed with clinical information. Such

experience emphasizes that physicians, in collaboration with their respective professional societies, are best and most appropriately positioned to define what constitutes high-quality care.

We support data-driven approaches to quality measurement, improvement, and reporting. Building truly continuous quality improvement systems is dependent on the collection and analysis of risk-adjusted clinical outcomes and utilization data. Most importantly, it requires providing feedback on those data to physicians. Clinical data can then be linked with administrative data to track the cost of care over time and provide an assessment of clinical and cost effectiveness, including for issues related to new technologies and devices. Only a clinical database with a sufficient volume of clinical records can be credibly risk-adjusted for case mix to yield accurate and comparable findings.

STS has successfully linked its clinical data with Centers for Medicare and Medicaid Services (CMS) MEDPAR information to obtain longitudinal outcomes data for a wide array of cardiothoracic surgery operations. The ability to link clinical data with administrative data has opened up important new ways to assess the effectiveness of treatment options and offered new avenues for medical research. Clinical data yield sophisticated risk-adjustment assessments, while administrative data provide information on long-term outcomes such as mortality rate, readmission diagnoses, follow-up procedures, medication use, and costs. Linked data are particularly useful in conducting comparative effectiveness research (CER) and establishing appropriateness of care.

The use of national clinical registries offers insight to a population of "real-world" patients and provides ready access to data that can yield analytic results quickly. Furthermore, these attributes of registry-based observational studies permit the analysis of patient populations far greater in size than that typically seen in randomized controlled trials and at a much lower cost. The use of clinical registries in this manner could well serve as an important national resource to compare long-term outcomes for a variety of medical devices and treatment options. By pinpointing appropriate care, the application of these registry-based studies should improve outcomes, minimize overuse of therapeutic options by reducing waste and ineffective diagnostic and therapeutic measures, and ultimately reduce health care costs.

Recommendations
STS strongly urges Congress to mandate that the Department of Health and Human Services (HHS) incentivize development of specialty and/or condition-specific, outcomes-focused clinical data registries and utilize funds available in the Center for Medicare and Medicaid Innovation for such purposes.

Additionally, we support well-designed comparative clinical CER to evaluate treatments and procedures, the long-term efficacy of drugs and devices, and appropriateness criteria for utilization -- all of which can best be addressed with valid clinical data. Therefore, Congress should fully fund the Patient Centered Outcomes Research Institute (PCORI). With its focus on clinical rather than cost data, PCORI would provide the appropriate avenue for conducting CER in a transparent manner. Congress also should direct AHRQ to utilize valid clinical registries whenever possible.

Alternative Payment Systems
Accountable care organizations (ACOs), bundled payments for defined episodes of care, and gainsharing are three mechanisms CMS is considering to encourage collaboration among physicians, hospitals, and other relevant providers by aligning incentives for improving the quality of care and lowering costs. STS takes the position that in order to ensure optimal health care delivery, these alternative payment systems must be physician led, patient centered, and quality driven.

We recognize that ACOs and other innovative payment models can help physicians deliver more efficient and more effective care, but not all physician practices will be able to change their organizational structure and processes in order to participate in these new payment models. Thus, ACOs must be completely voluntary, and those physicians who cannot or choose not to participate must not be penalized. Of equal importance, although ACOs may prove effective in improving the management of common conditions, payment systems must also recognize that, in reality, there are significant numbers of patients with uncommon conditions who require highly complex procedures or treatments. ACOs may not have the financial resources to develop expertise for these conditions, and therefore payment mechanisms must exist to compensate those who provide this type of tertiary/quaternary care.

Any payment model implemented should use an effective and rigorous risk-adjustment methodology so that ACOs are rewarded, not penalized, for accepting sicker patients and addressing their needs in the most effective way possible. But risk adjustment alone is not enough; some patients will have unique problems that require unusually expensive care not adequately captured by any risk-adjustment methodology. Even a single patient of this nature could be financially devastating for a specialized physician practice, whereas a large health system would be much less affected. Thus, in addition to appropriate risk-adjustment methodologies, limits should be established on an ACO's accountability for the total cost of services to any individual patient. Moreover, timely and detailed feedbaek to physician practices is needed if opportunities for cost and quality improvements are to be identified.

We believe that shared-savings arrangements encourage wise allocation of health care resources and provide a guide for sustained savings. Bundling Part A and Part B Medicare payments would also shift incentives from the current volume-based system to one that rewards physicians for using only the most appropriate procedures and reducing post-operative complications – efforts that ultimately can reduce expensive hospital readmissions. This bundled payment model could be applied to the care of beneficiaries with defined conditions over a distinct period of time, particularly for those with the most costly diseases and chronic conditions. A bundled payment system should also reward attainment of outcomes benchmarks, such that underutilization of services is not encouraged. The coupling of outcomes measures with bundled payment would align incentives to improve the quality of care for Medicare beneficiaries, leading to reductions in costly complications, the creation of quality-guided resource utilization, and the achievement of sustained savings, efficiency, and innovation.

Recommendations
STS recommends that Congress support the development of incentive programs offering physicians the opportunity to share in savings generated by quality improvement efforts. Patient-centered systems of care should be encouraged to reform and reorganize the delivery of health care. Care must be refocused around the needs of patients, and systems of delivery should allow and encourage collaboration across

organizational boundaries and disciplines. Moreover, to lower cost and improve quality, payment must be restructured to create incentivized integrated delivery systems that focus on specific patient needs. While we support the concept of shared savings programs, we believe that incentives should not be based solely on cost savings (use of claims data exclusively), but should also include increases in value (quality divided by cost).

STS also recommends that Congress address legal concerns that might arise for physicians who provide patient care as part of an alternate payment system. We are concerned that a general waiver of the rules regarding discretionary decisions to not pursue enforcement actions will leave providers inadequately protected within the context of these types of arrangements. We urge Congress to ensure the Federal Trade Commission (FTC), Department of Justice (DOJ), CMS, and the HHS Office of the Inspector General (OIG) develop explicit protections from antitrust laws, the physician self-referral prohibition, the Federal anti-kickback statute, and the civil monetary penalty (CMP) laws for physicians providing care in alternative arrangements such as ACOs. These protections are absolutely imperative as attempts at shared savings programs involving cardiothoracic surgeons have been derailed, in part due to OIG and the DOJ concerns regarding physician self-referral and CMP laws.

Medical Liability Reform

Meaningful medical liability reform, a critical component of any payment reform, is necessary both to protect patients' access to quality care and slow the rising cost of health care. The inefficiencies of our current medical liability system, which contribute to escalating and unpredictable monetary awards, and the high cost of defending against malpractice lawsuits contribute to the increase in medical liability insurance premiums. As insurance becomes unaffordable or unavailable, physicians must make difficult decisions about whether to alter or limit their services because of liability concerns, an outcome that impedes patient access to care and increases costs. In addition, the cost of our liability system is borne by everyone as defensive medicine adds billions of dollars to the cost of health care each year, resulting in higher health insurance premiums for patients. The Congressional Budget Office has recognized the steep cost of our current medical liability system and has estimated approximately $40 billion in scored savings from comprehensive medical liability reform. The current system for compensating injured patients drives defensive medicine practices and so increases health care costs. Additionally, access to life-saving high-risk procedures is increasingly compromised by lawsuit abuse.

Recommendations

STS urges Congress to enact meaningful liability reform, such as that outlined in H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011.

Public Reporting

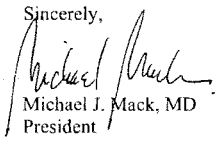
STS supports public reporting initiatives that are generated from credible, reliable and valid sources and utilize risk adjusted clinical outcomes data. Such initiatives should use clinical data that have been tested and found appropriate to drive improvement in care. It is important not to misinform patients, and to avoid the unintended consequences of delivering misleading or inaccurate guidance utilizing less sophisticated administrative data. STS feels strongly that consistency of formats in reporting on cardiac surgery outcomes is critical and believes that data are only as useful as they are understandable.

In that regard, STS has partnered with Consumers Union (CU), publisher of *Consumer Reports*, to make outcomes data – voluntarily submitted by U.S. cardiac surgery practices participating in the STS Adult Cardiac Surgery Database – available to the public. In September 2010, Consumers Union posted star ratings based on the STS composite quality measure on its website. STS has now launched its own public reporting initiative, STS Public Reporting Online, which provides the quality composite scores of more than 350 STS Adult Cardiac Surgery Database participants. While complementing the CU effort, STS Public Reporting Online provides more granular data and covers a more expansive timeframe.

Recommendations
STS urges Congress to temper those policies that expand public accountability of Medicare providers and set specific criteria and limits on the public release of raw administrative data reports in favor of alternative public reporting formats based on risk-adjusted clinical outcomes data similar to those currently used by STS and CU.

STS greatly appreciates the opportunity to offer these comments for the Committee's consideration as it addresses concerns related to the current Medicare physician payment system. We look forward to working with you toward repeal of the SGR and implementation of a more stable payment system that is patient-centered, physician-led, and quality-driven. We welcome the opportunity to serve on a witness panel to provide testimony during the upcoming Committee hearings. Please contact Phil Bongiorno, STS Director of Government Relations, at (202) 787-1221 or pbongiorno@sts.org if you have any questions.

Sincerely,



Michael J. Mack, MD
President

cc:
The Honorable Henry Waxman
The Honorable Joe Barton
The Honorable John Dingell
The Honorable Joe Pitts
The Honorable Frank Pallone
The Honorable Michael Burgess, MD

American Association of Clinical Endocrinologists
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April 29, 2011

The Honorable Fred Upton
Chairman
House Energy & Commerce Committee
Room 2125 Rayburn HOB
Washington, D.C. 20515

The Honorable Henry Waxman
Ranking Member
House Energy & Commerce Committee
Room 2322 A Rayburn HOB
Washington, D.C. 20515

Dear Chairman Upton and Ranking Member Waxman:

The American Association of Clinical Endocrinologists (AACE) welcomes the opportunity to provide input on Medicare physician payment reform and looks forward to serving as a resource to each of you and your staffs on this issue.

AACE represents over 5,000 endocrinologists in the United States alone and is the largest association of clinical endocrinologists in the world. The majority of AACE members are certified in Endocrinology and Metabolism and concentrate their work on the treatment of patients with endocrine and metabolic disorders including diabetes, thyroid disorders, osteoporosis, growth hormone deficiency, cholesterol disorders, hypertension and obesity. AACE members are committed to providing the highest quality of care to the patients they serve.

We strongly urge that reforms to the Medicare physician payment system recognize the unique role of different medical specialties in the health care system and reimburse each specialty for their unique expertise and their level of training.

The primary care physician and the medical specialist both play vital roles in patient care and in the nation's health care system. Several initiatives enacted under the Patient Protection and Affordable Care Act (PPACA) are intended strengthen the role of primary care physicians under Medicare, and AACE supports efforts to increase access to primary care. We believe, however, that medical specialists, and the care they provide, face their own set of challenges that impact access to care. Appropriate payments to medical specialists must also be addressed for specialties, such as endocrinology, to remain viable for ensuring continued beneficiary access to high quality, well-coordinated care under the Medicare program.

A recent change in Medicare physician payment policy to no longer provide payment for consultation service codes is in direct conflict with health system reform goals that both parties agree on (i.e., improving care coordination and the management of chronic diseases). The elimination of consultation service code payments has disrupted the physician-to-physician consultative process, between teams of specialists and primary care physicians to manage all aspects of the Medicare beneficiary's care. Endocrinologists and other cognitive specialists must have adequate resources in order to participate in integrated systems of care that promote coordination and optimal patient care, and reduce unnecessary spending associated with duplicate tests, fragmented care, preventable illness and costly hospitalizations.

Endocrinologists undergo extensive, specialized training in the diagnosis and treatment of diabetes and other endocrine disorders during a two to three-year endocrine fellowship following completion of an internal medicine residency program. As a result, endocrinologists primarily work as consultants to general internists and primary care physicians, providing expert opinion and assistance in the management of patients with complex, and often difficult, medical conditions. An integral element of these types of consultative interactions is an educational component for the primary care physician that results in improved quality of patient care, based on the training and skills in the care and management of endocrine diseases and disorders that the endocrinologist possesses. Diabetes, for example, requires complicated, individualized treatment plans as well as comprehensive care for associated risk factors. There are many different treatment strategies for

managing diabetes, and endocrinologists spend a significant amount of time determining what the best strategy is for each individual patient.

The work of an endocrinologist to manage a patient's diabetes is cognitive and extremely time and labor intensive. Any new Medicare physician payment system must recognize the importance and value of these cognitive skills and support physicians spending the time necessary to care for patients with complications. Current Medicare payment policy does not recognize and fairly account for the level of time, effort, and analysis involved in providing the level of service needed for patients with chronic diseases, affecting the majority of the Medicare population. The endocrinologist must complete an exhaustive clinical evaluation and review the patient's medical history and then use his or her expertise and experience to analyze and synthesize the medical data into meaningful recommendations that are individualized to patients' needs.

The Medicare program currently marginalizes the role of the endocrinologist in providing appropriate care to Medicare beneficiaries, which is forcing endocrinologists to reduce the number of new Medicare patients they will see in both their office and in the hospital setting. The result is a reduction in quality of care and increased cost to the Medicare program when complications from diabetes occur, such as blindness, cardiovascular disease, kidney disease and neuropathy.

AACE is also concerned about the impact of the current payment system on the future workforce and the ability of Medicare to meet the future health care needs of the country. Current policy provides a disincentive for future medical residents to pursue fellowships and advanced study in endocrinology as opposed to remaining a primary care physician or becoming a procedural specialist. Current workforce shortages in fields such as endocrinology will be exacerbated and patient access to the specialized care provided by endocrinologists will be severely restricted, if not eliminated in some areas of the country.

On behalf of AACE, I offer whatever assistance we can provide to assist you in developing meaningful and sustainable Medicare physician payment reform that will ensure continued access to care, and keep the promise of health care following retirement made to all Americans. Please feel free to contact me or Sara Milo, AACE Director of Legislation and Governmental Affairs, at 904-353-7878 or smilo@aace.com. We believe if payment reform results in participation in Medicare being a viable option for endocrinologists, the program will achieve better health care and quality of life for our aged population and remain fiscally stable and sustainable well into the future.

As Congress and the medical community work together to develop and enact viable and fair payment reform, AACE urges Congress to provide annual updates for physicians in the interim transition period. Without congressional action, the automatic double-digit payment cuts physicians face under the current flawed SGR program will further destabilize the Medicare program and further reduce access to care.

Thank you for your consideration of these issues.

Sincerely,

Yehuda Handelsman, MD, FACP, FACE, FNLA
President

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May 5, 2011

The Honorable Joseph Pitts
The Honorable Frank Pallone
Subcommittee on Health
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Pitts and Ranking Member Pallone:

As the nation's first and largest specialty network of rehabilitation therapists in independent practice, PTPN and its members who function as small businesses are pleased to offer this statement to the Health Subcommittee of the House Committee on Energy and Commerce as it convenes the hearing May 5 hearing entitled "The Need to Move Beyond SGR." PTPN has led the rehabilitation industry in national contracting, quality assurance and provider credentialing since 1985, elevating the standard of therapy practice. PTPN continued its role as a rehab pioneer by becoming the first organization of its kind to launch a mandatory third-party outcomes measurement program in 2006. The network has more than 1,000 provider offices (including 3,500 physical therapists, occupational therapists and speech/language pathologists) in 23 states. PTPN contracts with most of the major managed care organizations in the nation, including insurers, workers' compensation companies, PPOs, HMOs, medical groups and IPAs. All members of PTPN must be independent practitioners who own their own practices.

As you proceed with your efforts to reform and ensure stability of the Medicare program -- particularly the Physician Fee Schedule -- we would urge you to be continuously mindful of the independent rehabilitation therapy providers and suppliers who function as small businesses and who are an important, integral element of our delivery system. PTPN members provide a valuable service to communities across the nation and they do so in a convenient, cost-effective manner. But as is typical for small businesses, narrow margins are jeopardized when a significant sector of its market cuts reimbursement without regard to the value of the service provided. Moreover, when such an action is unpredictable and is taken by an influential payer such as Medicare, the effect is to negatively influence the business environment and create an untenable situation for the providers. More importantly, the Medicare beneficiaries are left in a vulnerable position, unable to depend on the access to convenient, cost-effective, high-quality care to which they have become accustomed.

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PTPN provides critical health care services to beneficiaries under Medicare Part B to enable individuals to return to their highest functional potential. Yet, PTPN member practices will be among those who will see Medicare reimbursement rates cut by 29 percent on January 1, 2012, unless Congress takes some important and necessary action. As the Committee on Energy and Commerce Committee considers legislative options for reforming Medicare payment policies, PTPN is pleased to offer the following guidance and suggestions:

SGR Repeal
A 29 percent cut in Medicare reimbursement, if allowed to take effect next year, would have a crippling impact on private practice physical therapists and their small businesses. Since many private insurers benchmark their payment rates to Medicare, the impact of such a significant cut would be felt far beyond the Medicare community. The recent history of extending a minimal rate increase for a few months or even a year is an unwise and detrimental way to run an insurance program for 47 million beneficiaries. It is time for Congress to repeal the flawed and dysfunctional formula known as the sustainable growth rate (SGR) which has created an unpredictable and untenable business environment for Medicare Part B providers.

In doing so, PTPN would urge Congress to consider placing more emphasis on the value of the service provided, including the resultant effect of the care on the patient.

Electronic Health Records
Congruent with this notion is the need for Congress to expand the incentives for providers to establish electronic health records. Non-physician providers such as independent physical therapists were not included in the federal programs that encourage and reward the adoption of health information technology. Yet, our members provide an important and valuable service that should be coordinated and communicated electronically. What sense does it make to encourage an information superhighway, but only allowing a certain select type of car to drive on it? The sooner Congress and the administration can set the standards for an interoperable electronic health records the sooner waste and redundancy can be wrung out of the system.

Therapy Cap Repeal
Congress can and should take a related step to correct an injustice in the Medicare system that punishes the beneficiaries who are the most impaired and disabled. The arbitrary, per beneficiary annual therapy caps were authorized as part of the Balanced Budget Act of 1997, and were scheduled for implementation on January 1, 1999. Since then, Congress has intervened numerous times to place a moratorium on therapy caps. And, since 2005, Congress has extended a broad-based exceptions process. These caps were intended to be temporary until "an alternative payment method" could be developed.

And while such an alternative has not materialized in 14 years, one is possible if Congress and the Centers for Medicare and Medicaid Services (CMS) would commit to collecting the necessary descriptive data upon which such an alternative could be predicated.

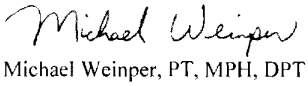
A limited (and targeted) extension of exceptions process for 2012, 2013, and 2014 combined with instructions to CMS to grant the therapy cap exception for care delivered in any setting that is collecting and reporting functional outcomes data would result in a database containing sufficiently robust information to design the alternative payment method envisioned by the 1997 BBA. Most importantly, such a payment model would not be based on an arbitrary limit, but rather on the amount and type of care to achieve the desired optimal outcome.

Implementation of the above policy need not be costly. In fact, when done thoughtfully and fairly, it may even generate modest savings. PTPN is eager to work with the Committee as well as CMS in advancing this short-term transition that can ultimately result in the therapy cap issue being put behind us.

Curbing Overutilization of Therapy
Currently under Medicare Part B there are various ways to bill for services. One policy in particular -- the Stark II in-office ancillary services exception to the self-referral law -- carries a proven propensity for overutilization. PTPN believes, and evidence shows, that elimination of this exception could provide potential cost-savings and improve the integrity of the services delivered and paid for by the Medicare program. The Office of the Inspector General of the United States Department of Health and Human Services has continued to identify a high rate (78 to 91 percent) of inappropriate billing of physical therapy services billed "incident to" a physician's professional services. Elimination of these practices must be addressed in an effort to provide a sustainable payment system for providers that serve the Medicare Part B program and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

On behalf of PTPN, thank you for your continued efforts to create a more effective and more efficient Medicare payment system.

Sincerely,



Michael Weinper, PT, MPH, DPT
President/CEO

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