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MEMORANDUM

July 17, 2012

To: **Committee on Energy and Commerce Democratic Members and Staff**

From: **Committee on Energy and Commerce Democratic Staff**

Re: **Hearing on "Using Innovation to Reform Medicare Physician Payment"**

On Wednesday July 18, at 10:00 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Health of the Committee on Energy and Commerce will hold a hearing entitled, "Using Innovation to Reform Medicare Physician Payment."

The sustainable growth rate (SGR) is a spending target for Medicare Part B services that controls the annual increase or decrease to physician and practitioner fees in Medicare. It has been overridden 13 times in the last decade and is scheduled to reduce fees for physicians and practitioners by 27% on January 1, 2013.[1] CBO estimates that it will cost nearly $300 billion simply to maintain physician fees at their current levels for the next 10 years.[2]

The Medicare physician fee schedule is the basis of Medicare's payments to physicians, nurse practitioners, and other non-physician practitioners. In addition, TRICARE, the military's civilian, family, and retiree health plan, uses Medicare's physician fee schedule to pay physicians, so the SGR affects Medicare beneficiaries and military families alike. There is broad consensus that the SGR mechanism needs to be replaced.

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[1] Centers for Medicare and Medicaid Services, *Medicare Physician Fee Schedule Proposed Rule, published July 6, 2012.*

[2] Congressional Budget Office, "Estimate of the Effects on Direct Spending of Provisions Related to Medicare and Medicaid Included in the President's Budget Proposal for Fiscal Year 2012, March 25, 2011, (online at http://www.cbo.gov/budget/factsheets/2011b/Presidents_Budget_ReEstimate_HealthProvisions.pdf).

A key problem with the current system is that there is a disconnect between the incentive system and the ability of an individual physician to impact his/her future payments. Under the SGR, an individual physician has no real incentive to be more efficient because the payment repercussions of his or her actions are spread nationwide across the entire physician community. However, if Congress were to repeal the SGR, something would have to replace it. The focus of this hearing is what improvements should be made to the delivery system for a post-SGR world.

This memo summarizes a number of delivery system efforts that are currently being tested by Medicare and the private sector. In addition, a separate, supplemental background paper summarizes the origins of the SGR, historical interventions to override payment cuts, problems with the SGR and the Medicare physician fee schedule, and recent efforts to address the SGR problem permanently.

I. PROMOTING NEW PAYMENT DELIVERY MODELS AS AN ALTERNATIVE TO THE FEE SCHEDULE

The difficulty with envisioning an entirely new payment system for physicians is that there are over 700,000 physicians and they vary in terms of specialty, group size, geographic location, and practice patterns. Because of this variety, no single payment model has been identified as the "silver bullet" to replace the physician fee schedule. And, many of the payment models under discussion are still being tested, refined, and evaluated. Issues surrounding new payment systems include: should they encompass physician services only or physician and facility payments? Should new payment systems be mandatory for physicians or should Medicare incentivize physicians to move to these alternatives, possibly by legislating increasingly negative updates to the fee schedule? What payment systems make sense in light of ACA's focus on delivery system reform?

A number of alternative payment models have been suggested that some observers believe would better incentivize physicians to provide high quality/high value care. The three models receiving the most attention are: patient-centered medical home (PCMH), bundled payments, and accountable care organizations. These models are being implemented in the private sector and also are being tested in the Medicare program.

The intent of these models is to reduce spending by improving coordination between providers, rewarding management of complex disease and outcomes rather than volume of services, and supply data to providers so that they can continually improve performance. The following is a description of how these models and how they are currently being implemented in the Medicare context.

II. DELIVERY SYSTEM REFORM MODELS AND PAYMENT CHANGES THAT FOCUS ON PRIMARY CARE

A. <u>Patient-Centered Medical Home (PCMH) Model</u>

Under the PCMH model, a physician, often a primary care physician, takes responsibility for coordinating patients' overall health care needs. Payment models can vary. They range from

paying a management/coordination fee to the primary care physician, in addition to what they receive under the fee-for-service system, to providing bonuses when spending is reduced compared to a target. In some cases, physicians can receive both the management fee and a bonus payment. The PCMH emphasizes the use of data and information systems to track patient outcomes, compliance with evidence-based guidelines, and communications with patients and other providers.

The Centers for Medicare and Medicaid Services (CMS) is currently implementing a "medical home" demonstration. Under this demonstration, physicians who manage patients with chronic disease would receive a payment to compensate them for coordinating and communicating among specialists, social workers, case managers, and the patient. Through improved monitoring of the patient's condition, visits to the emergency department may be avoided and hospitalizations also prevented.

B. Primary Care Incentive Payments

In 2011, Medicare began paying a 10% incentive payment to primary care physicians for primary care services nationwide. That year, Medicare paid over $560 million to over 156, 000 eligible practitioners. This tilts the balance towards primary care, which is the foundation of every efficient, coordinated care delivery system. Many private payers have begun to follow Medicare in this policy. For more information on the primary care incentive payments, please see the fact sheet at the following link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/PCIP-2011-Payments.pdf .

C. Comprehensive Primary Care Initiative

A collaboration between public and private payers and primary care practices to support patient-centered primary care in communities across the country. Primary care practices will receive new, public and private funding for primary care functions not currently supported by fee-for-service (FFS) payments, including an opportunity to share net savings generated through this program. In return, participating practices will agree to give patients 24-hour access to care, create personalized care plans for their patients, and coordinate with other providers to ensure patients are getting healthy and staying well. CMS has selected the markets for the primary care initiative in Arkansas (state-wide, 4 payers), Colorado (state-wide, 9 payers), New Jersey (stat-wide, 5 payers), New York (Capital District-Hudson Valley, 6 payers), Ohio and Kentucky (Cincinnati-Dayton Region, 10 payers), Oklahoma (Greater Tulsa Region, 3 payers), and Oregon state-wide, 7 payers). Recruitment is underway to select 75 practices in each market. Applications from all practices are due by July 20, 2012.

D. Federally Qualified Health Center Advanced Primary Care Practice Demonstration

Testing whether advanced primary care practice at community health centers can improve care and patients' health, and reduce costs. In October 2011, 500 community health centers in 44 States were selected to receive approximately $42 million over three years to reorganize as Patient Centered Medical Homes and improve the coordination and quality of care

they give to people with Medicare and other patients. CMS began this initiative last November, and currently more than 200,000 Medicare beneficiaries are covered under this demonstration.

E. Multi-Payer Advanced Primary Care Practice Demonstration

This demonstration is evaluating whether state-led, multi-payer collaborations to help primary care practices will reduce unjustified utilization and expenditures, improve the safety, effectiveness, timeliness, and efficiency of health care, increase patient decision-making and increase the availability and delivery of care in underserved areas. Announced on September 16, 2009, this demonstration is still ongoing in 8 states (Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. On May 31, 2012, CMS published a Federal Register Notice on this initiative, which can be found at this link: http://www.gpo.gov/fdsys/pkg/FR-2012-05-31/pdf/2012-13207.pdf.

F. Independence at Home Demonstration

The Independence at Home Demonstration will provide chronically ill patients with a complete range of primary care services. CMS will join with medical practices to test the effectiveness of delivering primary care services in a home setting on improving care for Medicare beneficiaries with multiple chronic conditions. Medical practices led by physicians or nurse practitioners will provide primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations. Sixteen practices have been selected to participate in the demonstration. The list is available here: http://innovations.cms.gov/initiatives/Independence-at-Home/index.html.

III. DELIVERY SYSTEM REFORM MODELS FOCUSING ON BUNDLED OR CASE RATE PAYMENTS

Under bundled or case rate payments, payment is made for a defined set of services, such as all physician and possibly hospital services, associated with a procedure or illness. If the physicians and hospital can provide the services for less than the bundled or case rate payment, they keep the difference. If the providers' cost is greater than the payment, they cannot seek additional payments. As an example of bundling, a hospital and a group of physicians may agree to a bundled payment for a coronary bypass operation. All of the services for anesthesia, surgery, operating room, recovery room, and intensive care would be combined into one fee for the procedure. Bundling eliminates any incentives to do additional tests or treatments beyond what is necessary for the specific procedure, and provides incentives to identify savings from use of less expensive medical devices or personnel.

A. Bundled Payment for Care Improvement Initiative

CMS has begun an initiative that builds on episode-based payment models pioneered in the private sector by redesigning payment to match the patient experience. It offers providers four patient-centered episode of care models to choose from, allowing providers the flexibility to choose the conditions they believe make sense to bundle; decide how best to work together to deliver high-quality, coordinated episodes-of-care; and determine participating providers' share

of payment. Health care organizations will give Medicare a discount off the current cost of care for the episodes covered under the initiative, thereby ensuring Medicare Trust Fund savings. CMS has accepted applications for all four models, but has not yet announced the selected organizations for any of the four models and time frame for starting the program.

B. Accountable Care Organizations

Accountable Care Organizations (ACOs) are groups of providers who agree to work together to coordinate the care of a population. The Affordable Care Act included ACOs as part of the Medicare program. Under the Medicare program, the ACO receives a share of any savings achieved if spending for the population managed by the ACO is less than what Medicare projects, so long as the ACO also meets quality standards. CMS is working on a number of ACO models: the Medicare Shared Savings Program, Pioneer Accountable Care Organization Model Initiative, Advanced Payment Model Initiative, and the Physician Group Practice Payment Transition Initiative. In all, as of July 1, more than 2.4 million beneficiatires are receiving care from providers participating in the Medicare shared savings initiative and there are 154 separate organizations enrolled.

- **Medicare Shared Savings Program:** In the Shared Savings Program, groups of providers come together as accountable care organizations to improve care coordination for Medicare beneficiaries and can share in savings they generate for Medicare if they meet certain quality improvement metrics. On April 1, 2012, 27 ACOs started their participation, and another 89 began on July 1, 2012.

- **Pioneer Accountable Care Organization Model Initiative:** Testing the rapid transition to a new payment model where experienced organizations are paid according to their ability to improve the health of their patient population, rather than for each specific service they provide. Participating organizations must create similar arrangements with other private sector payers so that more patients have access to this highly coordinated care. Currently, 32 organizations are participating in the Pioneer ACO Model to test what can be achieved through highly coordinated care for more than 750,000 Medicare fee-for-service beneficiaries.

- **Advanced Payment ACO Model Initiative:** This model is testing whether pre-paying a portion of future shared savings will allow more physician-based and rural ACOs to participate in the Medicare Shared Savings Program, to improve care for beneficiaries and generate greater Medicare savings more quickly. Of the 27 ACOs that began participating in the Shared Savings Program on April 1, 2012, there are 5 ACOs participating in the Advanced Payment model. Participation of additional ACOs in this Advanced Payment Model (from those which began their contracts on July 1, 2012) will be announced shortly. Additional organizations will be announced for those ACOs with a 2013 start date.

- **Physician Group Practice Transition Demonstration:** Under the PGP Demonstration begun in 2005, physician groups earn incentive payments based on the quality of care they provide and the estimated savings they generate in Medicare expenditures for the patient population they serve. This was the precursor to the Shared Savings Program in Medicare. Six of the physician groups will continue to participate in the new PGP Transition Demonstration, a two-year supplement to the original PGP Demonstration. These groups represent 5,000 physicians and 220,000 Medicare fee-for-service beneficiaries.

IV. QUALITY AND VALUE POLICIES IN THE CURRENT PHYSICIAN PAYMENT SYSTEM

In addition to the broader delivery system reform demonstrations that are underway, there have been a number of initiatives to incorporate quality and value into the Medicare physician fee schedule. A brief summary of those efforts is below.

A. Physician Quality Reporting System (PQRS)

The Physician Quality Reporting System (PQRS) began in 2007. Currently, this is a voluntary program that provides physicians with bonus incentive payments if they successfully report specified quality measures. In 2011, the bonus was one percent. For 2012-2014, the bonus is 0.5 percent. In 2015, physicians will face a 1.5 percent penalty if they are not participating in PQRS. CMS also proposes to use the PQRS quality measures in the value-based modifier program (see below).

According to a CMS report, 29 percent of eligible physicians participated in PQRS in 2010 (CMS 2010 PQRS and Electronic Prescribing Reporting Experience). This was a slight increase from the 25 percent participation rate in 2009. The participation rates varied greatly by specialty, ranging from 65.6 percent in emergency medicine to 2.7 percent in psychiatry. A total of approximately $325 million in PQRS incentive payments were distributed in 2010.

For more information on the PQRS (and E-Prescribing) programs, see the report that was published in February 2012: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2010_PQRS_and_eRx_Experience_Report_03162012.zip

B. Electronic Prescribing (E-Prescribing)

E-Prescribing was mandated by the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008. This program provides a combination of incentive payments and penalties through 2014 to physicians to encourage them to be electronic prescribers. In 2010, physicians were eligible to receive a two percent increase to their Medicare payments if they met E-prescribing requirements. This amount was reduced to one percent in 2011 and 2012 and 0.5 percent in 2013. To receive the incentive physicians must document 25 unique electronic prescribing events.

Physicians who are not successful E-prescribers face a one percent payment reduction in 2012. This amount will increase to 1.5 percent in 2013 and 2.0 percent in 2014. To avoid the 2012 reduction, physicians must document 10 unique electronic prescribing events in the first six months of 2011. After 2014, the program will end because the electronic health record (EHR) "meaningful use" program will provide penalties for non-compliance of E-prescribing.

According to CMS, in 2010, 19 percent of eligible physicians participated in the program which was an increase from the 2009 rate of participation of 15 percent. In 2010, about $228 million in incentive payments were distributed to physicians.

C. Physician Feedback Reports

Since 2010, CMS has provided confidential Physician Feedback reports to certain physicians and groups of physicians. These reports provide quality and cost information among physicians and physician group practices relative to the performance of their peers. In 2011, CMS provided feedback reports to 35 large physician group practices; in March 2012, CMS made these reports available to all physicians in four states--Kansas, Missouri, Iowa, and Nebraska. In 2013, CMS plans to use these reports to inform physician groups about their value-based modifier score (see below).

According the CY 2103 physician fee schedule proposed rule, as of June 12, 2012, 31 percent of the physicians in the four states had accessed their feedback reports.

D. Value-Based Payment Modifier

The Medicare statute requires that in 2015 a "value-based payment modifier (VBM or modifier)" be applied to the fee schedule payments for certain physicians based upon both the quality and costs of care furnished to patients. Physicians who provide high quality, low cost care will receive a positive modifier to their payments, while physicians who provide low quality, high cost care will have a negative modifier.[3]

CMS has discretion as to which physicians would be included in the program in 2015; however, in 2017 the modifier will apply to all physicians. The quality and costs of services provided in 2013 will serve as the basis for determining the level of the modifier.

The physician fee schedule proposed rule, released by CMS on July 6, provides information as to how CMS would like to implement the modifier (See page 560 of the display version of the proposed rule.) Briefly, CMS proposes to apply the VBM in 2015 only to

[3] In the calendar year (CY) 2012 final rule, CMS finalized that for the cost component of the VBM, they would use a cost composite score that would reflect total per capita costs for all beneficiaries (not include Part D payments), as well as total per capita costs for beneficiaries with certain chronic conditions (chronic obstructive pulmonary disease, heat failure, coronary artery disease and diabetes). The CY 2013 proposed rule would risk-adjust the costs.

physician groups of 25 or more. At the outset, physician groups that do not successfully report their data for the PQRS quality measures would receive a VBM of -1.0% (this would be in addition to the -1.5 percent penalty established by the PQRS program for 2015).

CMS proposes that physician groups that successfully report PQRS measures may choose to receive a modifier of 0 percent, meaning their payments would be unaffected. However, these groups could instead elect to participate in a quality-tiering methodology. Under this approach, physician groups that have quality and cost performance scores significantly above or below the national average would receive either a positive or negative adjustment, respectively. Physicians that treat high-risk patients and have high quality/low cost value scores would be eligible for larger increases.

E. Meaningful Use Reporting

Another quality reporting system is part of the electronic health record (EHR) "meaningful use" Incentive Program. Established by the 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act provides incentive payments to physicians who adopt EHRs, but also imposes payment cuts, beginning in 2015, to providers who do not adopt EHRs. HITECH requires that providers not only adopt EHRs, but that they "meaningfully use" them to improve the care of patients. Reporting quality measures electronically is part of meeting the "meaningful use" requirements.

F. Post-Discharge Transitional Care Management Payment

In the CY 2013 Medicare physician fee schedule proposed rule, CMS proposes to create a new payment code that would pay community physicians, or qualified non-physician practitioners, approximately $100 for care management services provided to moderate and high complexity patients within 30 days after their discharge from either a hospital, skilled nursing facility, or other specified setting. This payment is intended to better recognize the "non-face-to-face' services that primary care practitioners provide during this period, including reviewing discharge summaries and establishing or modifying the patient's plan of care post-discharge. Currently, physicians can be paid only if they see a patient.

V. OTHER PROGRAMS TO ACCELERATE OR ENHANCE SPREAD OF DELIVERY SYSTEM REFORM

A. The Partnership for Patients

Under this initiative, CMS is working with hospitals, physicians, nurses, and other clinicians, consumer groups and employers to reduce hospital-acquired conditions and preventable hospital readmissions. The program is a public-private partnership with over 7,100 organizations participating as of January 2012 — including more than 3,200 hospitals. By joining the Partnership, these organizations have pledged to meet the Partnership's two goals – to reduce preventable harm in hospitals by 40 percent and readmissions to hospitals within 30-days of discharge by 20 percent in the next three years. In 2011, CMS awarded $218 million to 26 state, regional, national, or hospital system organizations to be Hospital Engagement Networks

(HENs). As HENs, these organizations will help identify solutions already working to reduce health care acquired conditions, and work to educate other hospitals and health care providers. The 26 organizations are listed here: http://www.healthcare.gov/compare/partnership-for-patients/safety/index.html#hen.

The other component of the Partnership for Patients is the Community-Based Care Transitions Program.[4] This program encourages community organizations to develop networks and partnerships to help minimize adverse events for patients as they transition back home from institutional care. Applications are accepted on a rolling basis. Currently, 30 organizations have been selected. The list of organizations is available here: http://www.healthcare.gov/compare/partnership-for-patients/safety/index.html#hen.

B. Innovation Advisors Program

The goal of this program is to create a network of experts in improving the delivery system for Medicare, Medicaid and CHIP beneficiaries. These advisors will utilize their knowledge and skills in their home organizations or communities in pursuit of the three-part aim of improving health, improving care, and lowering costs through continuous improvement; work with other local organizations or groups in driving delivery system reform; develop new ideas or innovations for possible testing of diffusion by the Innovation Center; and build durable skill in system improvement throughout their area or region. In December of 2011, CMS selected 73 individuals out of 920 applications, who have already started their six-month intensive orientation. .

C. Health Care Innovation Challenge

Recognizing that many of the best ideas will come from physicians, other health care providers, and innovative thinkers in communities across the country; CMS is awarding up to $1 billion in grants to applicants who put into practice the most compelling new ideas for rapidly delivering better health, improved care and lower costs to people enrolled in Medicare, Medicaid and CHIP, particularly those with the highest health care needs. The initiative is also looking for new models of workforce development and deployment to support the transition toward high-value care. The Center for Medicare and Medicaid Innovation (CMMI) announced the first batch of 26 awardees on May 8, 2012, and the second (final) batch of 81 awards on June 15, 2012, for a total of 107 awards. The project profiles are available here: http://innovations.cms.gov/Files/x/HCIA-Project-Profiles.pdf. Applicants include providers, payers, local government, public-private partnerships and multi-payer collaboratives.

[4] Affordable Care Act, Section 3026.

VI. WITNESS LIST

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