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4 ``USING INNOVATION TO REFORM MEDICARE PHYSICIAN PAYMENT''

5 WEDNESDAY, JULY 18, 2012

6 House of Representatives,

7 Subcommittee on Health

8 Committee on Energy and Commerce

9 Washington, D.C.

10 The Subcommittee met, pursuant to call, at 10:03 a.m.,  
11 in Room 2123 of the Rayburn House Office Building, Hon. Joe  
12 Pitts [Chairman of the Subcommittee] presiding.

13 Members present: Representatives Pitts, Burgess,  
14 Shimkus, Murphy, Gingrey, Latta, Cassidy, Pallone, Dingell,  
15 Towns, Engel, Christensen, and Waxman (ex officio).

16 Staff present: Julie Goon, Health Policy Advisor; Debbie  
17 Keller, Press Secretary; Ryan Long, Chief Counsel, Health;  
18 Katie Novaria, Legislative Clerk; John O'Shea, Professional

19 Staff Member, Health; Andrew Powaleny, Deputy Press  
20 Secretary; Chris Sarley, Policy Coordinator, Environment and  
21 Economy; Heidi Stirrup, Health Policy Coordinator; Phil  
22 Barnett, Democratic Staff Director; Alli Corr, Democratic  
23 Policy Analyst; Amy Hall, Democratic Senior Professional  
24 Staff Member; Karen Lightfoot, Democratic Communications  
25 Director and Senior Policy Advisor; Karen Nelson, Democratic  
26 Deputy Committee Staff Director for Health; and Roger  
27 Sherman, Democratic Chief Counsel.

|  
28 Mr. {Pitts.} The subcommittee will come to order.

29 Chair recognizes himself for an opening statement.

30 There is no disagreement that the current Medicare  
31 physician reimbursement system, the Sustainable Growth Rate,  
32 or SGR, is broken. Time and again, Congress has had to  
33 override schedule cuts in physician reimbursement to avert  
34 disaster, and we will have to do it again before the end of  
35 this year. Absent congressional actions, physicians will  
36 face a 27 percent cut starting January 1, 2013.

37 There is also no disagreement that the SGR needs to be  
38 replaced with something that actually is sustainable, and  
39 reimburses for outcomes and quality instead of just volume of  
40 services.

41 The focus of today's hearing is not the well-documented  
42 deficiencies of the current system, it is about the future.  
43 What should the new physician payment system look like, and  
44 what can we learn from the private sector's experience in  
45 this area that may serve as a roadmap for reform? What has  
46 been tried and failed, and what has worked?

47 Our witnesses today are here to share with us the  
48 innovative payment systems and care delivery models they have  
49 experimented with, and their outcomes. I want to thank all  
50 of them for their testimony.

51           So thank you. I yield the remainder of my time to the  
52 vice chairman of the subcommittee, Dr. Burgess.

53           [The prepared statement of Mr. Pitts follows:]

54   \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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55           Dr. {Burgess.} I thank the chairman for the  
56 recognition. It has been a very interesting congressional  
57 term. We are now 18 months into it. I think this term I  
58 have seen more work done on this problem than I had at any  
59 other time that I have been in Congress, but we are still  
60 pretty far away from the goal that we expect to achieve.  
61 Everyone on both sides of the dais accepts the premise of the  
62 SGR has got to go. The conversation about actual innovative  
63 replacements that providers in the future--and really, I do  
64 want to ensure, my vision is that people will have options,  
65 that they will not see a ``one size fits all'' that we think  
66 is best for their practice, but they will actually be able to  
67 choose the option that is best for their practice. But in  
68 the meantime, we have got to sketch out the means by which to  
69 ensure that Medicare beneficiaries can continue to see their  
70 physicians.

71           We have been in the process of testing models for years.  
72 The witnesses at the table also have been in the process of  
73 developing models for some time, and we expect that they are  
74 going to have some interesting ideas to share with the  
75 committee, and look forward to that.

76           But we have got a cut coming in just a few months, and a  
77 lot of uncertainty as we face elections, while we face

78 expiration of existing tax policy, we have the payroll tax  
79 holiday ending, we face unemployment insurance needing to be  
80 extended, and oh yeah, who can forget all the collegiality  
81 that existed in this body a year ago with the discussion of  
82 the debt limit. We are likely to face that again, but this  
83 time, without all of the good feeling that we all had last  
84 August.

85         We could have taken this problem and moved it a little  
86 farther away from December, recognizing that December is  
87 going to be such an uncomfortable month for so many reasons.  
88 I had--many members of this committee had asked for a 2-year  
89 extension in December of last year. A 2-year extension  
90 passed without a lot of other things attached to it so that  
91 it would be sure to pass. In fact, we could probably do it  
92 on suspension on a Monday afternoon. But I didn't get that.  
93 We didn't get that. You didn't get that. And as a  
94 consequence, we got a 1-year extension or what ended up being  
95 a 1-year extension that expires in the middle of this fiscal  
96 holocaust at the end of the year.

97         So all I would suggest is we know that we are not likely  
98 to end up doing something that will provide that long-term  
99 relief and long-term replacement for the Sustainable Growth  
100 Rate by December 31. I wish we could, but I have been here  
101 long enough to know that that is a goal that is going to be

102 difficult to achieve. But what I would like to suggest is  
103 this month, before the August recess, the House of  
104 Representatives could pass yet an additional extension to  
105 give us that 2 years that we asked for in December of last  
106 year so that we have time to fully vet and evaluate the  
107 proposals that are before us. The committee staff has done a  
108 good job in developing some of these ideas. It is now up to  
109 us to take them to doctors across the country and get their  
110 feedback so we get the best possible policy. So I will be  
111 introducing that legislation later today or this week to  
112 extend the SGR for an additional year.

113         Mr. Chairman, I thank you for the recognition. I will  
114 yield back to you the time.

115         [The prepared statement of Dr. Burgess follows:]

116 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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117           Mr. {Pitts.} The chair thanks the gentleman and now  
118 recognizes the ranking member of the subcommittee, Mr.  
119 Pallone, for 5 minutes for an opening statement.

120           Mr. {Pallone.} Thank you, Mr. Chairman. Let me  
121 associate myself with the remarks of Dr. Burgess. Of course,  
122 I don't know how he is paying for the 2-year extension, so I  
123 won't associate myself with that until I see what the pay-for  
124 is. But I think that what he said overall is very true. I  
125 think we have to be very honest with the physician community.  
126 We all agree that the SGR needs to be replaced, but you know,  
127 the question is is there political will to do that, and  
128 whether or not it can be done effectively by the end of the  
129 year with all these other problems that need to be addressed  
130 out there? It is very questionable. I don't have any doubt  
131 that this committee and the members of this committee would  
132 like to accomplish that, but I don't know whether or not the  
133 House or the GOP leadership, you know, would be willing to  
134 put it on the agenda for a long-term fix.

135           I want to, though, go beyond what Dr. Burgess said and  
136 say that I also think we have to be very careful that when we  
137 talk about pay-fors, because pay-fors, it is not only a  
138 question of the new formula, but also the pay-for. I think  
139 we have to be very careful. We need a pay-for that is big.

140 I have always suggested the overseas contingency operation  
141 fund, or the PEACE dividend, as it is called, for the pay-  
142 for, because we need a large amount of money. I think that  
143 this idea of constantly picking at other providers, whether  
144 it is hospitals or nursing homes, home health care providers,  
145 is not the way. It bothers me many times when I hear other  
146 physicians say well, you know, we can take it from other  
147 parts of the health care system. I don't see that. And I  
148 would also warn my GOP colleagues that I certainly will not  
149 support, and I think it is useless politically, to try to  
150 take the money away from the Affordable Care Act. You know,  
151 I don't want to say for sure, but so many times the answer  
152 has been oh, you know, let us get rid of the prevention fund,  
153 let us get rid of the community health centers, let us get  
154 rid of, you know, the subsidies or the tax credits that would  
155 make premiums more affordable for certain incomes. That is  
156 not the answer. I think that the health care system is in  
157 crisis, and the other providers have the same problems. And  
158 so for us to suggest that we are going to, you know, go after  
159 the ACA or other providers I think is really a huge mistake.

160 So the question remains, how do we fix it? I don't  
161 think there is a ``one size fits all'' approach. Any new  
162 payment system should rely on improved outcomes, quality,  
163 safety, and efficiency. In addition, while there must be

164 fee-for-service within the future payment system, we must  
165 stop rewarding doctors for volumes of services. Primary care  
166 must be strengthened and given special consideration, and a  
167 new system must better encourage coordinated care while  
168 incentivizing prevention and wellness within the patient.

169 Now, there a number of innovative programs that are  
170 currently underway across the country. We will hear today  
171 from two private pair plans that are learning and building on  
172 successes from such initiatives as pay for performance,  
173 patient-centered medical homes, bundle payments, and of  
174 course, arrangements with accountable care organizations.  
175 Many of these initiatives recognize the local needs of their  
176 marketplaces, which is something worthy of consideration  
177 moving forward. Local markets have different needs, and  
178 while one payment model may work in New Jersey, it doesn't  
179 necessarily work in Montana.

180 While we are eager to hear from the private sector, we  
181 mustn't forget about the delivery system reforms already  
182 underway in the public sector. The Center for Medicare and  
183 Medicaid Innovation created by the Affordable Care Act gives  
184 CMS the ability to pursue many similar demonstration programs  
185 in both Medicare and Medicaid. Currently they are testing a  
186 few new models, including ACOs in the patient-centered  
187 medical homes. The ACA also strengthens incentives for

188 reporting on quality measures for physicians. Meanwhile, in  
189 2011, Medicare began paying a 10 percent incentive payment of  
190 primary care physicians for primary care services nationwide.

191       So together, the public and private sectors can and  
192 should work together to get the health care system on a  
193 better path to sustainability. I look forward to hearing  
194 today about the exciting work being done in this field. I  
195 want to thank our witnesses. I want to especially note the  
196 American College of Surgeons who have taken a leading role on  
197 conceptualizing a new proposal to replace the SGR, which they  
198 are going to talk about today.

199       And again, Mr. Chairman, I think this is a very  
200 important hearing. I appreciate your having it. This  
201 committee has worked effectively on dealing with the--with  
202 PDUFA and other things on a bipartisan basis. I think we can  
203 do the same here.

204       I am sorry, I guess I am out of time.

205       [The prepared statement of Mr. Pallone follows:]

206 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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207           Mr. {Pitts.} The chair thanks the gentleman. I now  
208 recognize the gentleman from Georgia, Dr. Gingrey, for 5  
209 minutes for opening statement.

210           Dr. {Gingrey.} Mr. Chairman, I won't take the entire 5  
211 minutes, but thank you for recognizing me.

212           The Sustainable Growth Rate we all know is broken and  
213 none of us support it, and it must, must go. Therefore, I  
214 look forward to the testimony of those here today, our  
215 witnesses, on what payment models might be used to replace  
216 SGR.

217           I do want to mention one thing. House Republican  
218 physicians worked very closely with the House leadership last  
219 year to put forward a multi-year SGR patch. I think my  
220 colleague as I walked in, Dr. Burgess, was talking about  
221 that. It wasn't the full repeal that I wanted, but it  
222 ensured some level of stability for physicians and our  
223 patients. Ultimately we couldn't get the Senate on board and  
224 it failed, as you all know.

225           Now we find ourselves facing SGR cuts again in January  
226 of what, 27.4 percent if something is not done. I urge this  
227 Congress to put partisan and election politics aside, and let  
228 us work together to get rid of SGR once and for all.

229           I don't agree with my colleague from New Jersey, the

230 ranking member of the Health Subcommittee, in regard to the  
231 pay-fors, and that--but I do agree with him that that is a  
232 huge problem, how we are going to pay for the cliff. The  
233 last figure I saw of that cliff to bring the baseline back  
234 down to zero was something of the magnitude of \$300 billion,  
235 but that OCO money we talked about and that got kicked around  
236 by the Super Committee, overseas contingency operation,  
237 honestly from my perspective, it really looks like funny  
238 money, very much like funny money. You can't convince me  
239 that it isn't. I agree with Mr. Pallone and his concerns, of  
240 course, about goring--oxing the gore or goring the ox or  
241 whatever of other providers within the Medicare program.  
242 Every one of them are concerned about cutbacks and taking  
243 money out of--whether it is home health care or hospice or  
244 whatever. I agree with him on that point, but I am not for  
245 OCO money.

246 I will just conclude by saying that myself and the GOP  
247 Doctors Caucus, my colleagues, 21 of us, will be working with  
248 leadership again in the House, and also with our Democratic  
249 colleagues, because there is no way to get this done in a  
250 one-party, Majority party effort. This has got to be done in  
251 a bipartisan way. And indeed, the House can't fix the  
252 problem alone. It has to be bicameral.

253 So Mr. Chairman, thank you for calling the hearing

254 together today. This hearing is hugely important. We can  
255 all work together--we have to to get this done, and I am  
256 looking forward to this expert panel of witnesses.

257 I yield back, Mr. Chairman.

258 [The prepared statement of Dr. Gingrey follows:]

259 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
260 Mr. {Pitts.} Is there anyone else seeking time on this  
261 side of the aisle?

262 If not, the chair thanks the gentleman and recognizes  
263 the ranking member of the full committee, Mr. Waxman, for 5  
264 minutes for opening statement.

265 Mr. {Waxman.} Thank you very much, Mr. Chairman. I  
266 would like to start by acknowledging and welcoming the  
267 bipartisan interest in transforming the Medicare physician  
268 payment system from one that focuses on rewarding volume to  
269 one that focuses on rewarding quality and outcomes.

270 While Congress has yet to come to a bipartisan agreement  
271 on how to accomplish the shared goal of repealing and  
272 replacing the flawed Sustainable Growth Rate, SGR, mechanism,  
273 there seems to be bipartisan agreement that it should be  
274 done. We must find a way to end the unsustainable system of  
275 cuts that loom over our physicians every year. The  
276 uncertainty created by the current system serves no one well:  
277 the physicians who have no stability in payments, the  
278 beneficiaries who worry about access to their doctors, and  
279 even Congress. Even more encouraging is a bipartisan  
280 agreement that delivery system reforms, many of which were  
281 included in the Affordable Care Act, hold promise in a post-  
282 SGR world. We must work towards a new way of paying for care

283 for both physicians and other providers that encourages  
284 integrated care, improving care for individuals, improving  
285 care for populations, and reducing costs.

286 Right now, the way we pay for care doesn't always  
287 support these goals. The Affordable Care Act makes major  
288 strides to improve the way Medicare deals with physicians and  
289 other providers. Some of the new care models supported by  
290 the ACA include Accountable Care Organizations, bundled  
291 payments, medical homes, and initiatives that boost primary  
292 care and encourage paying for value and outcomes, not volume.  
293 As we will hear today, the private sector is exploring these  
294 avenues as well.

295 I yearn for the day when the Republicans knew how to  
296 handle this problem. They simply extended the SGR payments  
297 and didn't pay for it. They didn't do a lot of things to pay  
298 for what they charged to the taxpayers of the United States  
299 towards the Medicare prescription drug benefit, SGR, didn't  
300 pay for it. Now they want to be sure that every way to pay  
301 for this is airtight. Well, it is a new day where  
302 Republicans are giving us their fiscal responsibility side of  
303 things. We need to work together. Our goal should be to  
304 enact a permanent repeal to the existing flawed physician  
305 payment system this year. Let us do it this year. We had  
306 chances to do it, as Mr. Burgess pointed out, but we couldn't

307 get the Republican leadership, his Republican leadership, to  
308 go along with what he and we wanted. So it is time for the  
309 Republican leadership to recognize this is a problem that we  
310 ought to resolve, not just, well, I guess, not just kick it  
311 down the road, but I guess we would be satisfied just for  
312 that for a couple years.

313 But we got to get on with the job of doing what is  
314 responsible. I want to yield the balance of my time to Mr.  
315 Dingell.

316 [The prepared statement of Mr. Waxman follows:]

317 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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318           Mr. {Dingell.} Mr. Chairman, I thank the gentleman from  
319 California for his kindness to me. I have a splendid  
320 statement. I ask unanimous consent that the fullness of it  
321 be inserted in the record.

322           Mr. {Pitts.} Without objection, so ordered.

323           Mr. {Dingell.} I commend my colleagues on the  
324 Republican side for their desire to keep Medicare fiscally  
325 solvent to address the SGR problem, and to see to it that we  
326 fix the concerns of the medical profession in seeing to it  
327 that they are properly compensated. Their complaint is a  
328 real and a valid one, and it is a thing to which we should  
329 pay heed.

330           As any good physician will tell you, we need to cure the  
331 underlying problem, not to just treat the symptoms, and the  
332 patchwork job that we have done in addressing these problems  
333 over the years has done nothing but to create a growing and  
334 painful problem, which gets worse and worse as time passes.  
335 So curing the matter for once and all with proper attention  
336 from this committee, as we have done in the past and in a  
337 bipartisan fashion, is the way out of this thicket.

338           I commend my colleagues on both sides of this, and I  
339 look forward to working with them towards that very important  
340 end.

341 Thank you, Mr. Chairman.

342 [The prepared statement of Mr. Dingell follows:]

343 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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344           Mr. {Pitts.} Chair thanks the gentleman, and now will  
345 introduce today's panel. First, Mr. Scott Serota is  
346 President and Chief Executive Officer of Blue Cross Blue  
347 Shield Association. Second, Dr. Bruce Nash is Senior Vice  
348 President and Chief Medical Officer of the Capital District  
349 Physicians' Health Plan. Thirdly, Dr. David Bronson is  
350 President of the American College of Physicians; then Dr.  
351 David Hoyt is the Executive Director of the American College  
352 of Surgeons; and finally, Dr. Kavita Patel is the Managing  
353 Director for Clinical Transformation and Delivery at the  
354 Engelberg Center for Health Care Reform at the Brookings  
355 Institution.

356           Your written testimony will be made matter of the  
357 record. We ask that you summarize in 5 minutes. Mr. Serota,  
358 you are recognized for 5 minutes for your opening statement.

|  
359 ^STATEMENTS OF SCOTT SEROTA, PRESIDENT AND CHIEF EXECUTIVE  
360 OFFICER, BLUE CROSS AND BLUE SHIELD ASSOCIATION; DR. BRUCE  
361 NASH, SENIOR VICE PRESIDENT, MEDICAL AFFAIRS, AND CHIEF  
362 MEDICAL OFFICER, CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN;  
363 DR. DAVID L. BRONSON, EXECUTIVE DIRECTOR, AMERICAN COLLEGE OF  
364 PHYSICIANS; DR. DAVID HOYT, EXECUTIVE DIRECTOR, AMERICAN  
365 COLLEGE OF SURGEONS; AND DR. KAVITA PATEL, MANAGING DIRECTOR  
366 FOR CLINICAL TRANSFORMATION AND DELIVERY, ENGELBERG CENTER  
367 FOR HEALTH CARE REFORM, THE BROOKINGS INSTITUTION

|  
368 ^STATEMENT OF SCOTT SEROTA

369 } Mr. {Serota.} Thank you, Mr. Chairman.

370 Mr. {Pitts.} Poke that button there.

371 Mr. {Serota.} Sorry about that. I will try again.

372 Thank you, Chairman Pitts, Ranking Member Pallone, and  
373 members of the Health Subcommittee for inviting me here to  
374 testify today. I am Scott Serota, President and Chief  
375 Executive Officer of the Blue Cross Blue Shield Association,  
376 which represents 38 independent community-based Blue Cross  
377 Blue Shield companies that collectively provide health care  
378 coverage for 100 million Americans. I commend the  
379 subcommittee for convening today's hearing.

380 Blue Plans are leading efforts in their communities to  
381 implement payment, benefit, and delivery system reforms that  
382 will improve quality and reign in costs. We believe that  
383 Medicare cannot only learn from, but also should align with  
384 these successful initiatives.

385 Today, I would like to focus on three interrelated  
386 strategies. First, Blue Plans are changing payment  
387 incentives by putting place models that move away from fee  
388 for service and link reimbursement to quality and outcomes.  
389 The goal is to promote patient-centered care that pays for  
390 desired outcomes, rather than the number or intensity of  
391 service. These payment innovations include pay for  
392 performance initiatives, bundle payment arrangements in more  
393 than 32 States, arrangements with accountable care  
394 organizations in 29 States, and patient-centered medical  
395 homes, with Blue Plans collectively supporting the Nation's  
396 largest network of medical homes in 39 States. These models  
397 are driving substantial improvements in care quality, while  
398 taking avoidable costs out of the system. For example,  
399 CareFirst Blue Cross Blue Shield's Medical Home Initiative  
400 includes 3,600 primary care physicians and nurse  
401 practitioners caring for one million members. Preliminary  
402 2011 results indicate that 60 percent of the eligible primary  
403 care panels earned outcome incentive awards, which are based

404 on a combination of savings achieved and quality points.  
405 Among these panels, costs were 4.2 percent less than  
406 expected. In Pennsylvania, Highmark Blue Cross Blue Shield's  
407 Quality Blue pay for performance program has prevented 42  
408 wrong site surgeries, reduced hospital-acquired infections,  
409 raised breast cancer screening rates nine points above the  
410 national average, all while saving \$57 million over 4 years.

411 Our second strategy is to partner with clinicians to  
412 give them individualized support to be successful under new  
413 payment and care delivery models. This includes sharing data  
414 about a patient's full continuum of care, helping improve the  
415 way care is delivered, enhancing care coordination, and  
416 providing powerful health IT capabilities.

417 For example, a powerful way to improve the quality of  
418 care for beneficiaries with chronic illness is to enhance  
419 care coordination. Horizon Blue Cross Blue Shield of New  
420 Jersey has partnered with Duke and Rutgers Universities to  
421 train at least 200 nurses as practiced-based population care  
422 coordinators in medical homes and other settings. This first  
423 of its kind nurse training curriculum recognizes the  
424 workforce enhancement necessary to enable a statewide  
425 expansion of medical homes.

426 None of these innovations would succeed without our  
427 third strategy, engaging patients. This includes providing

428 information on cost and quality to help patients make  
429 informed decisions about their care, tiered benefit designs  
430 that encourage patients to seek care from high quality  
431 providers, and tools for members to improve their health and  
432 wellness. For example, Blue Cross Blue Shield Association's  
433 national consumer cost tool lets members obtain information  
434 on estimated costs for more than 100 of the most commonly  
435 billed elective procedures for hospitals, ambulatory surgery  
436 centers, and freestanding radiology centers in nearly every  
437 U.S. zip code. In addition, Blue Plans are using health  
438 informatics from a database of claims data for more than 110  
439 million individuals nationwide collected over a 7-year  
440 history. The analytics capability made possible by Blue  
441 Health Intelligence, or BHI, are resulting in healthier lives  
442 and more affordable access to safe and effective care. For  
443 example, BHI collaborated with Independence BlueCross in  
444 Pennsylvania to determine the best-performing facilities in  
445 bariatric surgery. Looking at 3 years of data, BHI analyzed  
446 potentially avoidable complications at 214 facilities and  
447 identified Pennsylvania's Crozer-Chester Medical Center as  
448 having an extraordinarily low complication rate for bariatric  
449 surgery, just four-hundredths of a percent compared to the  
450 nationwide average of 6.7 percent. We designated Crozer as a  
451 best-in-class provider in this specialty under the Blue

452 Distinction Initiative, which encourages patients to seek  
453 care from high quality providers.

454         Achieving a high quality, affordable care system will  
455 require a multi-faceted approach, using all the strategies  
456 that I have outlined. Sustaining and building on these  
457 successes will require a continuously evolving approach of  
458 fine-tuning strategies and implementing new ones. We believe  
459 a compelling opportunity exists to accelerate Medicare's  
460 adoption of these private sector initiatives. Payment  
461 approaches and technical assistance must be adapted to fit  
462 local delivery system conditions, which vary widely. This  
463 assumes patients can meet practices where they are, rather  
464 than attempting to overlay a one size fits all solution that  
465 may not be workable. The time is right to accelerate the  
466 pace of reform for Medicare, and we are pleased that Blue  
467 Plans are participating in pilots to test these approaches,  
468 and urge successful approaches be expanded rapidly beyond  
469 pilot markets.

470         I appreciate the opportunity, Mr. Chairman. Thank you  
471 very much.

472         [The prepared statement of Mr. Serota follows:]

473 \*\*\*\*\* INSERT 1 \*\*\*\*\*

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474           Mr. {Pitts.} Chair thanks the gentleman. I now  
475 recognize Dr. Nash for 5 minutes for an opening statement.

|  
476 ^STATEMENT OF DR. BRUCE NASH

477 } Dr. {Nash.} Good morning. My name is Bruce Nash, and I  
478 am the Chief Medical Officer of Capital District Physicians'  
479 Health Plan, which is based in Albany, New York. CDPHP, as  
480 we are known, is a not-for-profit physician-sponsored network  
481 model plan with close to 400,000 members who live in the 24  
482 counties in upstate New York. We are the capital district's  
483 largest provider of managed commercial Medicare and Medicaid  
484 products. I also serve as the Chairman of the Medical  
485 Directors' Council for the Alliance of Community Health  
486 Plans, or ACHP, whose members include 22 of the Nation's  
487 leading non-profit regional health plans, who share our  
488 commitment to the Triple Aim, a concept created by the  
489 Institute for Health Care Improvement, that is improving the  
490 patient's experience of care, improving the health of  
491 populations, and reducing the per capita cost of care.

492 CDPHP was founded by the physicians of the Albany County  
493 Medical Society 28 years ago, and to this day is governed by  
494 a board whose majority are practicing physicians who are  
495 elected by their peers. Our board chair is also required to  
496 be a practicing physician. As a consequence, we have enjoyed  
497 a close relationship with our provider community, enabling us

498 to deploy market-leading initiatives that improve the care  
499 delivery for our members, despite not directly employing any  
500 of the clinicians. This has led to us being recognized as a  
501 top-ranked health plan in the State and the Nation for our  
502 member satisfaction and quality metrics.

503         Four years ago, our board emerged from a strategic  
504 planning session with a directive for management to address  
505 the impending primary care crisis. It was noted that our  
506 local medical school was no longer graduating significant  
507 numbers of new physicians who were choosing primary care as a  
508 career. While the causes for this were multiple, we chose to  
509 focus on improving a primary care physicians' income  
510 potential. It was clear that for this to be accomplished it  
511 would have to be funded by changing the way physicians  
512 practice with more effective and efficient care as a result.  
513 This began the program that we later labeled our Enhanced  
514 Primary Care program, or EPC.

515         We began with an initial pilot of three practices, and  
516 over a 2-year period of time were able to demonstrate an  
517 improvement in 14 of 18 specific quality metrics; a 15  
518 percent reduction in hospital utilization; a 9 percent  
519 reduction in emergency department usage; a 7 percent  
520 reduction in the use of advanced imaging. All of this  
521 resulted in an \$8 per member per month savings in total

522 health care costs.

523         On the strength of these early data, CDPHP expanded its  
524 EPC program by establishing training programs for selected  
525 practices lasting 12 months and requiring significant  
526 commitment of time and effort from the practices as they  
527 learned the basics of Enhanced Primary Care. We currently  
528 have 75 such practices, representing 384 providers and almost  
529 100,000 of our members. We are now launching our next cohort  
530 which will add an additional 70 practices.

531         While much of what I have described is common to many  
532 successful patient-centered medical home initiatives  
533 nationally, we believe our unique contribution to this effort  
534 has been the creation and deployment of a novel reimbursement  
535 methodology. This model involves a risk-adjusted global  
536 payment for all services that the physician provides, in  
537 conjunction with a significant bonus based upon the elements  
538 of the Triple Aim, the patient's experience of care, the  
539 quality, and the cost efficiency. It creates an opportunity  
540 for a physician to enhance his or her reimbursement by an  
541 average of 40 percent.

542         Our base payment is a unique global payment to the  
543 practice for each of their patients. This is driven by a  
544 severity factor that was developed for our use by the  
545 scientists associated with Verisk Health, Inc., a global

546 analytics firm. This severity score predicts the amount a  
547 primary care physician should be paid for a specific patient  
548 based upon the diagnoses of that patient. This score is then  
549 multiplied by a conversion factor to determine the payment  
550 for that given patient based upon their plan type, that is,  
551 Commercial, Medicare, or Medicaid, and we pay this to the  
552 practice on a monthly basis.

553 We still pay fee-for-service for a small subset of  
554 physician services, about 15 percent. These payments  
555 represent things that we would like to incent the primary  
556 care physicians to do in their office as opposed to referring  
557 to a specialist, such as minor skin biopsies, or for the  
558 acquisition cost of things like immunizations.

559 The bonus or pay-for-performance aspect of the model is  
560 focused on the Triple Aim. We measure the satisfaction of  
561 the practice's patients to determine bonus eligibility for  
562 the practice. Currently we utilize HEDIS metrics to measure  
563 the quality of care delivery. A weighted average of 18  
564 distinct metrics creates a quality score for the practice.  
565 Our efficiency metric is an output of our Impact Intelligence  
566 software which accomplishes the required risk adjustment  
567 across the total cost of care. The annual bonus payment to a  
568 practice is determined in a manner that has been described as  
569 a ``tournament'' system, simply said, practices need to

570 perform better than other practices in the network to achieve  
571 their optimal payout.

572         Our initial data for the EPC program was based on a  
573 population of only 12,000 members. We are fortunate that the  
574 Commonwealth Fund has provided a grant to an external  
575 evaluator, Dr. David Bates of the Brigham and Women's  
576 Hospital, to evaluate our 2012 experience. These data will  
577 become available in the latter half of 2013.

578         CDPHP has also been active in the development of  
579 alternative reimbursement models for certain specialist and  
580 hospital partners. While we have yet to develop the  
581 experience that we have with the EPC program, we firmly  
582 believe that all components of the delivery system need to  
583 engage with us in payment models that align financial  
584 incentives with the needs of our communities.

585         Thank you for inviting me to be here today, and I look  
586 forward to your questions.

587         [The prepared statement of Dr. Nash follows:]

588 \*\*\*\*\* INSERT 2 \*\*\*\*\*

|  
589           Mr. {Pitts.} Chair thanks the gentleman, and now  
590 recognizes Dr. Bronson for 5 minutes for opening statement.

|  
591 ^STATEMENT OF DR. DAVID L. BRONSON

592 } Dr. {Bronson.} Good morning. I am David Bronson,  
593 President of the American College of Physicians, the Nation's  
594 largest medical specialty organization, representing 133,000  
595 internal medicine specialists who care for patients in  
596 primary and comprehensive care settings, internal medicine  
597 subspecialists, and medical students who are considering a  
598 career in internal medicine. I reside near Cleveland, Ohio.  
599 I am Board-certified in internal medicine and practice at the  
600 Cleveland Clinic on the downtown campus. I am also President  
601 of Cleveland Clinic Regional Hospitals, and a Professor of  
602 Medicine at the Cleveland Clinic Lerner College of Medicine  
603 of Case Western Reserve University. Thank you very much for  
604 allowing us to share our perspective.

605 This morning, instead of rehashing all of the reasons  
606 why the SGR must be repealed, I will focus on the innovative  
607 solutions being championed by ACP and others--others at the  
608 table, I might add--within the medical profession.

609 First, ACP recommends that the patient-centered medical  
610 home model of care be supported for broad Medicare adoption.  
611 Patient-centered medical home is an approach to providing  
612 comprehensive primary care in a setting that focuses on the

613 relationships between patients, their primary care physician,  
614 and other health care professionals. This care is  
615 characterized by the following features: a personal physician  
616 for each patient, physician-directed medical practice where  
617 the personal physician leads a team of individuals trained to  
618 provide comprehensive care, and a place where the treatment  
619 team can assist the patient in meeting their specific health  
620 care needs. The patient-centered medical home practices  
621 provide increased access to care to prevent avoidable  
622 emergency room and hospital use, processes to facilitate care  
623 coordination amongst all physicians, and address chronic  
624 illnesses present within the Medicare population, including  
625 patient self-management education. These, and other features  
626 of the medical home, contribute to the increasing quality of  
627 care and reducing avoidable costs to patients and health  
628 systems.

629         Patient-centered medical homes use quality management  
630 tools such as registries and outcomes reporting to  
631 proactively manage the health care of a whole practice  
632 population. There is an extensive and growing body of  
633 evidence on the medical home's effectiveness in improving  
634 outcomes and lowering costs. To cite just one example, in  
635 Genesee County, Michigan, the Genesee Health Plan in  
636 collaboration with local physicians and hospitals formed the

637 Genesys HealthWorks. This model, which is built upon a  
638 strong, redesigned primary care infrastructure, has  
639 demonstrated both significant cost savings and improved  
640 quality.

641 Many large insurers, including United Health, WellPoint,  
642 CareFirst, and Blue Cross Blue Shield affiliates, are in the  
643 process of scaling up their efforts in the medical home to  
644 thousands of primary care physician practices in tens of  
645 millions of ruralities across the country. In my practice at  
646 the Cleveland Clinic, all the primary care practice  
647 physicians taking care of adults are certified by the NCQA at  
648 the highest level as medical homes.

649 In the public sector, CMS Innovations Center is in the  
650 process of enrolling practices in its Comprehensive Primary  
651 Care Initiative. Primary care practices enrolled in this  
652 initiative will receive new public and private funding for  
653 primary care not included--primary care functions not  
654 included in the fee-for-service payments and will have the  
655 opportunity to share net savings generated through the  
656 program. Fifty-four commercial and state insurers are  
657 joining with Medicare and support approximately 500  
658 participating practices in seven markets.

659 The bottom line is that the medical home is no longer  
660 just an interesting concept, but a reality for millions of

661 Americans and thousands of practices. The commercial  
662 insurers are driving these innovations in many markets. This  
663 can also become a reality for Medicare patients.

664 To accomplish this, Congress needs to accelerate  
665 Medicare's adoption of the medical home model by providing  
666 higher payments to physician practices that have achieved  
667 recognition by deemed private sector accreditation bodies  
668 consistent with the standards to be developed by the  
669 Secretary. In a subsequent stage, performance metrics could  
670 be added and incorporated into the Medicare payment policies.

671 By supporting the PCMH, Medicare will accelerate the  
672 national adoption of this innovative approach to improving  
673 the health care system. The goal should be to promptly  
674 implement the payment policies to steadily grow physician and  
675 patient participation in medical homes over the next several  
676 years.

677 Second, Congress should enact payment policies to  
678 accelerate the adoption of the related medical home  
679 neighborhood. This concept is essential to the ultimate  
680 success of the medical home. It recognizes that specialty  
681 and subspecialty practices and others that provide treatment  
682 to the patient be recognized and provided with incentives to  
683 work together in a collaborative manner. With the patient-  
684 centered home neighborhood program, primary care physicians

685 and specialists work together to proactively reduce  
686 duplication, enhance quality, and reduce preventable  
687 hospitalizations.

688         Specifically, ACP proposes that Congress help increase  
689 non-primary care specialists' participation in the medical  
690 home neighborhood project by offering higher payment levels  
691 for those services. In my practice, PCPs and cardiologists  
692 specializing in heart failure have developed coordinated  
693 early intervention programs that have improved quality and  
694 reduced preventable admissions, and saved health care  
695 dollars.

696         Third, Congress should establish Medicare incentives to  
697 physicians to incorporate evidence-based guidelines in  
698 national specialty societies and to share decision-making  
699 with the patients. We think that is a vital step that is  
700 important to get there.

701         And finally, ACP believes that additional steps should  
702 be taken now to help physicians to move toward models aligned  
703 with value for patients, as well as awarding those who have  
704 taken leadership and risk in participating in new models,  
705 like medical homes and ACOs. Even as new models are being  
706 more thoroughly developed and pilot tested, physicians could  
707 get higher updates for demonstrating they successfully  
708 participated in such programs.

709           In conclusion, ACP believes that for the first time in  
710 many years, we can begin to see a vision for a better future  
711 where the SGR no longer endangers access to care, Medicare  
712 recognizes and supports the value of primary and coordinated  
713 care, and where every person who is enrolled in Medicare has  
714 access to a highly-functioning primary care practice through  
715 certified medical homes and other promising care coordination  
716 models. The current system disincentivizes the use of modern  
717 practice approaches that are proven to improve quality,  
718 prevent hospitalization, and save lives.

719           Thank you for your time, and I am pleased to answer  
720 questions.

721           [The prepared statement of Dr. Bronson follows:]

722 \*\*\*\*\* INSERT 3 \*\*\*\*\*

|

723           Mr. {Pitts.} Okay. Chair thanks the gentleman. Dr.

724 Hoyt is recognized for 5 minutes.

|  
725 ^STATEMENT OF DR. DAVID HOYT

726 } Dr. {Hoyt.} Chairman Pitts, Ranking Member Pallone, and  
727 members of the committee, I wish to thank you for inviting  
728 the American College of Surgeons to discuss the role of  
729 quality and improving the Medicare physician payment system.  
730 My name is David Hoyt. I am a trauma surgeon and the  
731 Executive Director of the American College of Surgeons. The  
732 ACS appreciates your recognition that the current Medicare  
733 physician payment system and its sustainable growth rate  
734 formula are fundamentally flawed. We wish to be a partner in  
735 the effort to develop a long-term solution that improves the  
736 quality of care while helping to reduce costs. My comments  
737 today will focus on the College's efforts in the area of  
738 quality improvement and the use of an ACS program to propose  
739 a Medicare physician payment proposal called the Value Based  
740 Update, or VBU.

741 Our belief is that any new payment system should be part  
742 of an evolutionary process that achieves the ultimate goals  
743 of increasing quality for the patient and reducing growth in  
744 health care spending. Over the past year, we have improved  
745 our quality improvement principles into the VBU, a Medicare  
746 physician payment reform proposal. Our proposal is

747 predicated on Congress finally eliminating the current SGR  
748 formula and fully offsetting the cost of permanent repeal. I  
749 will caution you that this is still a draft proposal. We  
750 look forward to working with Congress and other stakeholders  
751 to continue to develop this option.

752         In developing the VBU, we took the lessons learned in  
753 the American College of Surgeons National Surgical Quality  
754 Improvement Program, or NSQIP, and other quality improvement  
755 efforts and sought to expand them into the larger provider  
756 community. At the outset, we had a number of key concepts in  
757 mind. To be practical, we felt that the proposal must be  
758 patient-centered, politically viable, responsive to the  
759 changing needs of the health care system, and inspired by  
760 quality. Specifically, our proposal first compliments the  
761 quality-related payment incentives in current law and  
762 regulation, while making necessary adjustments in the current  
763 incentive programs to facilitate participation by  
764 specialists. Secondly, it incorporates the improvement of  
765 quality and the promotion of appropriate utilization of care  
766 into the annual payment updates. Third, it accounts for the  
767 varying contribution of different practices to the ability to  
768 improve care and reduce costs, and finally, it creates a  
769 mechanism to incentivize the provision of appropriate  
770 services that primary care can bring to the management of

771 increasingly more complex medical populations.

772         The VBU accomplishes these goals by allowing physicians  
773 who successfully participate in CMS quality programs to  
774 choose quality goals for the specific patients or conditions  
775 they treat. Rather than basing compensation on overall  
776 volume and spending targets, the VBU bases performance on  
777 carefully designed measures. The VBU is designed to break  
778 down the--of care among physicians and to begin to measure  
779 service lines of care.

780         The central component of the VBU is the Clinical  
781 Affinity Group, or CAG. Each CAG will have its own patient-  
782 oriented, outcomes-based, risk-adjusted quality measures  
783 designed to foster continuous improvement and help lower  
784 costs. These measures will be crafted in close consultation  
785 with the relevant stakeholders, including the specialty  
786 societies, who in many cases are already developing measures  
787 and other quality programs on their own. Providers will  
788 select their Clinical Affinity Group, but will have to meet  
789 certain eligibility requirements, based on patients they see  
790 and conditions they treat. Physicians whose specialties  
791 would work in concert to meet specific quality measurement  
792 goals which have met would improve care and help drive down  
793 the cost of care. Physicians would be measured against  
794 benchmarks that both occur at a national and a regional

795 level, allowing for continued innovation with medical  
796 communities. Finally, once implemented, physicians will have  
797 the opportunity to select their CAG on an annual basis.  
798 Goals can be adjusted regularly to ensure that the quality of  
799 care provided to the patient is continuously improving.  
800 Annual updates would then be predicated on this quality  
801 improvement. We believe this kind of a system will take 5 to  
802 7 years to fully implement.

803         The College strongly believes that improving quality and  
804 safety offers the best chance for transforming our health  
805 care system. Cost reduction alone cannot be the primary  
806 driving force of change. Change must instead be driven by  
807 quality measurement. The ACS has a rich history in quality  
808 improvements, and we have distilled what we have learned into  
809 four basic principles: first, set appropriate standards;  
810 second, build the right infrastructure to deliver the care;  
811 third, use the right data to measure performance; and fourth,  
812 expose yourself to external verification through peer review.

813         The ACS NSQIP program is built on these principles, and  
814 is the prime example of how properly structured quality  
815 improvement leads to cost savings. Participating hospitals  
816 have been seen to reduce expensive complications, and it is  
817 these same principles that we are, in this program, promoting  
818 for a Medicare physician payment system.

819           Our next payment system should focus on individual  
820 patients and patient populations, and rely on physician  
821 leadership to achieve improved outcomes, quality, safety,  
822 efficiency, effectiveness, and patient involvement.  
823 Improving outcomes in care processes and slowing the growth  
824 of health care spending are, in fact, complementary  
825 objectives.

826           Thank you again, Mr. Chairman, for the opportunity to  
827 participate in this hearing.

828           [The prepared statement of Dr. Hoyt follows:]

829 \*\*\*\*\* INSERT 4 \*\*\*\*\*

|  
830           Mr. {Pitts.} Chair thanks the gentleman, and now  
831 recognizes Dr. Patel for 5 minutes for opening statement.

|  
832 ^STATEMENT OF DR. KAVITA PATEL

833 } Dr. {Patel.} Thank you, Chairman Pitts, Ranking Member  
834 Pallone, and members of the Health Subcommittee for inviting  
835 me to testify today on this important topic. My name is  
836 Kavita Patel, and I am a fellow at the Engelberg Center for  
837 Health Care Reform at the Brookings Institution, and a  
838 practicing primary care physician.

839 Industries are often challenged with redefining what  
840 their business models are, and how they produce value.  
841 Health care is at this crossroad now. As a country, we are  
842 presented with an opportunity to make care and how we pay for  
843 it more rational, more productive, and better able to meet  
844 the needs of the American people. I would like to highlight  
845 the following key points, and then elaborate with a couple of  
846 clinical examples to illustrate a pathway forward in the near  
847 and short term, away from our current fee-for-service system.

848 One thing that is very clear is that our current  
849 reimbursement system does not incentivize the type of  
850 clinical practice efficiency that promotes value in care. We  
851 have heard from my other panelists, and as all of you have  
852 testified yourselves, this is a fact.

853 Number two, innovations in clinical practice must be

854 paired with timely and usable data from CMS and other payers,  
855 robust quality metrics and transparent measurement that is  
856 consistent. The timeliness and transparency of this is  
857 essential. Receiving data a year or even 6 months after your  
858 clinical practices are going on is not going to help  
859 physicians and other clinicians change the way they deliver  
860 care in that moment, and this has been an often criticized  
861 setback from a multitude of payers.

862         Third, over the next several years--not decades, not  
863 even more than 5 years--I would say over the next several  
864 years we must migrate towards a model that deals with  
865 coordination of care, as other panelists have outlined, but  
866 more importantly, sets a sight on translating that  
867 coordination of care into a larger, episodic or more  
868 globally-based payment model that takes into consideration  
869 the very flexibilities that we need for different types of  
870 clinical efficiencies. One size does not fit all, and we  
871 must therefore allow for flexibility in this transition. In  
872 this process, however, the importance of taking what we are  
873 currently doing right now and translating that into something  
874 that is more coordinated towards the path of flexibility is  
875 the way to move forward today from our current system.

876         For example, the American Board of Internal Medicine  
877 Foundation has already called upon a number of specialties to

878 say what are we doing right now that we do not need to be  
879 doing? This is something that the professional societies  
880 have corralled around to say here are the top five things we  
881 each know that we do not need to be doing. This is a perfect  
882 basis from which we can take current reimbursement and  
883 translate that by clinically evidence-informed models into a  
884 different form of payment towards that pathway for more  
885 coordinated care.

886 I will offer you an example in cardiology, since that  
887 gives us a great way of identifying one, some that the  
888 professional societies have agreed to. For example, in  
889 cardiology, a universal recommendation was to not perform  
890 stress cardiac imaging or advanced noninvasive imaging in the  
891 initial evaluation of patients without cardiac symptoms  
892 unless high risk cardiac markers are present. Sounds very  
893 straightforward; however, this is a very costly expense to  
894 Medicare today. So translating some of these services that  
895 have been brought forward by physicians and other clinical  
896 leaders into a case-based payment could get us on a pathway  
897 away from what we currently do today. Two practices in very  
898 different parts of the country are already doing this in  
899 cardiology, and have found reductions in cardiac spending on  
900 the level of millions of dollars, but they can't get payers  
901 to take them up on it. They are simply proposing a novel way

902 to translate how they deliver care to patients with chest  
903 pain and with congestive heart failure with communications  
904 between primary care physicians, cardiologists, hospilists,  
905 surgeons, and other specialists. A way to communicate  
906 through text messaging, e-mail, when we need to have a  
907 consult with a cardiologist, allowing for primary care  
908 physicians to be able to readily access that specialist and  
909 open an honest, timely delivery of data between physicians  
910 will allow for this type of care coordination that I  
911 described, all with the purpose of helping to teach  
912 clinicians how they can better reduce the numbers of services  
913 that they provide that they have acknowledged that do not  
914 provide value. That is one example in cardiology.

915       The second example, a short one, in primary care and  
916 behavioral health. We have a critical shortage of  
917 psychiatrists and mental health professionals in this  
918 country, yet depression and other mental illnesses are an  
919 overwhelming problem in primary care. Translating some of  
920 what we currently do to allow for better collaboration  
921 between a telepsychiatrist, for example, who does not need to  
922 see a patient, and a primary care physician to offer advice  
923 for high risk management is exactly the type of payment model  
924 that can move us away from our fee-for-service system.

925       I have many more examples with tangible savings that

926 could be accomplished today; however, payers, including those  
927 that are public and private, need to be responsive to do  
928 this, and it can start with action by Congress.

929 I hope that I have illustrated that not only does one  
930 size not fit all, but that there are absolutely elements of  
931 our current reimbursement system that we must retain in order  
932 to improve. And that instead when we give providers more  
933 flexibility, we can accomplish this in both the short term as  
934 well as deal with what we have started with the SGR.

935 I thank you and welcome any questions.

936 [The prepared statement of Dr. Patel follows:]

937 \*\*\*\*\* INSERT 5 \*\*\*\*\*

|  
938           Mr. {Pitts.} The thanks the gentlelady, and that  
939 concludes the opening statements.

940           I have a unanimous consent request. The chair requests  
941 the following statement be introduced into the record. It is  
942 a statement by Garrison Bliss, M.D., President of Qliance  
943 Medical Group, Seattle, Washington. You have seen it.  
944 Without objection, it is so ordered.

945           [The information follows:]

946 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
947           Mr. {Pitts.} I will now begin the questioning. I  
948 recognize myself 5 minutes for that purpose.

949           Mr. Serota, relatively small number of patients, perhaps  
950 10 percent, especially those with chronic conditions and  
951 multiple co-morbidities may consume the majority of health  
952 care services and resources. It seems to make sense to  
953 target resources toward the care of those patients. How do  
954 you get physicians across specialties to do this?

955           Mr. {Serota.} The idea of identifying those high risk  
956 patients or those high-utilizing patients with chronic  
957 conditions is the--essentially the essence of the health  
958 informatics that we use for clinical care. We work with  
959 providers to provide them a comprehensive look at their  
960 patient populations. All the care that they are receiving,  
961 we try to identify those patients which are consuming care,  
962 and then the genesis or the foundation in a patient-centered  
963 medical home is to get the primary care physician to manage  
964 all of those attributes, all of those providers that are  
965 participating in the care to ensure that there is a lack of  
966 duplication and better coordination of the care that those  
967 patients receive.

968           Mr. {Pitts.} Dr. Nash, your model appears to be a form  
969 of capitation payment. In the 1990s, capitation arrangements

970 fell into disfavor in many markets because of certain  
971 weaknesses. How does your model address those weaknesses?

972 Dr. {Nash.} Yes, I stated among many physicians when  
973 you bring up the ``C'' word, capitation, there is a reaction,  
974 and a lot of that is from the experience of the '90s where  
975 many capitations were structured around actually putting  
976 physicians at risk for services that they didn't directly  
977 provide. So they weren't prepared to handle that financial  
978 risk, that is what an insurance company really needs to  
979 handle. So that is part one. The model we have is really  
980 only for the services the physician directly provides.

981 The second major aspect, though, is capitations of those  
982 days were really just age/sex adjusted, so that I, as a  
983 family doc, you know, if I am in my office and I am paid on  
984 that model from the '90s, if I had a 40-year-old patient come  
985 in to see me from a plan being paid in that way, a 40-year-  
986 old male but I happen to get one with diabetes and asthma, I  
987 was not paid adequately for that because I was being paid on  
988 the average. So this specific model pays more for the sicker  
989 patient, so we pay significantly more for that patient so the  
990 doctor can spend more time with that patient.

991 Mr. {Pitts.} Thank you. Dr. Bronson, we hear a lot  
992 about how primary care providers are undervalued in  
993 comparison to specialists. Most people agree that a robust

994 primary care workforce is essential. However, according to  
995 the Association of American Medical Colleges Center for  
996 Workforce studies, there will be not only a shortage of about  
997 45,000 primary care physicians; there will also be a shortage  
998 of 46,000 surgeons and medical specialists in the next  
999 decade. Yet, in a system with finite resources, how do you  
1000 increase reimbursement for primary care without reducing  
1001 reimbursement for specialists, and thereby jeopardizing  
1002 access to specialty care?

1003 Dr. {Bronson.} Thank you, Mr. Chairman. We strongly  
1004 believe that the patient-centered medical home concept and  
1005 the value concepts provided here will provide additional  
1006 funding through shared savings opportunities to support those  
1007 initiatives.

1008 Mr. {Pitts.} Okay. Dr. Hoyt, how are physicians  
1009 assigned to the Clinical Affinity Groups you described? Do  
1010 physicians self-assign, or are they assigned automatically  
1011 based on the patients they treat?

1012 Dr. {Hoyt.} You know, we are still having a lot of  
1013 discussion about that, but the general principle you ask  
1014 about is a physician would self-select, and the success of  
1015 that, we believe, will be in getting the types of groups that  
1016 would be naturally incentivized to work together to lower  
1017 costs and improve quality would be the premise of these

1018 groups.

1019           So you know, there is going to be potentially some  
1020 conflict in that if you are talking about the management of,  
1021 let us say, coronary syndromes, you are going to have  
1022 specialists that right now are not necessarily incentivized  
1023 to work together, but that is, in fact, the concept, that  
1024 somebody could control what they selected to be a part of,  
1025 whether it is a coronary group or a GI group or oncology  
1026 group, based primarily on what they practice.

1027           Mr. {Pitts.} Okay. And Dr. Patel, one major criticism  
1028 of the ACO model is that it is overly prescriptive. It may  
1029 work in one part of the country or for certain medical  
1030 specialties, but not for everyone. Providers often complain  
1031 that they need to make significant changes in their practices  
1032 in order to comply with ACO requirements. How can Medicare  
1033 incorporate innovative models that are more flexible, and  
1034 therefore, less disruptive to existing practices?

1035           Dr. {Patel.} Thank you, Mr. Chairman. I think Medicare  
1036 is doing just that with trying to introduce, in addition to  
1037 the Accountable Care Organization model, other such models  
1038 that incorporate other payers such as the Advanced Primary  
1039 Care Initiative and others that are going on as we speak. I  
1040 do think it is worth noting that the Accountable Care  
1041 Organization movement has blossomed and we now have over 2.5

1042 million Medicare lives in the currently funded Medicare  
1043 shared savings programs and pioneer ACO programs. So adding  
1044 that flexibility I know is critical to ensuring the retention  
1045 of the clinical excellence in those beneficiaries.

1046 Mr. {Pitts.} My time is expired. Chair recognizes the  
1047 ranking member for 5 minutes for questions.

1048 Mr. {Pallone.} Thank you, Mr. Chairman. I am trying to  
1049 get in a bunch of questions here, so I am going to ask you to  
1050 be brief, if you can. I am shortening my questions.

1051 Many members have supported using--this is for Dr.  
1052 Bronson and Dr. Hoyt. Many members have supported using the  
1053 OCO funding, the Overseas Contingency Operation funding, to  
1054 offset the cost of repealing the SGR. There are even some  
1055 Republicans who have supported it. So I wanted to ask you,  
1056 would you support using the OCO funding as a way to pay for  
1057 repealing SGR, and if not, do you have an alternative  
1058 suggestion? Mr. Bronson first, I guess?

1059 Dr. {Bronson.} Thank you, sir.

1060 Mr. {Pallone.} Dr. Bronson.

1061 Dr. {Bronson.} We are supportive of using the OCO  
1062 concept for providing this particular funding that is  
1063 necessary for this program. I will add, we are not experts  
1064 in funding and are open to other idea.

1065 Mr. {Pallone.} Okay, thank you. Dr. Hoyt?

1066 Dr. {Hoyt.} Yes, we would support use of that for the  
1067 offset.

1068 Mr. {Pallone.} Thank you both.

1069 Now Dr. Bronson, there is a consensus that many of the  
1070 delivery reform models discussed today hold promise for  
1071 Medicare, however, it takes time to disseminate those models  
1072 nationwide. In the meantime, there is clear evidence that  
1073 there is a problem with the incentives for primary care  
1074 payment. Are there steps we can take now that will help  
1075 boost primary care and better reward primary care  
1076 practitioners?

1077 Dr. {Bronson.} We very much believe that this is--the  
1078 first thing we need to do is really fix this SGR problem for  
1079 all practices. Without doing that, we don't have the  
1080 flexibility that we need to go forward and improve primary  
1081 care as effectively as we could. Supporting the patient-  
1082 centered medical home initiative is very important. My  
1083 personal practice, more than half of my patients and  
1084 internists are Medicare beneficiaries. It is hard to  
1085 reorganize your practice into a--fully into a patient-  
1086 centered medical home if you are not getting reimbursed  
1087 effectively by your largest payer. We need to move fast on  
1088 this issue.

1089 Mr. {Pallone.} Now the July 6 proposed rule issued by

1090 CMS creates a new code for care management post discharge.  
1091 Do you believe that this new initiative is a good one, or is  
1092 there anything else CMS can do to boost primary care?

1093 Dr. {Bronson.} Well absolutely it is a good one, and a  
1094 necessary one, but it needs to be filtered in--more effort  
1095 needs to be filtered into a comprehensive solution that  
1096 changes the practice paradigm to manage populations and  
1097 prevent unnecessary--I shouldn't say unnecessary, but  
1098 preventable utilization.

1099 Mr. {Pallone.} Okay. Now I am just going to ask a  
1100 general question. I don't know what time is left here for  
1101 anybody. We all talk about getting rid of the SGR, but we  
1102 really mean simply eliminating the forma that provides a  
1103 global cap on spending unrelated to physician performance or  
1104 quality. The underlying fee schedule which payments are  
1105 based off would likely still remain. You know, we have heard  
1106 from witnesses at this hearing notice that at the heart of  
1107 the fee schedule we have mis-valued codes and payment  
1108 incentives that still aren't aligned to value, the right care  
1109 at the right time, and of course, primary care remains  
1110 undervalued. I would like to ask any witness, first, whether  
1111 you support eliminating the SGR mechanism. I think the  
1112 answer is yes, so let us just go to the second, whether you  
1113 believe that if the SGR mechanism is eliminated, we will

1114 still need to retain the fee schedule, and assuming there is  
1115 agreement to retain the fee schedule, what needs to be done  
1116 to better align payment incentives there? So my question is  
1117 about the fee schedule. I guess I will start with Mr. Serota  
1118 and see how far we go with the time.

1119 Mr. {Serota.} Well I will try to be brief. I think  
1120 that the most critical element is to link reimbursement with  
1121 outcomes and quality, and to begin to reimburse providers  
1122 based on the managing of populations, rather than the  
1123 episodic care. We can't get there overnight, so I think the  
1124 elements of a fee schedule will have to remain in place for  
1125 some period of time as we transition to a differing--  
1126 different type of payment model, so I don't think it can be  
1127 eliminated immediately. But I do think we have to evolve  
1128 away from a fee-for-service model at some point.

1129 Mr. {Pallone.} Dr. Nash?

1130 Dr. {Nash.} We have eliminated the fee schedule in the  
1131 program that I am speaking about. You know, it has been well  
1132 demonstrated that fee-for-service just promotes more care,  
1133 but I think the main method I would give is it limits  
1134 innovations. It is really only rewarding for that face-to-  
1135 face between the doctor and a patient. It really doesn't  
1136 reward for team-based care, it doesn't reward for telephone  
1137 care, web based care, a whole variety. So if we want

1138 comprehensive care, we should pay comprehensively.

1139 Mr. {Pallone.} Dr. Bronson, you may be the last one  
1140 because we are running out of time.

1141 Dr. {Bronson.} I couldn't agree more with Dr. Nash. We  
1142 have important shortages in several specialties, primary  
1143 care, general surgery. Adjustment of fee schedule can help,  
1144 but you know--in a proactive way, but we need to go to a more  
1145 comprehensive solution in the long run.

1146 Mr. {Pallone.} Dr. Hoyt?

1147 Dr. {Hoyt.} Well, we actually anticipate the need for  
1148 this in our proposal by anticipating the need to adjust  
1149 primary care. But to your question, in the future do we need  
1150 a way to relatively value services, I think we still do  
1151 because background, education, training, commitment to  
1152 various kinds of efforts is going to lead to a different  
1153 valuation of some services, and I think the--our proposal  
1154 would be to have physicians still be in charge of doing that.  
1155 I realize that that seems self-interested, but we feel that,  
1156 as evidenced through committees like the RUC that that is  
1157 really what the RUC has been able to do. Maybe not always  
1158 correctly in some people's minds, but it is really intended  
1159 to try and foster that debate amongst physicians what the  
1160 relative value of a particular service is.

1161 Mr. {Pallone.} Thank you.

1162 Mr. {Pitts.} Chair thanks the gentleman and now  
1163 recognizes Dr. Burgess, 5 minutes for questions.

1164 Dr. {Burgess.} Dr. Patel, you got left off that last  
1165 sequence. Would you care to respond to the ranking member's  
1166 question?

1167 Dr. {Patel.} Thank you. I would agree, briefly, that  
1168 we should definitely improve on the fee-for-service elements,  
1169 and there will be a need, as I mentioned, to retain elements  
1170 such that when we move towards these more flexible payment  
1171 models, we can incentivize the right behavior. And I do  
1172 think it is about helping to recalculate what the relative  
1173 value of those payments are, to make them more accurate for  
1174 what we actually want to achieve, which we don't have right  
1175 now.

1176 Dr. {Burgess.} And that is why I wanted you to give  
1177 that answer, so I am grateful that you did.

1178 Moving to a model where fee-for-service no longer exists  
1179 is, in some ways, problematic because it is the world that  
1180 many of us--I practiced medicine for 25 years. It is the  
1181 world that many of us grew up in. We understand it, we can  
1182 converse easily about that world.

1183 At the same time, if there is--and I will be honest with  
1184 you, there are places in Texas where I don't honestly see how  
1185 you do a bundled payment or a value-based purchasing or an

1186 ACO model in Muleshoe, Texas, where you got one guy. I mean,  
1187 I don't know how you do that. That person has to have a fee-  
1188 for-service environment, at least in my limited view of the  
1189 world. They have to have a fee-for-service environment, and  
1190 if all of our effort with SGR reform is to move away from  
1191 fee-for-service, what do you do with the patients who are  
1192 seeing the doc in Muleshoe, Texas?

1193 Dr. {Patel.} Thank you for that question, Mr. Vice  
1194 Chair. I couldn't agree with you more. I am from Texas  
1195 myself, and understand exactly the kinds of practices that  
1196 you are speaking of, and I can tell you that that is why the  
1197 element that really helps to link a way forward is retaining  
1198 some of our current system that can help to--allow physicians  
1199 to continue practices such as you pointed out, but also, I  
1200 would say to you that that physician and those of us who  
1201 practice in more isolated settings, or even smaller settings  
1202 in a city, what we are all looking for is a way to coordinate  
1203 our care better and to reach out, just like we did in medical  
1204 school and in training, to other colleagues that we know can  
1205 help us respond to our patient's needs.

1206 So I think a step towards something that is different  
1207 than what we have now is to allow the solo practicing doctor  
1208 to be able to engage in a model for some of their patients  
1209 that have high risk cardiac conditions that need to go to San

1210 Antonio, and coordinate care better there and reward that  
1211 behavior.

1212 Dr. {Burgess.} Right, and most--can we just stipulate  
1213 for the record, since you are from Texas, that Muleshoe,  
1214 Texas, actually exists? I didn't just make that up.

1215 Dr. {Patel.} I can--I will tell you where it is on a  
1216 map even, yes.

1217 Dr. {Burgess.} But the--you know, when we talked about  
1218 this, and we have talked about it at the committee level, you  
1219 know, how do you go to a world beyond fee-for-service? It  
1220 just seems to me we are going to have to--whatever we do with  
1221 SGR, and I know there are people who say we need alternative  
1222 payment models, we need a value-based system, we need an ACO  
1223 model, we need a bundled payment model. But honestly, we  
1224 have got to allow for the rich panoply of practices that are  
1225 out there to continue to thrive, because after all, the name  
1226 of the game is not just reworking a formula, the name of the  
1227 game is seniors need access to care. And right now, that  
1228 access is not being--is in jeopardy because of the actions  
1229 taken by Congress that instituted this payment system, and  
1230 then our last-minute rescues every year have been the--have  
1231 put practices on kind of a tenuous financial footing if they  
1232 have got to go to their banker for a short-term note at  
1233 probably 9 to 12 percent interest to fund because their cash

1234 across the counter was reduced by 15 percent because Congress  
1235 said oh, we will just hold your check at CMS until we get  
1236 back from congressional recess. I mean, that sort of  
1237 activity is just devastating to practices. So I want to see  
1238 us figure that out.

1239 Now, you talked a little bit about not doing tests that  
1240 are not necessary, and I agree with that, but at the same  
1241 time, I think anyone who has been in clinical practice also  
1242 recognizes that people don't often always function according  
1243 to protocol, and I think one of the comments you made was in  
1244 cardiology that there was no testing, no dynamic testing  
1245 unless there were high risk markers present. Did I  
1246 understand you correctly with that?

1247 Dr. {Patel.} Yes, that is correct. That is from the  
1248 American College of Cardiology.

1249 Dr. {Burgess.} But we have all been in situations where  
1250 we have that patient come in at the end of the day who  
1251 describes an unnatural fatigue, and you say okay, look. It  
1252 is the end of the day. I am tired, you are tired, we are all  
1253 tired. Go on about your business. But we have all had the  
1254 situation where we have referred that patient on for testing,  
1255 and in fact, she has been quite ill with really minimal  
1256 systems and had you not had that little spark of curiosity,  
1257 you might not have referred for the testing. But now if you

1258 got someone looking over your shoulder saying look, you are a  
1259 high utilizer for this type of testing and these indications  
1260 are very soft, who is going to help us with the liability  
1261 side of that question?

1262 Dr. {Patel.} So I will try to respond briefly.

1263 Dr. {Burgess.} No, you can use as much time as you  
1264 want. The chairman is very tolerant. I know him well.

1265 Mr. {Pitts.} You may proceed.

1266 Dr. {Patel.} Thank you for that.

1267 So the first element is that this cannot be something  
1268 where it is a dictum or a direction to providers that you may  
1269 never--notice when the American College of Cardiology  
1270 participated in identifying that very example around cardiac  
1271 stress imaging, it wasn't--it is not a ``you must never do  
1272 this,'' it was chosen as one of the conditions in which the  
1273 profession can help to teach themselves and their own  
1274 clinicians how to best deal with imaging issues when patients  
1275 present, and that includes the ability to order that test  
1276 when it is necessary, or you do have that spark of curiosity.

1277 So in the model that I am describing for payment that  
1278 helps to also deal with some of the issues you bring up of  
1279 liability or feeling the responsibility to order something or  
1280 not order something, it would be to take that--we know that  
1281 there is a proportion of payments that we are delivering in

1282 the fee-for-service system right now that are being used to  
1283 deliver those services. Take a proportion of those payments  
1284 and say to cardiologists, to internists, to family practice  
1285 doctors in Texas and say you know what, we know that there  
1286 are things that you don't like about the way you practice  
1287 that are responsive to what you think might be issues around  
1288 liability or things that might spark a curiosity, and you  
1289 want the flexibility to deal with that. But what we will  
1290 give you--we are not just going to give you free reign, you  
1291 can't just do what you want. What we want for you to do is  
1292 agree to be responsible by following what your own profession  
1293 and your own colleagues have said are the best-informed  
1294 evidence around an issue. Does that mean that it is 100  
1295 percent an absolute? No. Does that mean that we would need  
1296 rich ability to measure what we are doing and learn from it?  
1297 I think that is what is essential, and I think that is what  
1298 physicians are craving. They want to know that they have  
1299 some flexibility and autonomy to practice the way they want,  
1300 but also to get the information that can help them be better.  
1301 And that will help the very small businesses that are small  
1302 practices to thrive in a newer business model and be more  
1303 efficient.

1304 Mr. {Pitts.} Chair thanks the gentleman and now  
1305 recognizes the ranking member of the full committee, Mr.

1306 Waxman, for 5 minutes for questions.

1307           Mr. {Waxman.} Thank you, Mr. Chairman. I want to thank  
1308 all the witnesses. This has been an excellent panel, and I  
1309 think you have given us a lot to think about.

1310           We want a health care system that works. We want some  
1311 innovation, experimentation, but no one size fits all, and we  
1312 have got to be open to looking at what makes sense, given the  
1313 circumstances. Of course, the main thing that makes sense at  
1314 the moment is to deal with this SGR problem because it is--  
1315 nothing else seems to work unless we take care of SGR. That  
1316 is why it is so frustrating that we didn't use the OCO, which  
1317 is just a bookkeeping thing, but the SGR is just a  
1318 bookkeeping thing, and we are stuck. And we ought to solve  
1319 those two issues, pay for it, get this thing resolved.

1320           Dr. Patel, I am not sure how closely you have been  
1321 following what has been going on in the House of  
1322 Representatives, but last week, the Republicans brought  
1323 forward a bill to repeal the Affordable Care Act. Not only  
1324 does the Affordable Care Act provide countless benefits for  
1325 families, such as protections against pre-existing condition  
1326 exclusions and lifetime caps on coverage, tax breaks of  
1327 \$4,000 a year per family for health care, improve free  
1328 preventive care, lowered out of pocket costs for prescription  
1329 drugs, but the Affordable Care Act also includes important

1330 provisions to drive delivery, reform, in fee-for-service  
1331 Medicare. One part of the Affordable Care Act provides for  
1332 Accountable Care Organizations within Medicare, or bundled  
1333 payment programs in Medicare. The law even established the  
1334 innovation center, which is taking unprecedented steps to  
1335 help providers, payers, and patient groups develop and spread  
1336 new and successful innovations, including through medical  
1337 homes and multi-payer initiatives.

1338           Obviously, the Affordable Care Act is just one piece of  
1339 improving quality and outcomes for Medicare, but I believe it  
1340 is an important one. If the Republican plan to repeal the  
1341 Affordable Care Act were to become law, what effect would  
1342 that have on Medicare's work to improve quality and outcomes  
1343 and realign payment incentives to focus on value? Do you  
1344 believe that would be a setback?

1345           Dr. {Patel.} I do believe it would be setback to turn  
1346 back all of the important work that has been done in the past  
1347 2 years and beyond, even before the Affordable Care Act was  
1348 passed, around savings and Medicare system, the Medicaid  
1349 system, and then what is even more remarkable is that we  
1350 can't turn back, even with the repeal, what has already taken  
1351 place as a result of the important initiatives you mentioned,  
1352 sir, in the private market.

1353           So now we have created a very complex web that is

1354 starting to produce some amazing results, as you have heard  
1355 today. So a repeal and any setback would really undo  
1356 valuable work and send a signal, I believe, to clinicians  
1357 around the country who are looking for a way to move forward.

1358       Mr. {Waxman.} It certainly would send a signal to a lot  
1359 of people who don't have health insurance that they are not  
1360 going to have an opportunity to get health insurance because  
1361 of the barriers that they have been unable to overcome prior  
1362 to the Affordable Care Act being passed and being fully  
1363 implemented.

1364       It occurs to me as I listen to the testimony that our  
1365 health system has hundreds, if not thousands, of groups  
1366 pursuing reform in some way. Each health plan, provider  
1367 organization, even Medicare and Medicaid has a slightly  
1368 different take on a medical home or an Accountable Care  
1369 Organization, for example. I am wondering how we ensure that  
1370 all of these efforts are complimentary, not contradictory?

1371       Dr. Patel, in your testimony you mentioned the need to  
1372 identify mechanisms to further multi-payer efforts to  
1373 transform the delivery system. I know that CMS is, as a  
1374 result of the new authority in the Affordable Care Act, is  
1375 working on some of these multi-payer initiatives. For  
1376 example, the Comprehensive Primary Care Initiative is a  
1377 collaborative effort between public and private payers and

1378 primary care practices to reward care management. The Multi-  
1379 payer Advanced Primary Care Demonstration is developing  
1380 state-led multi-payer collaborations with primary care  
1381 practices to improve care. Dr. Patel, could you talk about  
1382 why multi-payer initiatives are so important; what CMS,  
1383 through the Affordable Care Act, is doing in this area, and  
1384 what more can be done?

1385 Dr. {Patel.} Multi-payer initiatives are critical  
1386 because it is very hard for clinicians to provide care for  
1387 only one stream of patients, measure quality on those  
1388 patients, and then have a completely different set of  
1389 expectations, incentives, and reporting, which is what is  
1390 going on right now. So some of the important initiatives  
1391 that you just mentioned at the state level, in the primary  
1392 care setting, and even the Accountable Care Organization  
1393 model really send a strong signal to other payers, and that  
1394 started with actions taken in Medicare by CMS as a result of  
1395 the Affordable Care Act. So do believe that the continuing  
1396 work of encouraging, but then also having a way to set  
1397 forward the actual mechanism for other payers to be involved.  
1398 And that means, as I said in my testimony, consistent quality  
1399 measures. We can't have one set of quality measures that I  
1400 report to for one payer, which is what I do in my practice  
1401 now, and a completely different set of metrics for another.

1402 That is where the multi-payer efforts are huge and critical.

1403 Mr. {Pitts.} Chair thanks the gentleman. Now  
1404 recognizes Dr. Cassidy, 5 minutes for questions.

1405 Dr. {Cassidy.} As an open question to follow up on Mr.  
1406 Waxman's affection for the ACA, according to who you listen  
1407 to, Medicare is going bankrupt in 5 to 12 years. I am sure  
1408 he and his affection would love that ACA takes \$500 billion  
1409 in savings from Medicare and spends it elsewhere as opposed  
1410 to shoring up the program. That is a feature that  
1411 Republicans object to, and frankly, it is terrible for  
1412 Medicare. But that is part of the ACA and I am sure he would  
1413 not want that repealed either.

1414 That said, as a practicing physician myself, I have  
1415 observed that only fiduciary linkage between patients and  
1416 physicians seems to consistently lower costs. That is a  
1417 little bit of a theme I have heard from you.

1418 Mr. Serota, I am curious, do you do MA plans, Medicare  
1419 Advantage programs?

1420 Mr. {Serota.} We do have Medicare Advantage programs,  
1421 yes.

1422 Dr. {Cassidy.} What is your--so you have got a very  
1423 nice system where you are getting feedback--each of you  
1424 described this, Dr. Nash, Dr. Patel--where you are giving  
1425 feedback to the practicing physician, clearly, that costs

1426 money. What is the MLR, your medical loss ratio, of the MA  
1427 plans that you have?

1428 Mr. {Serota.} It is widely variated based on the  
1429 marketplace. I don't have a single--

1430 Dr. {Cassidy.} Is it over 15 percent?

1431 Mr. {Serota.} The medical loss ratio itself? The  
1432 administrative expense piece of that?

1433 Dr. {Cassidy.} Yes.

1434 Mr. {Serota.} In some markets it may be.

1435 Dr. {Cassidy.} Now you are contracting with these  
1436 physician groups. I am assuming they have their own MLR--and  
1437 Dr. Nash, you can weigh in as well. Are you doing Medicare  
1438 Advantage as well?

1439 Dr. {Nash.} Yes, we are.

1440 Dr. {Cassidy.} So can I ask what you are contracting  
1441 with the--are you directly contracting with CMS or with the  
1442 Medicare Advantage program?

1443 Dr. {Nash.} We--our Medicare Advantage program is  
1444 directly through CMS.

1445 Dr. {Cassidy.} So you are an MA plan?

1446 Dr. {Nash.} Correct.

1447 Dr. {Cassidy.} So you get--what is your MLR?

1448 Dr. {Nash.} Well, the medical loss ratio is an amount  
1449 of premium that is spent on medical care, so we are roughly

1450 about 88 percent or something of that nature.

1451 Dr. {Cassidy.} So your administrative cost is only 12  
1452 percent?

1453 Dr. {Nash.} Correct.

1454 Dr. {Cassidy.} That is pretty good. Some other plans  
1455 similar to yours seem to have higher than that. It has been  
1456 instructed some of the physician groups contracting with the  
1457 insurance companies, the insurance company keeps 12 but then  
1458 the medical plan itself has an additional MLR. Mr. Serota is  
1459 kind of nodding his head yes. It seems that in the  
1460 aggregate, the MLR is greater than the 15 percent or 20  
1461 percent defined by the so-loved ACA.

1462 Now, if you didn't have the ability to do your data  
1463 systems, would you be as effective in managing that care?

1464 Yes.

1465 Dr. {Nash.} Absolutely not. I mean, the data is  
1466 essential for any of this.

1467 Dr. {Cassidy.} That wasn't a trick question. It seemed  
1468 so self-evident. By the way, I admire the fact that you as  
1469 practicing physicians understand there are some things fee-  
1470 for-service works better for. Then again, as a practicing  
1471 doc, I also see that, so let me just kind of compliment you  
1472 on that model.

1473 Now, for all of you--Dr. Hoyt, it seems like yours is

1474 effectively a bundled payment system, correct? If somebody  
1475 has--I have a pain in my neck and it is not from any of you,  
1476 it is just from a bad neck, so if I am grimacing, that is the  
1477 reason why. It seems like you are a bundled system. If  
1478 somebody has colon cancer, they would come to you and  
1479 contract, if you will, for the management of that care, is  
1480 that correct?

1481 Dr. {Hoyt.} Well, in our system bundled payments could  
1482 be accommodated, but the system is really about updates for  
1483 the overall Medicare reimbursement on an annual basis. And  
1484 it simply puts a group of physicians to quality of metrics  
1485 around a specific disease target or something like that. It  
1486 doesn't necessarily, per se, bundle the responsibility by,  
1487 you know, that same group.

1488 Dr. {Cassidy.} Let me ask you, because really, this is  
1489 about finding ways to save enough money and translate those  
1490 savings into doing away with SGR forever, once and for all,  
1491 and continuing to reward patients for appropriate payment,  
1492 correct?

1493 Dr. {Hoyt.} Correct, and I think, you know, that is an  
1494 assumption in our model that we have to prove. We are  
1495 planning to do some modeling to actually see if it shakes  
1496 out, but your comment that all of these attempts at cost  
1497 savings is ultimately where the extra money comes from to pay

1498 for increased access or individual--more individualized care  
1499 for high risk patients, et cetera, that has to be the  
1500 assumption, that there are some ways that can be--

1501 Dr. {Cassidy.} Dr. Patel, I really liked your  
1502 testimony. I like your written, and I like the way you  
1503 delivered it. Let me just compliment you. But that said,  
1504 everybody has talked about somewhat of a big government-type  
1505 solution. You are going to need a lot of structure here.  
1506 You are going to need this big, overarching overhead. And  
1507 going back--I will go to Louisiana, FP and Pointe Coupee  
1508 Parish, small place, overworked, underpaid, driven, wife is  
1509 wondering why he is not home on time. And that is too  
1510 common. Now what do you think about the direct medical care  
1511 model? We have the written testimony from Qliance where you  
1512 pay the doc \$50 to \$100 a month depending on the complexity  
1513 and age of the patient, and she or he manages all the  
1514 outpatient services, referring to the inpatient setting as  
1515 separate. It is not totally capitated, but it allows a doc  
1516 to manage the outpatient and then the inpatient then goes on  
1517 another ticket. What are your feelings about that?

1518 Dr. {Patel.} I have had a chance to learn more about  
1519 the Qliance model over a year ago, and have been very  
1520 interested in exactly the way they are able to risk adjust  
1521 and charge a sliding fee per month for beneficiaries and have

1522 amazing kind of access points for those beneficiaries to e-  
1523 mail with their doctors, talk to them, and I think that that  
1524 is a great model that would actually fit in nicely with  
1525 helping to offer a flexibility for a primary care physician  
1526 in Louisiana to do something exactly like that, and that  
1527 would be a very rich way to ensure financial sustainability  
1528 in their practice--

1529 Dr. {Cassidy.} Exactly.

1530 Dr. {Patel.} --all the while really creating models  
1531 inside that practice that reward coordination. Let the  
1532 doctors and the MAs and the nurses figure out what they need  
1533 to do.

1534 Dr. {Cassidy.} Sounds good. My last thing, and I am  
1535 out of time. Thank you, Mr. Chairman.

1536 Mr. Serota, for the record, I will ask you if you would  
1537 give us your MLR for your various MA plans, and what you  
1538 estimate that the MLR is of the group with whom you are  
1539 contracting, because I think that would be very informative  
1540 to us.

1541 Mr. {Serota.} We can get that information.

1542 Dr. {Cassidy.} Thank you.

1543 Mr. {Pitts.} Chair thanks the gentleman, now goes to--  
1544 recognizes Mr. Dingell for 5 minutes for questions.

1545 Mr. {Dingell.} Mr. Chairman, I thank you. I commend

1546 you for this hearing. I commend the panel. This is one of  
1547 the best presentations and one of the best hearings I have  
1548 heard for a while. I also want to commend our panelists for  
1549 their fine testimony.

1550         These questions will go to Dr. Patel. I want to thank  
1551 you for being here today. Please answer the following  
1552 questions yes or no. Is it fair to say from your testimony  
1553 that fee-for-services models do not promote the highest  
1554 quality and highest value health care? Yes or no.

1555         Dr. {Patel.} Yes.

1556         Mr. {Dingell.} Is it also fair to say that models such  
1557 as the patient-centered medical home have the most promise to  
1558 provide our citizens with the best and most affordable health  
1559 care? Yes or no.

1560         Dr. {Patel.} Yes.

1561         Mr. {Dingell.} Is it possible that other benefits from  
1562 these things could occur, such as a reduction in both cost  
1563 and the rate of growth of cost?

1564         Dr. {Patel.} Yes.

1565         Mr. {Dingell.} Now Doctor, I believe that on March 23,  
1566 2010, the President signed the Affordable Care Act into law.  
1567 I am sure you are aware that ACA provides a shared savings  
1568 program through Accountable Care Organizations that serve 2.4  
1569 million Americans, is that right?

1570 Dr. {Patel.} Yes.

1571 Mr. {Dingell.} Now Doctor, ACA is legislation that  
1572 includes the authority to embark on many innovative paths. I  
1573 believe that is a desirable thing, is it not?

1574 Dr. {Patel.} Yes.

1575 Mr. {Dingell.} Now Doctor, are you aware that CMS  
1576 programs such as innovation advisors, and innovation  
1577 challenge grants that seek to promote groundbreaking work in  
1578 health care, would you say that is useful? Yes or no.

1579 Dr. {Patel.} Yes.

1580 Mr. {Dingell.} By the way, Doctor, I am sorry to do  
1581 this to you. You are a very good witness, but I have got a  
1582 lot of questions and not much time.

1583 Dr. {Patel.} No problem.

1584 Mr. {Dingell.} Dr. Patel, it is clear from your  
1585 testimony that you understand the importance of excellent  
1586 primary care. This is an area of great shortage in this  
1587 country, and potentially worse shortage, is it not?

1588 Dr. {Patel.} Yes.

1589 Mr. {Dingell.} Did you know that CMS has a  
1590 comprehensive primary care initiative that encourages  
1591 public/private collaboration on promoting primary care? Yes  
1592 or no.

1593 Dr. {Patel.} Yes.

1594 Mr. {Dingell.} Dr. Patel, I think we both agree that  
1595 CMS must do more to reform physician payment systems. Is  
1596 that your view?

1597 Dr. {Patel.} Yes.

1598 Mr. {Dingell.} And I hope you also recognize that the  
1599 Affordable Care Act is assisting CMS in beginning the  
1600 important process towards these vital reforms. Do you agree  
1601 with that statement?

1602 Dr. {Patel.} Yes, sir.

1603 Mr. {Dingell.} Doctor, do you want to make a comment as  
1604 to how that particular process is working? This is not a yes  
1605 or no question.

1606 Dr. {Patel.} Thank you. Yes, I am happy to just  
1607 briefly tell you that I do know that CMS has been working,  
1608 even with the most recently mentioned physician payment rule  
1609 that was released last week, to add modifications that  
1610 acknowledge some of the issues we discussed today around the  
1611 relative value of some fee-for-service elements, as well as  
1612 ways to better integrate quality with work that is already  
1613 going on in clinical specialty societies and primary care.

1614 Mr. {Dingell.} Does that offer promise for the future  
1615 in addressing these miserable problems we have--

1616 Dr. {Patel.} It does, sir.

1617 Mr. {Dingell.} --with regard to cost increases and

1618 things of that kind?

1619 Dr. {Patel.} It does, and it also offers insights into  
1620 what we need to do more work in, even outside of the Medicare  
1621 program.

1622 Mr. {Dingell.} Now how does--how is it that this  
1623 program is going to benefit us in terms of addressing cost  
1624 increases and the rate of increase of costs?

1625 Dr. {Patel.} It all has to do with making sure that  
1626 what we are incentivizing, where we put the dollars, actually  
1627 matches towards the value that has already been identified  
1628 that we do not attain in this country. So it is really about  
1629 taking resources that we know are not going towards valuable  
1630 care, and redirecting those towards things that we know  
1631 promote value. And those come from the very work that we are  
1632 hearing about that are led by clinicians.

1633 Mr. {Dingell.} Now you just said something very  
1634 important. How do we do that? What are the steps that we  
1635 take to make that happen?

1636 Dr. {Patel.} The very short-term steps over the next 2  
1637 years, for example, transferring a proportion of what we do  
1638 in fee-for-service payment right now into this coordinated  
1639 care model that we are discussing. It is even beyond the  
1640 patient-centered medical home. It could be a model that  
1641 allows for an oncologist, for example, to better coordinate

1642 care for a colorectal cancer patient. And then from that  
1643 point, what we can't do is leave it alone at that step. What  
1644 we must do is transfer and think about how that money, those  
1645 dollars and care coordination can not only be reinvested back  
1646 into the system, but what savings we create from that can  
1647 move towards either these larger kind of episode or bundled  
1648 payments that we have discussed, or other mechanisms that  
1649 other physicians have brought up today.

1650 Mr. {Dingell.} Do you believe that the medical  
1651 profession will support that?

1652 Dr. {Patel.} I believe they will, and I believe they  
1653 have already been putting these models forward, sir.

1654 Mr. {Dingell.} Thank you. Thank you, Mr. Chairman.

1655 Mr. {Pitts.} Chair thanks the gentleman and now  
1656 recognizes the gentleman from Ohio, Mr. Latta, 5 minutes for  
1657 questions.

1658 Mr. {Latta.} Thank you, Mr. Chairman, and thanks very  
1659 much to our panel members for being with us today. It has  
1660 been very enlightening.

1661 If I could start with Mr. Serota, if I could ask you--it  
1662 is kind of interesting in your first page of your testimony,  
1663 you state that U.S. health care spending exceeds \$2.5  
1664 trillion annually, and studies estimate that 30 cents of  
1665 every health care dollar goes to care that is ineffective or

1666 redundant, and those dollars are not being well spent.

1667           Let me ask you, why is that happening and where are  
1668 those dollars going?

1669           Mr. {Serota.} Well, I think you have heard virtually  
1670 everyone on the panel answer that question in a slightly  
1671 different take, but the reality is that we are providing  
1672 care, as Dr. Patel just said, that isn't valuable and we need  
1673 to redirect that care to things that are going to provide  
1674 better outcomes. Why is it happening? We have a system that  
1675 incents volume and doesn't incent population management,  
1676 quality, and outcome. So when you have a system that incents  
1677 volume, you get volume. That is what is transpiring.

1678           Mr. {Latta.} Let me ask, does this include a lot of  
1679 tests that don't need to be done because folks out there are  
1680 fearful if they don't do the test that they will be held  
1681 liable?

1682           Mr. {Serota.} Certainly.

1683           Mr. {Latta.} And what should we do about that?

1684           Mr. {Serota.} Well, I think we have to look at the  
1685 health care system comprehensively, which would include  
1686 looking at reforming the tort system as well.

1687           Mr. {Latta.} Dr. Nash, I saw you nodding your head.

1688           Dr. {Nash.} Yes, absolutely correct. I mean, if you  
1689 speak to physicians, that is the first thing I put forward

1690 and was raised even in today's discussion. But the other  
1691 side of the coin is really the patients and the patients  
1692 demand for services because of their own anxieties and  
1693 concerns, and both need to be dealt with.

1694 Mr. {Latta.} That is one of the things, you know, that  
1695 we have been talking about around here and that we have to  
1696 get done, because you can't really, you know, have meaningful  
1697 health care reform if we don't do something about the tort  
1698 system in this country and a lot of these junk lawsuits.

1699 Let me ask this question. This is to Dr. Bronson. I  
1700 was just over at Cleveland Clinic on Monday for a meeting,  
1701 and I am from northwest Ohio, but you know, we have been  
1702 talking a lot about what is happening in the health care  
1703 system here, but let me ask you this. We hear a lot about  
1704 the physician's role in promoting high quality of care and  
1705 avoiding unnecessary spending, and you know, really, what is  
1706 the role of the patient now that we have to be looking at?

1707 Dr. {Bronson.} Well, the role of the patient is very  
1708 important, and that is why we support initiatives to get  
1709 patients more actively engaged in shared decision making in  
1710 an effective manner, and that should be supported in  
1711 practices. I would like to add to the comment on liability  
1712 reform, that we are very strongly in support of a variety of  
1713 steps for liability reform. You may recall that I came to

1714 your office and spoke to you about the--health courts is  
1715 something that we should test nationally to see if having  
1716 impartial judges involved in this type of process, instead of  
1717 volatile juries could be a more effective manner in handling  
1718 liability reform.

1719 Mr. {Latta.} As we look at that, how do we incentivize  
1720 those patients to make sure that they can do more, and those  
1721 people that are in the system, to make sure that, you know,  
1722 they are not--we were talking about this the other day about,  
1723 you know, 20, 30, 40 years ago folks couldn't go to the  
1724 emergency room as much, you know. Folks might have stayed  
1725 home and taken care of things a little bit more. But how do  
1726 we incentivize those people for making better health care  
1727 decisions on their own?

1728 Dr. {Bronson.} Well, number one, we have to fix the  
1729 access problem in primary care. My experience is patients  
1730 really don't want to be sitting 3 to 4 hours in the emergency  
1731 room waiting to be seen for an acute minor problem. They  
1732 would really rather see their personal physician. Part of  
1733 the concept of what we are getting at is rewarding efforts to  
1734 enhance access to restructure practices to be more effective,  
1735 to use extenders more efficiently in practices to get  
1736 patients in. We believe that those types of steps will  
1737 reduce unnecessary utilization, and hopefully avoid

1738 preventable omissions and expenses.

1739 Mr. {Latta.} Okay. If I could, Dr. Nash, ask you this  
1740 question. You know, if the SGR, let us just say, is reduced  
1741 at the end of this year by 27-1/2 percent, how would that  
1742 affect rural areas in this country, and would they suffer  
1743 disproportionate hit more than an urban area? How would you  
1744 see that?

1745 Dr. {Nash.} If it was not?

1746 Mr. {Latta.} Right, if it--

1747 Dr. {Nash.} If it remained enforced?

1748 Mr. {Latta.} Right.

1749 Dr. {Nash.} Yes, it would be devastating, you know.

1750 The access currently for Medicare patients across the  
1751 country, particularly in rural areas, is threatened even on  
1752 the current state, let alone if that was the outcome.

1753 Mr. {Latta.} Mr. Chairman, I yield back my time.

1754 Mr. {Pitts.} Chair thanks the gentleman and recognizes  
1755 the gentleman from New York, Mr. Towns, 5 minutes for  
1756 questions.

1757 Mr. {Towns.} Thank you very much, Mr. Chairman. Let me  
1758 begin by first thanking you for having this hearing, and to  
1759 thank these panelists for outstanding testimony. I think  
1760 that as has been stated, this is a very serious issue and of  
1761 course, I think that we need to spend as much time as we need

1762 to do in order to try and correct some of the problems that  
1763 are going on as we look at access and of course, liability  
1764 and all of these things I think are connected.

1765         So let me begin with you, Dr. Patel. If we shift away  
1766 from the FFS payment system, what would that transition  
1767 process look like? We have identified the resource base  
1768 relative value scale, particularly the RVUs as a source of  
1769 much trouble, direct and focused to volume instead of value.  
1770 So are you proposing we do away with RVUs altogether, and how  
1771 else can we quantify the value of physician services?

1772         Dr. {Patel.} I think it is important to preserve the  
1773 notion of what a value unit is. I think it is what relative  
1774 value units have been that have been the problem, so in a  
1775 transition, I mentioned that even in a long-term vision we  
1776 would need to keep some elements of our current reimbursement  
1777 system because there are elements that work. But I do think  
1778 that in order to improve the RVU process, as well as how we  
1779 incentivize some of the fee-for-service services that we  
1780 cover, in the short term, in the next year or two, we need to  
1781 actually identify what it is that we are not deriving value  
1782 from, and what that amount of dollars are in the Medicare  
1783 system, and translate that to models that are not necessarily  
1784 RVU driven. That doesn't mean that we are eliminating all  
1785 the RVUs, but taking the proportion of RVUs that we know are

1786 really not providing that very term, relative value, and  
1787 improving upon them to create incentives for care  
1788 coordination.

1789         So taking what we have, not eliminating it totally,  
1790 taking what we have that we know does not provide value and  
1791 translating that into dollars and payments that do provide  
1792 value, and improving--meanwhile, I think improving upon the  
1793 RV system, which is what CMS is trying to do right now with  
1794 the updates to payments in primary care, for example.

1795         Mr. {Towns.} All right, thank you very much.

1796         Dr. Hoyt, you mentioned the right infrastructure is  
1797 absolutely--in order to provide high quality care. What do  
1798 you really mean by that? Could you expound on that?

1799         Dr. {Hoyt.} Well, you know, I think when you describe  
1800 standards for care, you are really describing outcome  
1801 standards or you are addressing what the ultimate goal of  
1802 treating a disease is. The infrastructure standards are  
1803 really the details of the actual physical plan, the  
1804 communications, the essential specialists that need to be  
1805 part of decision making. When you are talking about complex  
1806 disease, having consensus and then committing to the building  
1807 of the infrastructure is really the second step in the  
1808 quality process. So for instance, if you are going to  
1809 develop a trauma center, which is my background, you have to

1810 commit to certain elements. If you are going to develop a  
1811 cancer center, you have to commit to certain elements. And  
1812 you have to do more than that; you have to actually commit to  
1813 being externally peer-reviewed if you are really going to  
1814 assure the public that what you say you are doing, you are  
1815 actually doing.

1816 Mr. {Towns.} You know, the term here today that has  
1817 been used, one size does not fit all, what do you really mean  
1818 by that? I understand what you are saying, but what do you  
1819 really mean when you say one size does not fit all?

1820 Dr. {Hoyt.} I don't believe that was my comment, but I  
1821 will be glad to--

1822 Mr. {Towns.} Thank you, Dr. Patel.

1823 Dr. {Patel.} I do not think that the very situation  
1824 that we got into with our current reimbursement system was an  
1825 attempt over time to have a unifying kind of standard. Even  
1826 though we talked about relative value unit, what we have  
1827 ended up doing is really incentivizing volume. And to say  
1828 that one size does not fit all, that is an acknowledgment  
1829 that not every clinical practice, when you open the door to  
1830 see the doctor, is going to look the same, nor should it look  
1831 the same, and that is the kind of payment model that Medicare  
1832 needs to reach, so that we are not actually just saying to  
1833 doctors--which is what we are doing right now--we will pay

1834 you more if you do more. That is not a message we should  
1835 send. And so one size fits all means that there are many  
1836 different models, and we are already seeing some of these in  
1837 practice, that can offer more value and save the system money  
1838 overall.

1839 Mr. {Towns.} All right. Thank you very much, and I see  
1840 my time is expired.

1841 Mr. {Pitts.} Chair thanks the gentleman, and now  
1842 recognizes Dr. Gingrey for 5 minutes for questions.

1843 Dr. {Gingrey.} Mr. Chairman, thank you very much. I  
1844 will first go to Dr. Bronson and Dr. Hoyt.

1845 Doctors, you were asked earlier in your testimony and  
1846 the Q&A about the OCO money being used to eliminate the cliff  
1847 in regard to the SGR problem and fixing--eliminating the SGR  
1848 and of course, paying the \$300 billion to get the baseline  
1849 back to zero. And OCO money, for those who might not know--I  
1850 think everybody pretty much does--Overseas Contingency  
1851 Operation, basically a supplemental appropriations that are  
1852 used on an annual basis to fund a war effort, not part of the  
1853 standard appropriation procedure, emergency funding. So if  
1854 you don't use that money, if you cut back on the war effort  
1855 and you don't need it, how can you actually use it to pay for  
1856 something else? And you said you would be in favor of using  
1857 it to pay for something else. Do you want to confirm that

1858 that is your opinion on that, both of you, Dr. Bronson and  
1859 Dr. Hoyt?

1860 Dr. {Bronson.} I will confirm that. Of course, it is a  
1861 congressional decision, but yes, I would confirm that we  
1862 support that.

1863 Dr. {Gingrey.} Dr. Bronson, do you feel the same way?

1864 Dr. {Bronson.} Yes--Hoyt.

1865 Dr. {Gingrey.} Dr. Hoyt.

1866 Dr. {Hoyt.} Yes. Well, we understand the discussion of  
1867 some disagreement of whether it is real money or not, or  
1868 whether it can or cannot be used. We--if it is available and  
1869 it exists, we would support using it.

1870 Dr. {Gingrey.} If funny money is going to be used, you  
1871 want it to be used to kind of help your situation. I  
1872 understand.

1873 Dr. {Hoyt.} If we could put it that way.

1874 Dr. {Gingrey.} Let me say this. I support SGR repeal,  
1875 and I think all physicians do. I also understand that  
1876 because of Obamacare, the Affordable Care Act, the threat to  
1877 physicians is compounded by a second SGR known as IPAB.  
1878 Except in this instance, physician reimbursements will now be  
1879 used to control cost in all of Medicare, not just Part B.  
1880 How important is IPAB repeal to physicians, and do you  
1881 believe Congress and the President should support the repeal

1882 of IPAB, again, Dr. Bronson and Dr. Hoyt?

1883 Dr. {Bronson.} We support the concept of IPAB, but a  
1884 significant change in IPAB. We think IPAB should be an  
1885 advisory body to Congress who, with a straight up and down  
1886 vote, could deal with their recommendations that Congress is  
1887 accountable to the people and should have the opportunity to  
1888 respond to their advice.

1889 Dr. {Gingrey.} Dr. Hoyt?

1890 Dr. {Hoyt.} We have not supported IPAB in principle  
1891 because of the concern that there is not adequate oversight  
1892 and participation of Congress, but also physicians.

1893 Dr. {Gingrey.} Would the two of you--thank you for your  
1894 answer. Would the two of you submit that response to me in  
1895 writing? I would appreciate that very much. Mr. Chairman,  
1896 thank you.

1897 Let me go to Dr. Patel. Dr. Patel, I just want to  
1898 clarify something that I heard from my colleagues, Mr.  
1899 Dingell and Mr. Waxman. They made statements that Medicare  
1900 innovation would go away if Obamacare was repealed. Maybe  
1901 they have forgotten or aren't aware that CMS demonstration  
1902 projects on payment models was begun back in 2005 under  
1903 President Bush. In fact, the Institute of Medicine called  
1904 for them back in 2001. Obamacare merely copied that idea and  
1905 Republicans would continue reforming Medicare if Obamacare is

1906 repealed. Would you like to comment on that? Do you agree  
1907 with me or disagree with me on that statement?

1908 Dr. {Patel.} I agree, sir, that the concept of  
1909 innovation as it has been introduced in Medicare started  
1910 before the Affordable Care Act, absolutely. Demonstrations--  
1911 in fact, it is important demonstrations that occurred, the  
1912 physician group practice demonstration and some other chronic  
1913 disease demonstrations that have taught us what we need to do  
1914 better, and also where we did not necessarily understand  
1915 enough about cost savings and the system. So I agree, sir,  
1916 that they did, in fact, begin before the Affordable Care Act,  
1917 but I will tell you that I think would be important to keep  
1918 and preserve absolutely are not just the Center for Medicare  
1919 and Medicaid Innovation, which has a great deal of activity  
1920 right now, but embedded into that language is also a number  
1921 of authorities that allow the Secretary and the Centers for  
1922 Medicare to rapidly scale those payments--

1923 Dr. {Gingrey.} Right, and my time is about to expire,  
1924 but thank you very much for that response, because I agree  
1925 with you that as we point out--and there are a number of  
1926 things were mentioned that are popular in the Affordable Care  
1927 Act. We always hear that keeping young people on their  
1928 parent's health insurance policy until they are 26 years of  
1929 age, even if they are not still in school, is probably a good

1930 thing. Eliminating lifetime and even, indeed, in many cases  
1931 annual caps, making sure that children with preexisting  
1932 conditions--I could go on and on. There are several things  
1933 that just like this innovation that existed before Obamacare,  
1934 PPACA was enacted, these other things that we all like in a  
1935 bipartisan way could easily be reincorporated into a new  
1936 plan.

1937 And with that, I see my time is expired, and I thank the  
1938 chairman.

1939 Mr. {Pitts.} Chair thanks the gentleman, and now  
1940 recognizes the gentleman, Mr. Engel, for 5 minutes for  
1941 questions.

1942 Mr. {Engel.} Thank you very much, Mr. Chairman. I just  
1943 have to comment that I have heard some of my colleagues on  
1944 the other side talking about Medicare potentially going  
1945 bankrupt. The Affordable Care Act extended the solvency of  
1946 Medicare, and I just find it very strange that we fought two  
1947 wars on the credit and we have had Bush tax cuts for the  
1948 wealthy, Medicare Part D unpaid for. We had surplus Bill  
1949 Clinton left office and we could have used that to shore up  
1950 Medicare, so I think that when we kind of look at why we are  
1951 in the trouble we are in, there is a lot of blame to go  
1952 around on all sides.

1953 First of all, let me thank all of you for excellent

1954 testimony. Every one of you was really excellent testimony,  
1955 and I think it is very, very important. This is an important  
1956 subject to have so many questions, and I just have to kind of  
1957 cut down.

1958         But let me just say, the SGR is obviously seriously  
1959 flawed and needs to be permanently replaced. I really  
1960 believe that physicians deserve to be fairly and  
1961 appropriately compensated for the important work they do, and  
1962 the SGR formula is failing our physicians. I think there is  
1963 nothing wrong with physicians wanting to be adequately and  
1964 fairly reimbursed. And that is why I want to say that the  
1965 Affordable Care Act appropriated \$10 billion in funding for  
1966 the Center for Medicare and Medicaid Innovation over 10  
1967 years. I think that is very, very important.

1968         I want to ask this question. Now, all of us recognize  
1969 the current fee-for-service model has resulted in emphasis on  
1970 procedures and quantity over quality of health care provided.  
1971 I am introducing legislation--one field I am particularly  
1972 interested in is palliative care, and it relies heavily on  
1973 care coordination and communication with patients. I believe  
1974 they are vital aspects to providing quality care, but ones  
1975 that are not properly incentivized under the current fee-for-  
1976 service system, and yet properly done, I think palliative  
1977 care often saves money, extends life of patients, and gives

1978 them peace of mind.

1979           So let me ask Dr. Nash, Mr. Serota, and Dr. Patel, what  
1980 role do you see for palliative care as the health care system  
1981 undergoes extensive delivery system reforms, and how can we  
1982 incentivize the integration of palliative care for  
1983 professionals into coordinated care teams?

1984           Dr. {Nash.} Dr. Nash. I believe that--yes, palliative  
1985 care is very important, and we have programs within our plan  
1986 to work with our physician community and the community at  
1987 large in regard to improving care at that phase of life. You  
1988 know, it is difficult in a few minutes to talk about how that  
1989 should be incorporated into payment models. I think it is a  
1990 broader dialog in regard on a community level that many  
1991 communities across the country have been successful with.

1992           Mr. {Serota.} This is an important issue for us, and we  
1993 do have a number of plans that--programs in place to help  
1994 members with advanced illness. As an example, our Anthem  
1995 Blue Cross Blue Shield plan in Virginia has an integrated  
1996 cancer care medical management model, which is, at its core,  
1997 trying to provide improved access to palliative care. They--  
1998 members who receive timely access to palliative care  
1999 generally achieve a better quality of life during these end  
2000 stage, lower cost related end of life treatment and acute  
2001 hospitalizations. They employ skilled care management

2002 nurses, decision support tools, medical director support, and  
2003 it is a comprehensive program. We also have a similar  
2004 program in Pittsburgh with our Highmark plan that, in fact,  
2005 provides coverage for consultative services to its members  
2006 with palliative care professions to ensure that that care is  
2007 appropriate. We think it is an essential element, and often  
2008 overlooked, so we appreciate your attention to it.

2009 Mr. {Engel.} Thank you. Dr. Patel?

2010 Dr. {Patel.} So very briefly, the concept of a patient-  
2011 centered medical oncology home is exactly alluding to the  
2012 kinds of services you are referencing, specifically  
2013 palliative care. Oncologists right now are caught up in the  
2014 same quantity over quality system that we all have to be  
2015 reimbursed in, and moving towards a coordination type fee,  
2016 oncologists have already put forward ideas and are practicing  
2017 palliative care referrals as well as palliative care medicine  
2018 in the space of their cancer patients.

2019 Mr. {Engel.} Thank you. Let me get in one quick  
2020 question. As part of the Affordable Care Act, Medicare  
2021 started paying primary care physicians a 10 percent incentive  
2022 payment, and it is my understanding that more than 156,000  
2023 primary care providers have benefitted from this. Now, I am  
2024 curious to see what efforts are being taken in the private  
2025 sector to incentivize physicians to practice in primary care.

2026 Perhaps Mr. Serota, Dr. Nash, can you elaborate on how your  
2027 organizations are working to encourage physicians to go into  
2028 primary care?

2029 Mr. {Serota.} Sure. We have done similar things. We  
2030 have increased the rate we pay primary care physicians. An  
2031 example in Philadelphia, our Independence Blue Cross plan  
2032 doubled base reimbursement to primary care physicians,  
2033 increased it--paid out nearly \$37 million additional dollars  
2034 in 2011. Anthem Blue Cross Blue Shield has announced a major  
2035 investment in strengthening primary care, increasing revenue  
2036 opportunities, bumped the fee schedule by 10 percent,  
2037 including payments for non-visits, essentially care  
2038 coordination, preparing care plans, managing patients with  
2039 complex conditions, and also have shared savings models for  
2040 quality improvement and reducing costs.

2041 So the whole concept is partnership with the primary  
2042 care physicians to improve their access to additional funds,  
2043 provided the outcomes and the improved safety is present for  
2044 our members.

2045 Dr. {Nash.} Those physicians in our program who commit  
2046 the time and energy to work over the period of time towards  
2047 the principles of the patient-centered medical home, we put  
2048 on a payment model as described which reimburses at a rate  
2049 that is 20 percent higher in this global model than they were

2050 receiving fee-for-service, and they get another opportunity  
2051 for 20 percent performance-based bonus, which you know, has  
2052 attracted a lot of attention among the physician community.

2053 Mr. {Engel.} Thank you. Thank you, Mr. Chairman.

2054 Mr. {Pitts.} Chair thanks the gentleman. I now  
2055 recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes  
2056 for questions.

2057 Mr. {Shimkus.} Thank you, Mr. Chairman, and I also want  
2058 to applaud the panel for being here. I have been a member  
2059 since January, '97 I got sworn in, voted for a balanced  
2060 budget act, amendments, created the SGR. It has been a bane  
2061 to my existence ever since. We did that to preserve and  
2062 protect Medicare. That is why we did it. Every year, we  
2063 have to deal with this, and for me, it will be 16 years now  
2064 dealing with the SGR. Also, just I am glad--and Mr. Gingrey  
2065 mentioned about the Overseas Contingency Operations. That is  
2066 not going to happen. Don't plan on it. We are not going to  
2067 use it to fix the SGR, so get that off the table. That is  
2068 why this panel is important, because if we just use that,  
2069 then we are in the same position. We haven't reformed, we  
2070 haven't changed things, we haven't moved forward.

2071 I also want to address this. Medicare, by the actuary,  
2072 says it is going to go broke 2024. It did get extended by  
2073 the \$500 billion cuts in--from Obamacare, but the \$500

2074 billion also was supposed to go to help pay for the  
2075 Affordable Care Act, the health care bill. We had Secretary  
2076 Sebelius right in the other hearing room. She admitted they  
2077 double counted, double counted \$500 billion. Extend solvency  
2078 of Medicare, pay for Obamacare. That is what we are living  
2079 under. So those who extol the virtues of that, they are  
2080 promoting the ability of double counting \$500 billion.

2081 Now Dr. Patel, that is not good budgeting processes, is  
2082 it? You wouldn't encourage using the same \$500 billion to  
2083 say you are preserving and extending Medicare when you are  
2084 also using that same money to fund the expansion of health  
2085 care?

2086 Dr. {Patel.} I would not encourage double counting.

2087 Mr. {Shimkus.} Thank you. I would agree.

2088 So let us first--and the other issue is we have always  
2089 talked about tort reform. We always talk about insurance--  
2090 private insurance being regulated by states. The federalism--  
2091 -we are back on the federalism bandwagon. I am glad. It  
2092 helps us talk about this. Now we are talking about Medicare,  
2093 but the tort reform savings, if--are significant, but we have  
2094 got this state issue of tort law and federalism that I like  
2095 to think--I know the Affordable Care Act did provide some  
2096 money for states for pilot programs, which I applaud, and I  
2097 hope that more states look at that.

2098           Where am I headed with all this? I am heading with  
2099 this--I am glad to hear what we are doing. I don't hear much  
2100 about the individual consumer. I hear about the primary  
2101 practice physician, I hear about--I mean, the fact that we  
2102 don't want to incentivize volume. We don't want  
2103 overconsumption. We don't want one size doesn't fit all.  
2104 Where is the consumer in this? Anyone?

2105           Dr. {Bronson.} The word patient-centered is in this  
2106 effort, patient-centered medical home. Consumer is really  
2107 dead set in the middle--

2108           Mr. {Shimkus.} Where? How?

2109           Dr. {Bronson.} --and it is key--how?

2110           Mr. {Shimkus.} Under a government-run program, what is  
2111 the consumer--what skin do they have in the game financially?

2112           Dr. {Bronson.} Well, they have whatever co-pays and  
2113 other things they have to--

2114           Mr. {Shimkus.} Significant co-pays really affect  
2115 change?

2116           Dr. {Bronson.} I don't know. I honestly don't know.

2117           Mr. {Shimkus.} Anybody?

2118           Dr. {Bronson.} Well, I will take that back. I do know.  
2119 I think we are seeing a decline in our business and our  
2120 market because of very high deductible policies, and people  
2121 are second-guessing questions about services and delaying

2122 services. Sometimes it is very effective and appropriate;  
2123 sometimes it is dysfunctional. I think it needs to be looked  
2124 at and organized in a way that you don't harm the health of  
2125 the person, but you don't incent overutilization.

2126 Mr. {Shimkus.} Let me go to Mr. Serota.

2127 Mr. {Serota.} Congressman, you put a twist in the  
2128 question when you said in a government-run program. I think  
2129 that what we are doing in the Blues in our markets is a  
2130 three-tiered strategy, and the third tier in that strategy is  
2131 patient engagement. A critical element of success for us in  
2132 the marketplace has been arming patients with information  
2133 about costs, about quality, about which providers to select,  
2134 and having them actively participate, and that includes  
2135 actively participate economically, as well as with  
2136 information.

2137 Mr. {Shimkus.} My time is expiring, and I appreciate  
2138 that. I am just going to finish up with this observation.  
2139 If we don't do that type of process--health care costs are  
2140 going up for everybody, even the private sector. In  
2141 corporate insurance, what are they doing? They are  
2142 incentivizing their workforce through wellness programs, they  
2143 are doing healthy living. They are really pushing people and  
2144 they push it by what, a price signal. And if we don't do  
2145 that in a government-run health care system and we always

2146 expect the Federal Government or CMS or some agency other  
2147 than the Federal Government to do that for them, we are  
2148 losing the opportunity to really reform our health care  
2149 system.

2150 Thank you, Mr. Chairman. I yield back.

2151 Mr. {Pitts.} Chair thanks the gentleman. I now  
2152 recognize the gentleman from Pennsylvania, Dr. Murphy, for 5  
2153 minutes for questions.

2154 Mr. {Murphy.} Good morning. This is of great concern  
2155 to me of how we handle this. Look, we all get it. If all  
2156 things being equal, if you pay someone by how many widgets  
2157 they make versus giving them a flat salary, they will make  
2158 more widgets. We understand that. The question comes of how  
2159 we reform this, and we are throwing around a lot of phrases  
2160 here, you know, quality, patient-centered, et cetera. I  
2161 really want to get into some of the specifics.

2162 I think yesterday the U.S. News and World Report annual  
2163 rating of hospitals came out. I don't know if any of you saw  
2164 that, big thing about Johns Hopkins was bumped out by Mass  
2165 General and who else in the top 10. Are you all aware of how  
2166 those ratings are done? Am I correct they survey thousands  
2167 of specialists and say who do you like best, right?

2168 Dr. {Bronson.} They use objective measures.

2169 Mr. {Murphy.} What are some of the objective measures

2170 that they use?

2171 Dr. {Bronson.} Some of the CMS measures.

2172 Mr. {Murphy.} Such as?

2173 Dr. {Bronson.} The core measures I believe are being  
2174 used. I would like to confirm that, but there is a  
2175 combination and it depends on the specialty.

2176 Mr. {Murphy.} Can you give me an example?

2177 Dr. {Bronson.} An example in psychiatry, for example,  
2178 they use almost all reputation as an--

2179 Mr. {Murphy.} Exactly, exactly. So it is articles they  
2180 publish, who knows who. I look upon it as voting for prom  
2181 king and queen.

2182 Dr. {Bronson.} Right, right.

2183 Mr. {Murphy.} They do not--because you can't survey  
2184 thousands of specialists around the country and ask them what  
2185 hospital has the best outcome measures? Who has the fewest  
2186 surgical complications? Who has the fewest nosocomial  
2187 infections? Who has the fewest ventilator-assisted  
2188 infections? Who has longer or shorter than expected risk  
2189 adjustment stay in an ICU? Who has different  
2190 rehospitalization rates? Yet am I correct in saying that  
2191 those are the kinds of things we need to be measuring? Okay.

2192 Now, I am wondering in that in terms of those--and if  
2193 there are other ideas you have, too, how we change this

2194 system from what I refer to as the poke, prod, pinch, push,  
2195 pull and prescribe payment system? That is what we get paid  
2196 for as health care professionals. We want to pay for  
2197 quality. In a very specific way, do we then attach dollar  
2198 value to some of these things so if a hospital has a decline  
2199 in the number of ICU days, a decline in the number of  
2200 readmissions, decline in the number of nosocomial infections,  
2201 how do we pay for that? Anybody? Dr. Nash?

2202 Dr. {Nash.} As mentioned earlier, we do have experience  
2203 working with our hospital partners, and we are regional plan.  
2204 But it is really a shared savings approach, not too  
2205 dissimilar to what Medicare is looking at, and that is we  
2206 identify opportunities where there is a chance to improve  
2207 quality, and instead of just taking all of that savings and  
2208 funneling it back into premium reductions, we are sharing  
2209 some of that with the hospitals for the opportunity for them  
2210 to transform their systems.

2211 Mr. {Murphy.} So I just want to make sure, because I am  
2212 trying to understand this. I am not trying to put you on the  
2213 spot. I have been working this since I wrote the patient  
2214 bill of rights law in Pennsylvania where we are fighting  
2215 managed care plans who would give a global payment to a  
2216 practice or hospital and say you figure it out, and the  
2217 scandals that came out of there were people were told you

2218 couldn't--you had to drive by this emergency room because you  
2219 had to go to this one, because this is the one that is  
2220 covered. Or you were not going to get covered for this, we  
2221 are going to cover you for that. And my worry is that I want  
2222 to make sure we don't get into those kinds of models where  
2223 someone is just saying okay, well, we will save money today  
2224 so we can get paid with this year's fund, and if the patient  
2225 ends up with the problems next year that is okay, they are  
2226 probably going to be with a different insurance company. How  
2227 do we avoid that? Dr. Patel, you look like you are--

2228         Dr. {Patel.} Yes. I want to just say that the two  
2229 things we do to avoid that, we shouldn't have something that  
2230 is so absolute, like a reduction in ICU days or reduction in  
2231 that unless we know that the second piece of information  
2232 exists, which is that a reduction in ICU days is actually  
2233 proven by evidence to have improved outcome in some way. So  
2234 the scenario that you are describing, I think the way to  
2235 instill--we have all talked in our societies and in our  
2236 clinical professions about some of the metrics that we are  
2237 coming up with, even as we speak, to ensure that those exact  
2238 examples don't happen.

2239         Mr. {Murphy.} What you just said is absolutely golden,  
2240 and something that this committee actually discussed when we  
2241 read it was knocked out of the health care bill, and that was

2242 if we allow the societies, the colleges, the specialties in  
2243 medicine that have their own protocols to determine things  
2244 appropriate as opposed to an IPAB board, it is a big  
2245 difference. An IPAB board takes an act of Congress to change  
2246 what they are coming up with, but you are saying this is  
2247 something that the various professional medical organizations  
2248 themselves are constantly looking at?

2249 Dr. {Patel.} Yes.

2250 Mr. {Murphy.} Dr. Hoyt, you were going to say something  
2251 on that?

2252 Dr. {Hoyt.} Well, yes. We have spent a lot of time  
2253 thinking about this, and in our model, the updates would  
2254 really require an annual rethinking of what the new target  
2255 would be, realizing that as a group of physicians reach a  
2256 target, that is no longer going to incentivize them to reduce  
2257 costs, so you are going to have switch the target. But I  
2258 think if the professional societies are charged with  
2259 developing that, they are capable of it.

2260 Mr. {Murphy.} Anyone else want to comment on it?

2261 Mr. {Serota.} Yes, I guess I would just say that in our  
2262 programs--we call it Blue Distinction--we used professional  
2263 societies to determine the appropriate quality standards, and  
2264 we do want to be careful to avoid substituting one piece work  
2265 measure for another piece work measure. So if we are not

2266 paying for poking and prodding but we are paying for days  
2267 reduction, we still are not getting at paying for outcomes,  
2268 paying for better quality and better outcomes, which is where  
2269 I think we ultimately have to get.

2270         Mr. {Murphy.} And I think this is one of those things  
2271 we still have to figure out how to do this, because quality  
2272 is a very nebulous term. But I still believe that empowering  
2273 the professional colleges and societies and panels in  
2274 medicine is more important than having an IPAB board by  
2275 which, by law, has to be less than half physicians and  
2276 medical people.

2277         I yield back. Thank you, Mr. Chairman.

2278         Mr. {Pitts.} Chair thanks the gentleman. That  
2279 concludes the members of the subcommittee. We have Dr.  
2280 Christensen who is here to ask questions. Dr. Christensen,  
2281 you are recognized for 5 minutes for questions.

2282         Dr. {Christensen.} Thank you, Mr. Chairman, and no  
2283 question, the SGR has outlived its non-usefulness and we need  
2284 a new methodology to fairly and adequately reimburse  
2285 physicians and other providers for care. But just to get  
2286 this off my chest, for the record, if the system had been set  
2287 up to pay primary care physicians for what we have always  
2288 done, provide patient-centered care, spend time with patients  
2289 and their families, and provide comprehensive care, whether

2290 at home, in the hospital, or in the office, and to coordinate  
2291 the care with specialists, we wouldn't be where we are today.  
2292 The Affordable Care Act, though, has done much to lay the  
2293 foundation to change this and add new models of care that are  
2294 being tested that you have been discussing and enable us to  
2295 once again practice the art of medicine and again, for the  
2296 record, it has strengthened Medicaid, it has improved  
2297 benefits, and it has actually lengthened the solvency, rather  
2298 than hurt Medicare.

2299         But this hearing is a really good beginning to move us  
2300 forward. I want to thank the chair and ranking member for  
2301 holding it, and thank all of our panelists for their time,  
2302 their work, and their thoughtful testimonies.

2303         I want to ask everyone this question. How did the  
2304 approaches that you are recommending take into account  
2305 physicians and other providers of color or who work in poor  
2306 communities where services are very limited, and the patients  
2307 are sicker with many co-morbidities, especially when we are  
2308 focusing a lot on outcomes? How do we take into account  
2309 where that patient started from, and when we are talking  
2310 about evidence-based medicine when many people of color, and  
2311 sometimes people with other co-morbidities are not in the  
2312 clinical trials that produce that evidence?

2313         Mr. {Serota.} I guess what I would say is our

2314 philosophy is--I mean, the term that has been used up here is  
2315 one size doesn't fit all. We really in the Blues believe you  
2316 have to meet the physician's practices where they are, and  
2317 you can't take a cookbook approach across the country and say  
2318 it worked here, therefore it will work everywhere. You have  
2319 to work with the local physician communities and the local  
2320 provider communities and develop a program that starts from  
2321 where they are and provides incentives, information, and data  
2322 to help them move the needle forward so that from wherever  
2323 they are starting from, you pay and you reimburse for  
2324 improvements from where they are, not measures against some  
2325 mythical standard that exists on a global basis.

2326         So we really believe that the closer you get to local  
2327 management, the better the outcomes and the better results  
2328 you are going to get from patient-centered medical homes. So  
2329 that is the way we would deal with those issues in all cases.

2330         Dr. {Christensen.} Dr. Nash?

2331         Dr. {Nash.} Yes, CDPHP is our region's largest provider  
2332 of managed Medicaid services, and we partner very closely  
2333 with our federally qualified health centers and other private  
2334 providers with large Medicaid populations. We support them  
2335 not only by paying them more comprehensively, as I have been  
2336 describing this morning, which allows them to sort of deploy  
2337 those resources as they see fit for those patients, but we

2338 deploy our own resources and that is we created community  
2339 health workers to work in the communities to go outreach the  
2340 patients to bring them into the doctors who aren't being  
2341 seen, as well as putting pharmacists and behavioral health  
2342 workers in those practices.

2343 Dr. {Christensen.} Dr. Bronson, did you want to add?

2344 Dr. {Bronson.} Well, there is nothing more important  
2345 that we learn how to reward practices for improving the  
2346 health status of their patients, and you have to go to where  
2347 they are at and understand the risk profile of that  
2348 community, the risk profile of those specific patients, and  
2349 have incentives that make sense for those communities. It is  
2350 well-observed that certain demographic characteristics will  
2351 not support--people with those characteristics will not  
2352 achieve the same outcomes as others in certain areas, and  
2353 that is very complex. Sometimes is it socioeconomic,  
2354 sometimes it is other issues of disparity that we need to  
2355 understand. So these have to be adjusted appropriately to  
2356 support those practices. We shouldn't disadvantage those who  
2357 are helping those in great need.

2358 Dr. {Christensen.} Thank you. Anyone else want to add?

2359 Dr. {Hoyt.} Yes, our past president, L.D. Britt, has  
2360 made the comment that there is no quality without access.  
2361 And I think that has led to us as an organization really

2362 trying to profile where we are deficient in some of those  
2363 areas. One of them is in the--sort of the systemus of  
2364 delivery of care is to assure that limited access  
2365 populations, whether it is geographic or it is economic or  
2366 color, et cetera, that those are overcome by getting adequate  
2367 data. And so we are really making a concerted effort to make  
2368 sure that the data we collect at a large hospital in a large  
2369 city is the same as the data that we can collect in a smaller  
2370 hospital or in a more remote or financially challenged area  
2371 to try and identify those problems, and then start to create  
2372 solutions for them.

2373 Dr. {Patel.} One additional thing that the Affordable  
2374 Care Act included were provisions for coverage of costs  
2375 associated with clinical trials, such that the very issue you  
2376 describe with deep disparities in clinical trial enrollment,  
2377 especially in cancer, can be dealt with, and that is very  
2378 important.

2379 Dr. {Christensen.} I thank you for your answers, and  
2380 thank you, Mr. Chairman, for giving me the time.

2381 Mr. {Pitts.} Chair thanks the gentlelady. That  
2382 concludes all the questions from the members. Again, let me  
2383 say this has been an excellent panel. Thank you for your  
2384 testimony, your answers, and we will send you any further  
2385 questions from the members--

2386 Mr. {Pallone.} Mr. Chairman?

2387 Mr. {Pitts.} --if you please respond.

2388 Mr. {Pallone.} Mr. Chairman, I just wanted to--I have  
2389 heard a number of my colleagues mention this double counting  
2390 issue, and I think it is a red herring, so I am asking to  
2391 insert Secretary Sebelius's letter on the matter into the  
2392 record. I would ask unanimous consent.

2393 Mr. {Pitts.} Without objection, so ordered.

2394 [The information follows:]

2395 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
2396           Mr. {Pitts.} I remind members that they have 10  
2397 business days to submit questions for the record, and I ask  
2398 the witnesses to respond to questions promptly. Members  
2399 should submit their questions by the close of business on  
2400 Wednesday, July 31. Without objection, the subcommittee is  
2401 adjourned.

2402           [Whereupon, at 12:10 p.m., the Subcommittee was  
2403 adjourned.]