

Prepared Testimony for the House Energy & Commerce Committee

The Need to Move Beyond SGR

May 5, 2011

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

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

At the same time, the fiscal challenges facing the Medicare program have gotten far worse. Medicare spending already accounts for roughly 3.5 percent of GDP. If scheduled physician payment reductions continue to be overridden, and provider payments continue to grow at current rates, then Medicare expenditures could surpass 5% of GDP by 2030. Not only would this require substantial additional tax revenues; if the past is any guide, it also means that other key Federal priorities will be squeezed down.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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