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3 HEARING ON THE NEED TO MOVE BEYOND THE SGR

4 THURSDAY, MAY 5, 2011

5 House of Representatives,

6 Subcommittee on Health

7 Committee on Energy and Commerce

8 Washington, D.C.

9 The Subcommittee met, pursuant to call, at 10:04 a.m.,
10 in Room 2123 of the Rayburn House Office Building, Hon. Joe
11 Pitts [Chairman of the Subcommittee] presiding.

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

16 Also present: Representatives Harper and Christensen.

17 Staff present: Allison Busbee, Legislative Clerk; Paul
18 Edattel, Professional Staff Member, Health; Julie Goon,

19 Health Policy Advisor; Debbie Keller, Press Secretary; Ryan
20 Long, Chief Counsel, Health; John O'Shea, Professional Staff
21 Member, Health; Heidi Stirrup, Health Policy Coordinator;
22 Stephen Cha, Democratic Senior Professional Staff Member;
23 Alli Corr, Democratic Policy Analyst; Tim Gronniger,
24 Democratic Senior Professional Staff Member; Karen Lightfoot,
25 Democratic Communications Director and Senior Policy Advisor;
26 Karen Nelson, Democratic Deputy Committee Staff Director for
27 Health, and Mitch Smiley, Democratic Assistant Clerk.

|
28 Mr. {Pitts.} The subcommittee will come to order. The
29 chair recognizes himself for 5 minutes for an opening
30 statement.

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

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

41 According to surveys by the American Medical Association
42 faced with cuts of this magnitude as many as 82 percent of
43 physicians say that they will need to make significant
44 changes in their practices that will affect access to care.

45 We have been here before. In fact, we have been in this
46 situation for almost a decade. Since 2002, Congress has
47 acted repeatedly to avert scheduled fee cuts. In 2010, alone
48 Congress passed one--two 1-month overrides, two 2-month
49 overrides, one 6-month override, and most recently for 2011,
50 Congress passed a 1-year override. All this was done without

51 resolving the underlying problem.

52 Meanwhile, the cost of fixing the problem continues to
53 grow. In March the Congressional Budget Office estimated
54 that the price just to wipe out the accumulated debt and
55 return to the baseline would be \$298 billion. This
56 staggering price tag is just one side of the physician
57 payment reform problem. The current payment system is
58 fundamentally flawed, and keeping the current system or
59 making minor adjustments is no longer a viable option. Even
60 maintaining the current system with 0 percent updates through
61 2020, would cost \$275.8 billion.

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

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

74 I want to thank the distinguished panel of experts that

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

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

83 ***** COMMITTEE INSERT *****

|
84 Mr. {Pitts.} And I yield the remaining time to the vice
85 chair, Dr. Burgess.

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

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

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

103 I have always thought you start with a relatively simple
104 question, what does it cost to--for a doctor to provide the
105 service, and then you build in a reasonable profit for
106 participation and coordination. But today we send all the

107 wrong messages to our doctors. We say work harder and
108 faster, deal with weekly expansions of services and
109 regulations of the CMS, none-physician bureaucrats will tell
110 you how to practice and will do more so, in fact, under the
111 President's new healthcare law, we are going to hold your
112 checks, but we need you to take more patients. Practice
113 costs are rising but don't expect us to help you meet your
114 costs, and oh, by the way, a 30 percent pay cut in December.

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

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

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

134 Mr. {Pitts.} Without objection.

135 Dr. {Burgess.} Thank you.

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

137 ***** COMMITTEE INSERT *****

|
138 Mr. {Pitts.} So ordered. The chair thanks the
139 gentleman and recognizes the distinguished ranking member of
140 the subcommittee, Mr. Pallone, for 5 minutes.

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

148 Today's hearing is appropriate because we really must
149 move beyond the sustainable growth rate in Medicare's payment
150 policy. It is unstable, unreliable, and unfair, and we
151 really must move beyond legislating SGR policy in month-long
152 intervals. You know, I know last December when we passed the
153 1-year fix it was the twelfth time we had passed a patchwork
154 bill in the last decade and the sixth time in 1 year alone.

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

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

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

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

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

186 ***** COMMITTEE INSERT *****

|
187 Mr. {Pallone.} I would yield now the remainder of my
188 time to the gentleman from Michigan, our ranking member
189 emeritus, Mr. Dingell.

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

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

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

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

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

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

221 ***** COMMITTEE INSERT *****

|
222 Mr. {Pallone.} Thank you, Mr. Chairman. I don't know
223 if any of my other colleagues would want the time.

224 If not, I will yield back.

225 Mr. {Pitts.} The chair thanks the gentleman and now
226 recognizes the full committee chairman, Mr. Upton, for 5
227 minutes.

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

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

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

245 Clearly something has got to change. Although we cannot
246 afford the current rate of spending on physician services, we
247 also know that if the pending 29.4 percent fee cuts are
248 allowed to go into effect, a large good number of doctors
249 will be forced out of Medicare, and a large number of
250 Medicare beneficiaries will lose their access to care. We
251 are all well aware of the inadequacies of the sustainable
252 growth formula as a payment policy, and we are also aware of
253 the budgetary burden that is failing to fix the problem it
254 has caused.

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

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

263 [The prepared statement of Mr. Upton follows:]

264 ***** COMMITTEE INSERT *****

|
265 Mr. {Barton.} Thank you, Chairman Upton, and we welcome
266 Congressman Harris to the committee. He looks good here and
267 maybe one day he will be here permanently.

268 Thank you, Chairman Pitts and Ranking Member Pallone for
269 holding this hearing today. I remember very well back in
270 2006, when I had--we had lost the majority on the Republican
271 side, but we were in a lame duck session, and Congressman
272 Dingell and Senator Baucus came to me as the chairman at that
273 time and said, let us work right now in the lame duck to fix
274 the SGR. And knowing how difficult it was to do, I said no
275 to that because I wanted them to have the fun of having to
276 fix it.

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

283 As Chairman Upton just pointed out, we are going to see
284 a decrease in reimbursement of over 29 percent by next year
285 if we do nothing. The deficit now in the SGR is at
286 approximately \$300 billion. That is a big number, even in
287 Washington where we have \$3.5 trillion budgets and \$1.5

288 trillion annual deficits. But it is a fixable problem if we
289 really mean it when Mr. Dingell and Mr. Pallone and Mr.
290 Waxman say the same general things as Mr. Upton and Mr. Pitts
291 and people like myself.

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

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

300 [The prepared statement of Mr. Barton follows:]

301 ***** COMMITTEE INSERT *****

|
302 Dr. {Gingrey.} Mr. Chairman, I thank the former
303 chairman of the committee for yielding to me.

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

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

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

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

322 I also want to thank personally my good friend, Dr. Todd
323 Williamson from the great State of Georgia, in fact, former
324 president of the Medical Association of Georgia. Todd, it is

325 great to see you as a witness before the committee again

326 today, and with that, Mr. Chairman, I yield back.

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

328 ***** COMMITTEE INSERT *****

|
329 Mr. {Pitts.} The chair thanks the gentleman.

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

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

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

350 Democrats in the last Congress, in the House, passed the
351 only bill ever by either body that would permanently solve

352 the SGR problem. It did not become law. That is why we
353 repeatedly worked to pass short-term patches to block the
354 SGR. But that is not the way to solve the problem. It is
355 essential that we find another way to get this done.

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

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

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

376 private sector to identify the best path forward.

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

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

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

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

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

404 ***** COMMITTEE INSERT *****

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

412 On March 28, 2011, the Energy and Commerce Committee
413 sent a bipartisan letter to 51 physician organizations asking
414 for input on reforming the Medicare Physician Payment System.
415 The chair will introduce the responses from the following
416 organizations as part of the permanent record. The American
417 Association of Clinical Endocrinologists, The American
418 Academy of Dermatology Association, the Association of
419 American Medical Colleges, the American Academy of
420 Otolaryngology, AARP, the American College of Obstetricians
421 and Gynecologists, the American College of Rheumatology, the
422 Alliance for Integrity in Medicine, the American Medical
423 Association, the American Academy of Ophthalmology, the
424 American Geriatrics Society, the American Physical Therapy
425 Association, the American Society of Clinical Oncology, the
426 American Society for Clinical Pathology, the American Society
427 of Cataract and Refractive Surgery, the American Society of

428 Gastrointestinal Endoscopy, the American Society of
429 Hematology, the American Society of Plastic Surgeons, the
430 American Neurologic Association, the American Academy of
431 Neurology, the American College of Surgeons, the Medical
432 Group Management Association, the American College of
433 Cardiology, the Society of Hospital Medicine, the Society of
434 Nuclear Medicine, and the Society of Thoracic Surgery.

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

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

440 [The information follows:]

441 ***** COMMITTEE INSERT *****

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

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

|

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

|

471 ^STATEMENT OF MARK B. MCCLELLAN

472 } Dr. {McClellan.} Thank you, Chairman Pitts,
473 Representative Pallone, and distinguished members of the
474 subcommittee. I very much appreciate this opportunity to
475 speak with you on the critical issue of Medicare physician
476 payment. Physicians and the health professionals who work
477 with them are the linchpin of our healthcare system.

478 Unfortunately--

479 Mr. {Pitts.} Is your microphone on?

480 Dr. {McClellan.} It is on. Maybe I am not speaking
481 quite--

482 Mr. {Pitts.} Pull it a little closer.

483 Dr. {McClellan.} Is that better?

484 Mr. {Pitts.} Yes. That is better.

485 Dr. {McClellan.} I will get right up to it.

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

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

503 As Congress considers how to address this problem, I
504 urge the subcommittee to look beyond approaches that remain
505 tied to the existing formula simply by delaying it again or

506 by resetting baselines to higher spending levels. This is an
507 opportunity to provide better support for physicians who lead
508 in improving care, and the best starting point for doing so
509 are the many practical ideas to improve quality and lower
510 costs already being developed and implemented by physicians
511 and other health professionals around the country, often in
512 spite of Medicare payment rules.

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

522 For example, oncologists have noted how much Medicare
523 payments are tied to the volume and intensity of chemotherapy
524 they provide. As Medicare reimbursement rates have been
525 squeezed, the margin between what it costs to obtain
526 chemotherapy drugs and what Medicare pays to administer them
527 has become more important in covering their practice costs.
528 At the same time, oncology practices get relatively little
529 support for time spent working out a treatment plan that

530 meets these individual patients' needs, for managing
531 patients' symptoms, for coordinating care with other
532 providers.

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

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

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

554 important is providing timely information on Medicare
555 beneficiaries to providers.

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

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

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

578 [The prepared statement of Dr. McClellan follows:]

579 ***** INSERT 1 *****

|

580 Mr. {Pitts.} Thank you, Dr. McClellan.

581 Dr. Wilson, you are recognized for 5 minutes.

|
582 ^STATEMENT OF CECIL B. WILSON

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

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

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

601 In addition, Congress should enact H.R. 1700, the
602 Medicare Patient Empowerment Act. This bill would establish
603 an additional Medicare payment option to allow patients and

604 physicians to freely contract without penalty while allowing
605 patients to use their Medicare benefits.

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

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

624 Additional models are needed to embrace a wide spectrum
625 of physician practices, including models focusing on
626 conditions for specific capitation, warranties for inpatient
627 care, and mentoring programs. While these models are being

628 tested we also need evidence on how to properly structure and
629 implement models which show the most promise while addressing
630 complex issues such as effective risk adjustment and
631 attribution.

632 To assist with this process the AMA is working with
633 specialty and State medical societies to form a new physician
634 payment and delivery reform leadership group. This group
635 will include physicians who are participating in payment and
636 delivery innovations and by sharing expertise and resources
637 physicians can then assess the models that will improve
638 patient care, and they can be implemented across specialties
639 and practice settings. They can also learn how to get the
640 programs off the ground, address challenges, and assess the
641 impact of these reforms on patient care and practice
642 economics. And the lessons learned can be widely
643 disseminated to physician practices across the country as we
644 move toward reform.

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

651 So thank you for the opportunity to be here today, and I

652 look forward to your questions.

653 [The prepared statement of Dr. Wilson follows:]

654 ***** INSERT 2 *****

|
655 Mr. {Pitts.} The chair thanks the gentleman.

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

660 Dr. Hoyt, you are recognized for 5 minutes.

|
661 ^STATEMENT OF DAVID B. HOYT

662 } Dr. {Hoyt.} Chairman Pitts, Ranking Member Pallone, and
663 Members of the subcommittee, I am David Hoyt, a trauma
664 surgeon and the Executive Director of the American College of
665 Surgeons. On behalf of the more than 75,000 members of the
666 College, I want to thank you for inviting the American
667 College of Surgeons to testify today.

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

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

678 The first to reforming, the step toward reforming
679 Medicare payment formula is to immediately eliminate the SGR
680 and set a realistic budget baseline for future Medicare
681 payment updates. The new baseline should fairly reflect the
682 costs of providing quality healthcare, preserve the patient-

683 physician relationship, and ensure that patients have
684 continued access to the physician of their choice. Following
685 the elimination of the SGR, we believe it is essential to
686 provide a transition period of up to 5 years to allow for
687 testing, development, and future implementation of a wide
688 range of alternative payment models aimed at improving
689 quality and increasing the integration of care.

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

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

706 With the right approaches we can improve both quality of

707 patient care and at the same time reduce healthcare costs.
708 The American College of Surgeons has been able to
709 significantly improve surgical quality for more than 100
710 years in the specific fields of trauma, bariatric surgery,
711 cancer, and surgery as a whole. These initiatives reduce
712 complications and save lives, which translates into lower
713 costs, better outcomes, and greater access.

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

722 The first, the core process that must be followed in any
723 quality improvement program is to establish, follow, and
724 continually reassess and improve best practice. Standards
725 must be set based on scientific evidence so that surgeons and
726 other healthcare providers can choose the right care at the
727 right time given the patient's condition. It could be as
728 fundamental as ensuring that surgeons and nurses wash their
729 hands before an operation, as urgent as assessing and
730 triaging a critically-injured patient in the field, or as

731 complex as guiding a cancer patient through treatment and
732 rehabilitation.

733 Secondly, to provide the highest quality care surgical
734 facilities must have in place appropriate and adequate
735 infrastructures, such as staffing, specialists, and
736 equipment. For example, in emergency care we know that
737 hospitals have to have proper staff, equipment such as CT
738 scanners, and infection prevention measures. If the
739 appropriate structures are not in place, patients' risks
740 increases.

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

751 And then finally the final principle is to verify
752 quality. Hospitals and providers must allow an external
753 authority to periodically verify that the right processes and
754 facilities are in place, that outcomes are being measured and

755 benchmarked, and that the hospitals and providers are doing
756 something to address the problems they identify. The best
757 quality programs have long required that processes,
758 structures, and outcomes of care be verified by an outside
759 body. Emphasis on external audits will accompany efforts to
760 tie payment to performance and rank the quality of care
761 provided.

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

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

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

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

774 ***** INSERT 3 *****

|
775 Mr. {Pitts.} The chair thanks you, Dr. Hoyt, for your
776 recommendations, testimony.

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

779 [Recess.]

780 Mr. {Pitts.} The recess having expired we will
781 reconvene with the testimony, and we are up to Mr. Miller.

782 You are recognized for 5 minutes.

|
783 ^STATEMENT OF HAROLD D. MILLER

784 } Mr. {Miller.} Thank you, Mr. Chairman and members of
785 the committee. It is nice to be here with you today.

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

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

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

805 patients, and I think the patients would find desirable.

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

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

827 The other approach is to have what I like to call
828 comprehensive care payment, which is to have a single payment

829 for a physician practice for all of the care that a patient
830 needs to manage their--the particular conditions that they
831 have. Paying in that way provides the flexibility for
832 physicians to decide exactly what the right way is for care
833 to be delivered to that patient as well as the accountability
834 for overall costs, and where these programs have been tried
835 they have worked.

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

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

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

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

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

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

871 Now, the best way to organize this, I don't think, is
872 through a one-size-fits-all federal program. I think it
873 needs to be done at the community level because care is
874 structured and delivered differently in every community. And
875 in a growing number of communities around the country there
876 are now entities called Regional Health Improvement

877 Collaboratives. These are non-profit, multi-stakeholder
878 entities. They don't deliver care, they don't pay for care,
879 but they help to provide the kind of data and analysis and
880 technical assistance to physician practices to be able to
881 evolve in this direction.

882 And I think that Congress can help these regional
883 collaboratives in three key ways. One is by providing them
884 data. Today it is impossible to get data from Medicare to
885 know how you are doing for Medicare patients if you want to
886 change that. Second, you can give them some modest federal
887 funding to support what they are doing, and when I say
888 modest, I am talking millions, not billions, and third, you
889 can encourage or require Medicare to participate in the cases
890 where they have developed multi-payer payment reforms already
891 at the local level. The big thing that they are missing is
892 having Medicare at the table, and I think that is going to be
893 a very important strategy to support that.

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

896 [The prepared statement of Mr. Miller follows:]

897 ***** INSERT 4 *****

|
898 Mr. {Pitts.} Thank you for those excellent
899 recommendations.
900 Dr. Chernew, 5 minutes.

|
901 ^STATEMENT OF MICHAEL CHERNEW

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

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

920 But before launching into a description of the AQC I
921 would like to speak broadly about payment reform. First, it
922 is important to distinguish between the form of payment, fee-

923 for-service versus bundled, and the level of payment. The
924 form of payment creates incentives that influence behavior,
925 but even the best payment system can function poorly if
926 payment rates are set too low or even too high.

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

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

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

945 Briefly, the AQC is integrated into the Blue Cross Blue
946 Shield HMO product and rests on three fundamental pillars.

947 First, a global payment in which providers' systems receive a
948 budget to cover the cost of providing all of an enrollee's
949 care. Second, the AQC incorporates a comprehensive pay-for-
950 performance system that rewards provider groups for
951 performance on 64 quality measures ranging from process
952 measures to outcome measures, from clinical measures to
953 patient experience measures, and third, the AQC includes a
954 significant data and analytic support for participating
955 physician groups which helps them identify areas to target
956 for improvement and training and other things as well.

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

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

969 Global payment systems in the past have raised several
970 concerns. For example, many have worried that they would

971 lead to a lower quality of care. The AQC is designed to
972 prevent this by setting the global budget at least equal to
973 the prior year payment so no provider group will be forced to
974 reduce access to care and by incorporating the quality bonus
975 system. Early evidence suggests that these features have led
976 to an increase, not decrease in the quality of care
977 delivered.

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

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

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

993 The AQC is not without its weaknesses. For example, the
994 AQC is not tied to benefit design, and I believe a greater

995 integration with value-based insurance design would be an
996 improvement. Second, while I am a big believer in markets,
997 any private sector model must contend with issues of provider
998 market power. Because of its size Blue Cross Blue Shield may
999 be better positioned to do this than other smaller plans.

1000 So far the agency has passed the test of the market with
1001 enrollment growing from 26 percent to 44 percent of Blue
1002 Cross Blue Shield HMO membership as more provider groups have
1003 chosen to join. Some AQC principles are already evident in
1004 the recently-proposed Accountable Care Organization
1005 regulations and in several other bundled payment
1006 demonstrations.

1007 Broad application of such models would be facilitated in
1008 Medicare if beneficiaries were incented or required to
1009 designate a physician without giving up existing benefits or
1010 rights regarding choice of provider.

1011 In summary, a fee-for-service physician system for
1012 Medicare, SGR or not, generates inherent problems. Bundled
1013 payment systems such as the AQC offer considerable promise as
1014 a way forward. These systems are comprehensive and give
1015 autonomy to providers which ultimately will be preferable to
1016 other strategies to control spending.

1017 Thus I urge you to support ongoing bundled payment
1018 demonstrations and others like them which will create a more

1019 rational and effective payment system that allows our
1020 expectations and aspirations to be met in a fiscally-
1021 sustainable manner.

1022 [The prepared statement of Dr. Chernew follows:]

1023 ***** INSERT 5 *****

|

1024 Mr. {Pitts.} Thank you, Doctor.

1025 Dr. Williamson, you are recognized for 5 minutes.

|
1026 ^STATEMENT OF M. TODD WILLIAMSON

1027 } Dr. {Williamson.} Good morning. My name is Todd
1028 Williamson. I am a Board-certified neurologist, and I treat
1029 patients every day in my office in Lawrenceville, Georgia,
1030 just northeast of Atlanta. I would like to express my
1031 sincere thanks to Chairman Pitts and Ranking Member Pallone
1032 and the members of this committee for the opportunity to
1033 address the critical issue of Medicare's broken Physician
1034 Payment System.

1035 As background, I had the honor of serving as the
1036 President of the Medical Association of Georgia in 2008, and
1037 2009. I currently serve as the spokesman for the Coalition
1038 of State Medical and National Specialty Societies, which
1039 includes 16 associations representing nearly 90,000
1040 physicians from across the country. The full membership list
1041 is in our written statement.

1042 Medicare is the Nation's largest government-run
1043 healthcare program, and it represents the most glaring
1044 example of the need for change. As everyone in this room
1045 knows the current SGR System is failing to serve our Nation's
1046 seniors and physicians. As the gap between government-
1047 controlled payment rates and the cost of running a practice

1048 grows wider, physicians are finding it increasingly difficult
1049 to accept Medicare patients. Our coalition is, therefore,
1050 convinced that the key to preserving our Medicare patients'
1051 access to quality medical care is overhauling the flawed
1052 Medicare payment system.

1053 To address this problem our coalition supports the
1054 Medicare Patient Empowerment Act as an essential part of any
1055 Medicare reform. This legislation would establish a new
1056 Medicare payment option whereby patients and physician would
1057 be free to contract for medical care without penalty. It
1058 would allow these patients to apply their Medicare benefits
1059 to the physician of their choice and to contract for any
1060 amount not covered by Medicare. Physicians would be free to
1061 opt out or in of Medicare on a per-patient basis, while
1062 patients could pay for their care as they see fit and be
1063 reimbursed for an equal amount to that pay to participating
1064 Medicare physicians.

1065 Patients and physicians should be free to enter into
1066 private payment arrangements without legal interference or
1067 penalty. Private contracting is a key principle of American
1068 freedom and liberty. It serves as the foundation for the
1069 patient, physician relationship, and it has given rise to the
1070 best medical care in the world. It should, therefore, be a
1071 viable option within the Medicare payment system.

1072 Private contracting will help the Federal Government
1073 achieve fiscal stability while fulfilling its promise to
1074 Medicare beneficiaries. A patient who chooses to see a
1075 physician outside the Medicare System should not be treated
1076 as if they don't have insurance. Medicare should pay its
1077 fair share of the charge and allow the patient to pay any
1078 remaining balance.

1079 Private contracting is also the only way to ensure that
1080 our patients can maintain control over their medical
1081 decisions. The government has the right to determine what it
1082 will pay towards medical care, but it does not have the right
1083 to determine the value of that medical care. This value
1084 determination should be ultimately made by the individual
1085 patient.

1086 While private contracting would allow physicians to
1087 collect their usual fee in some instances, it would also
1088 allow them to collect less in others. It is reprehensible
1089 for a physician to be subject to civil and criminal penalties
1090 if he or she doesn't collect a patient's co-payment as is now
1091 the case. It is irrational for a senior who wants to see a
1092 doctor outside the usual Medicare System to be forced to
1093 forfeit their Medicare benefits. This simply isn't fair to
1094 someone who has paid into the Medicare System their entire
1095 working life.

1096 The day the Medicare Patient Empowerment Act becomes law
1097 every physician will become accessible to every Medicare
1098 patient. Private contracting is a sustainable patient-
1099 centered solution for the Medicare Payment System that will
1100 ensure our patients have access to the medical care they
1101 need.

1102 In summary, Medicare patients should be free to
1103 privately contract with the doctor of their choice without
1104 bureaucratic interference or penalty. This will empower
1105 individual patients to make their medical care decisions
1106 while providing the Federal Government with more fiscal
1107 certainty.

1108 Thank you for the opportunity to comment today.

1109 [The prepared statement of Dr. Williamson follows:]

1110 ***** INSERT 6 *****

|
1111 Mr. {Pitts.} The chair thanks the gentleman and
1112 recognizes Dr. Goertz for 5 minutes.

|
1113 ^STATEMENT OF RONALD A. GOERTZ

1114 } Dr. {Goertz.} Chairman Pitts, Mr. Pallone, and members
1115 of the subcommittee, I am Dr. Roland Goertz from Waco, Texas,
1116 President of the American Academy of Family Physicians.
1117 Thank you for the opportunity to testify today on behalf of
1118 over 100,000 members of the AAFP. I commend your bipartisan
1119 commitment to finding a solution to this critical problem.

1120 Congress understandably is most concerned with
1121 controlling federal expenditures for healthcare, especially
1122 the rising cost of Medicare. There is growing and compelling
1123 evidence that a healthcare system based on primary care will
1124 help control these costs, as well as increase patient
1125 satisfaction and improve patient health.

1126 We recommend reforms that eventually include a blended
1127 payment model that consists of the following three elements.

1128 One, some retention of fee-for-service payment, two, a
1129 care coordination fee that compensates for expertise and time
1130 requirement for primary care activities that are not now paid
1131 for, and three, performance bonuses based on quality.

1132 Simply reforming the fee-for-service system which
1133 undervalues primary care preventative health and team-based
1134 care coordination cannot produce the results that Congress

1135 and patients require. The solution to our dilemma of rising
1136 healthcare costs and stagnating quality will be complex, but
1137 it must include greater use of transformed team-based primary
1138 care.

1139 The evidence for the value of primary care and
1140 restraining costs and improving quality is very clear when
1141 that care is delivered in a team-based, patient-centered
1142 medical home. Growing evidence with PCMH and coordinated
1143 systems, particularly those that emphasize improved access to
1144 primary care teams, shows that they can reduce total costs,
1145 total overall costs by 7 to 10 percent, largely by reducing
1146 avoidable hospitalizations and emergency room visits.

1147 We believe that as a policy goal Congress should invest
1148 in Medicare reforms that increase primary care payments so
1149 they represent approximately 10 to 12 percent of total
1150 healthcare spending, particularly if done in ways that
1151 improve access to a broader array of services.

1152 Currently primary care is just 6 to 7 percent of overall
1153 total Medicare spending, so medical home projects went
1154 implemented recoup the entire cost of that implementation.
1155 To produce the savings Congress requires primary care cannot
1156 remain unchanged. AAFP has already taken the lead in urging
1157 its members practices to change but such transformation will
1158 take time. That is why we recommend a 5-year transition

1159 period. This will provide an opportunity to examine what
1160 works and to allow physicians to adopt those best practices
1161 that use a blended payment. When this transition is
1162 complete, fee-for-service should be a much less significant
1163 portion of physician payment.

1164 Meanwhile, it is important to increase the primary care
1165 incentive payment to 20 percent and maintain the support for
1166 making Medicaid payments for primary care at least equal to
1167 Medicare's payments for the same services. Both of these
1168 programs, along with the mandated payment updates that are 2
1169 percent higher for primary care, will help stabilize current
1170 practices that have been--seen so much financial turmoil in
1171 the past few years and will allow them to begin the process
1172 of redesign to the patient-centered medical home model.

1173 During the 5-year period of stability, it will be
1174 crucial to encourage as much innovation as possible. The new
1175 CMS Center for Innovation needs to be a key focus of this
1176 effort. We believe that this center can help CMS create
1177 market-based, private sector like programs that can
1178 significantly bend the healthcare cost curve. We recommend
1179 that CMS Innovation Center coordinate the various healthcare
1180 delivery models to ensure comparability and completeness of
1181 data.

1182 The physician community has always believed strongly in

1183 the value of evidence, and it is the responsibility of the
1184 Innovation Center to provide credible, reliable, and usable
1185 evidence for health system change. When implementation data
1186 becomes available, we would encourage Congress to engage in
1187 another discussion with the physician community with public
1188 and private payers, with consumers to determine not just what
1189 works but what is preferred.

1190 In the final analysis healthcare is such an important
1191 part of the economy and everyone's lives that we should try
1192 to find general agreement in what becomes the final
1193 replacement for the current physician payment model.

1194 Mr. Chairman and members of this subcommittee, thank you
1195 for the opportunity to share the view of family medicine with
1196 you today.

1197 [The prepared statement of Dr. Goertz follows:]

1198 ***** INSERT 7 *****

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1199 Mr. {Pitts.} The chair thanks the panel for their
1200 opening statements, and I will now begin the questioning and
1201 recognize myself for 5 minutes.

1202 Dr. Williamson, you advocate allowing physicians to
1203 privately contract with beneficiaries above Medicare
1204 payments. One concern with this arrangement is that sick
1205 patients may be at a disadvantage entering into a contract
1206 without sufficient knowledge about what they need or about
1207 the quality of care they are contracting for.

1208 Is there a way to structure this so that patients have
1209 more information about what they are contracting for? For
1210 example, could you combine private contracting with quality
1211 measurement and reporting or other tools such as shared
1212 decision making? Would you respond to that, please?

1213 Dr. {Williamson.} Thank you for the question, and that
1214 is a great question. I understand those concerns, and I
1215 would point out several items about that Medicare Patient
1216 Empowerment Act.

1217 Number one, there is a lot of openness in this act.
1218 Patients have to agree upfront what they are agreeing to
1219 before any care is delivered.

1220 Number two, this is merely an option within the current
1221 existing Medicare System, so this would not change any of the

1222 current ways that Medicare is financed otherwise. There are
1223 sufficient protections we believe already existing in the
1224 current Medicare Patient Empowerment Act as written so that
1225 urgencies or emergencies as currently defined under Medicare
1226 would be exempt from private contracting and also dual
1227 eligible patients, those patients that are most impoverished
1228 that are eligible for Medicaid, would not be eligible for
1229 private contracting.

1230 In terms of linking private contracting with quality
1231 measures and the other items that you outlined, this is
1232 something that physicians are trained to do, and I would say
1233 with respectful disagreement to some of the things that were
1234 said today, physicians are taught in medical school how to
1235 control costs. They are taught how to communicate with their
1236 peers. They are taught how to analyze data. This is
1237 something that we are taught from the very first day of
1238 medical school. I took a course called analytical medicine,
1239 and these things are already integral. Could we do more to
1240 emphasize these things? Absolutely, but I think within the
1241 Medicare Patient Empowerment Act there are sufficient
1242 protections to address your concerns.

1243 Thank you.

1244 Mr. {Pitts.} Thank you. Dr. Hoyt, your organization
1245 has done a lot very good work on quality measures. Can you

1246 give us an assessment of where we are today in terms of
1247 measuring quality? Are we just measuring processes, or can
1248 we also measure outcomes? How close are we to being able to
1249 come up with a metric that will help us decide how to pay for
1250 quality?

1251 Dr. {Hoyt.} Thank you. Yes. I think the way to
1252 characterize quality programs today is that probably the best
1253 example would be the National Surgical Quality Improvement
1254 Program or NSQIP, where outcomes in addition to processes of
1255 care can be measured.

1256 A very specific example. The implementation of that
1257 program in 112 hospitals over a 3-year period reduced
1258 complications, major surgical complications by about one
1259 complication per day per hospital. If you ascribe about
1260 \$10,000 to an average complication, which is probably a low
1261 figure, and multiply that out that turns out to be a savings
1262 of about \$2.5 million per hospital. If you roll that kind of
1263 program across all 4,000 hospitals, you are talking
1264 potentially billions of dollars each year save one program.
1265 You add to that comparative effectiveness, you add to that
1266 other cost reduction strategies, and I think that physicians
1267 can bring a lot.

1268 But the quality program tool, if you will, is proven.

1269 Mr. {Pitts.} Thank you. Dr. McClellan, there are

1270 several moving parts to this puzzle. On the one hand there
1271 are a number of forces pushing providers away from
1272 traditional fee-for-service towards the newer payment and
1273 delivery system such as ACOs and bundling payment agreements
1274 and medical homes, even capitation models.

1275 Yet on the other hand it seems that fee-for-service will
1276 continue to have a role at least for the foreseeable future.
1277 As we put the effort into developing these newer payment and
1278 delivery systems, what can we do to fee-for-service to make
1279 it less inflationary and more value based?

1280 Dr. {McClellan.} Mr. Chairman, I agree with you. I
1281 think fee-for-service and Medicare is going to continue to
1282 play a significant role for some time. I think what you have
1283 heard from the panel today, there are a lot of ways,
1284 including proven ways, to help make fee-for-service work more
1285 effectively with these other kinds of reforms, and, you know,
1286 if you--some of the reforms that you mentioned that are
1287 taking place in hospital payments and other parts of the
1288 Medicare Program, the episode payments involving hospitals,
1289 the accountable care payments, it would be very helpful if
1290 physicians could get better financial support in their own
1291 payment system to enable them to lead all of those efforts.
1292 And right now with fee-for-service staying the way it is,
1293 they are staying behind.

1294 So I think there are some real opportunities for
1295 alignment. We are not talking about, you know, radically
1296 changing the system, discarding all fee-for-service payments
1297 now, but, again, especially if these efforts can start with
1298 physician identified and physician-led efforts like you just
1299 heard about from Dr. Hoyt, they have the performance
1300 measures. These are things that Medicare could be paying to
1301 report on as part of its quality reporting payments instead
1302 of some of the other approaches that are being used now. It
1303 would be much more in line with where physicians are telling
1304 us we can improve care and save money, ideas that they
1305 already know how to do.

1306 Mr. {Pitts.} Thank you. My time has expired.

1307 Recognize the ranking member for 5 minutes for
1308 questioning.

1309 Mr. {Pallone.} Thank you, Mr. Chairman. I have three
1310 questions to three different people, so I am going to try to
1311 rush through them, and I hope you will bear with me.

1312 Some of the ideas that were mentioned today by the panel
1313 reminded me of the bill which I mentioned in my opening that
1314 the House passed I guess last year or the year before, which
1315 addressed the SGR problem in a larger sense. That was the
1316 Medicare Physician Payment Reform Act of 2009, H.R. 3961.

1317 Now, I am not suggesting we simply go back to that now

1318 because the Affordable Care Act creates a lot of new
1319 opportunities for fixing the SGR that we should build off
1320 today. But that bill, H.R. 3961, would have fixed the
1321 problem, and so I would like to get Mr. Goertz's thoughts on,
1322 you know, on it.

1323 As you may recall, it provided a guaranteed update
1324 during a transition to a new payment system, it would have
1325 created fairer growth targets by eliminating items not paid
1326 under the physician fee schedule, it would have provided an
1327 extra growth allowance for primary care services, and allowed
1328 ACOs to opt out of the spending targets. So I just wanted to
1329 ask Mr. Goertz about your thoughts on this legislation, what
1330 you like about it, and what maybe we could do better now that
1331 we are post Affordable Care Act?

1332 In about 1 minute.

1333 Dr. {Goertz.} I might be able to give you a 1-minute
1334 response, but it won't cover all those topics.

1335 Mr. {Pallone.} I know. I know.

1336 Dr. {Goertz.} Our organization, I don't remember the
1337 exact position on that legislation that we took, but if it
1338 satisfies the three elements that I mentioned because fee-
1339 for-service has inerrant positives and negatives. The
1340 positive is that it incents you work harder. The negatives
1341 is that it is inherently inflationary.

1342 So there has got to be some control on that. So we
1343 believe that if you put a patient coordination fee element
1344 into that that allows us to increase the things that we don't
1345 get paid for in communication with patients and the rest of
1346 the other physicians and team members that are needed, it
1347 will work. It will work.

1348 Now, the way the current model works it just simply puts
1349 everybody in one pool and treats them all the same way. The
1350 quality measures are mainly process right now, but we are
1351 making big strides in getting to the outcome decisions that
1352 are necessary for that, and what mix of those three things
1353 eventually evolve I think are going to be very interesting to
1354 watch. I don't know what the answers are, but all three work
1355 synergistically to have a better system than any one of them
1356 by themselves.

1357 Mr. {Pallone.} Well, thank you. Now, you mentioned
1358 fee-for-service. Let me ask Dr. McClellan the second
1359 question.

1360 Are there examples where physicians or provider-led
1361 organizations have stepped up to do the right thing, you
1362 know, under fee-for-service and the payment system has hurt
1363 them from doing that? You suggested that there might be
1364 cases, but, you know, give me an example of maybe where
1365 physicians were actually financially punished for doing the

1366 right thing, and, you know, I mean, that is the last thing I
1367 would like to see happen.

1368 Dr. {McClellan.} Lots of examples. One of the first
1369 meetings I had as CMS Administrator was with the leaders of a
1370 number of group practices that were doing things like working
1371 with nurse practitioners and pharmacists to do support for
1372 adherence medication, forming transition teams to help
1373 prevent readmissions. Point out that Medicare pays for none
1374 of that, and to the extent that it works they could bill less
1375 for the things that Medicare does pay for.

1376 Another good example is Virginia Mason Medical Center in
1377 Seattle that implemented some steps to lower costs and
1378 improve outcomes for patients with common problems like back
1379 pain. They were penalized financially and has made it very
1380 difficult for them to sustain their programs.

1381 Mr. {Pallone.} All right. Well, thanks.

1382 Now, last, Dr. Wilson, you, you know, I want to commend
1383 your proposal. It is clear that the AMA and the two other
1384 societies seated with you today took our request seriously
1385 and put some time into the response.

1386 But I am wondering if you could just attempt to give us
1387 your view of the consensus amongst the physician community,
1388 if any, and what we should do about the problems with the
1389 Physician Payment System? Is there a consensus at this point

1390 would you say?

1391 Dr. {Wilson.} In a general sense--

1392 Mr. {Pallone.} I don't know that that mike is on.

1393 Dr. {Wilson.} --I would say yes, and I think you heard
1394 that this morning that around certain principles, and that is
1395 we have a payment system that does not work. We need to get
1396 rid of it. We need to have a period of stability as we move
1397 to a different way of delivering care and paying for care,
1398 and you have heard a variety of options about models that
1399 might be effective. I think there is a great deal of
1400 consensus around there.

1401 Now, when we get down to the fine ink, fine print,
1402 clearly we will all have differences about what will work,
1403 but I think we should also have a realization that what will
1404 work in one part of the country will not work in another part
1405 of the country, and that is why we have continued to talk
1406 about a variety of options, not picking a one size that we
1407 expect will fit all. I can take you to my home State of
1408 Florida where what works in the Pan Handle doesn't work in
1409 Central Florida where I live and doesn't work in South
1410 Florida. So I think we need to keep that in mind.

1411 There is a temptation to feel like we ought to figure
1412 out one rule, and that solve it all. This system is so
1413 complex that we need to preserve that, and as a matter of

1414 fact, the Affordable Care Act in talking about accountable
1415 care organizations, I think, recognize that. It talked about
1416 a variety of models for those structures that would work. I
1417 think we need to keep that in mind, but I am impressed also
1418 as I go around the country talking to physicians. They
1419 understand there are ways that this can be done better, and
1420 they want to be involved in the process.

1421 Thank you.

1422 Mr. {Pallone.} Thank you, gentlemen. Thank you, Mr.
1423 Chairman.

1424 Mr. {Pitts.} The chair now recognizes the distinguished
1425 Chairman of the Full Committee, the gentleman from Michigan,
1426 Mr. Upton, for 5 minutes.

1427 The {Chairman.} Well, thank you, Mr. Pitts, and again,
1428 I just want to reiterate from this committee's viewpoint that
1429 I very much appreciate all of the input, not only from you
1430 today but the dozens of organizations that responded to the
1431 letter that was bipartisan that Mr. Waxman and I and others
1432 signed looking for information. This is on our short list of
1433 getting things done really this summer. Got a number of
1434 different things that are there, but this is an issue that we
1435 need to grapple with. It is time. We are way too late, and
1436 I appreciate the expertise, the questions of particularly Dr.
1437 Burgess, the vice chair of this subcommittee in addition to

1438 Mr. Pitts, Mr. Pallone, Mr. Waxman, and others.

1439 Personally I like the idea of taking the time, a number
1440 of different years, to look at a whole number of different
1441 models and see what might work best. I know from my
1442 district's perspective I have got some pretty urban areas in
1443 terms of Kalamazoo with two great hospital facilities with
1444 lots of physicians, Borgess and Bronson, as well as Lakeland
1445 Hospital in the county that I live in, and I have got some
1446 counties that frankly are very rural, some that don't even
1447 have a four-lane road practically. And so it is--we are a
1448 diverse Nation and different healthcare, and we need to look
1449 at those different priorities that are there for sure, and I
1450 just want to--again appreciate your time today.

1451 The question that I have and I want to focus this first
1452 to Professor Chernew but others might want to comment, you
1453 know, the IPAB was created by the Affordable Care Act as we
1454 all know. A number of folks on both sides of the aisle have
1455 expressed concern about the board and how it functions. For
1456 one thing as we know that the board sets expenditure targets,
1457 imposes spending cuts based on those targets, and we know
1458 that beginning 2018, the target will be based on GDP.

1459 Sounds a lot like SGR which we are trying to get rid of,
1460 and since hospitals are exempt from IPAB cuts through the
1461 rest of the decade, it seems that the IPAB has the potential

1462 to undermine any serious efforts a physician payment reform.

1463 And I would like to get your comments as it relates to
1464 that. So we will start with Professor Chernew and anyone
1465 else that would like to comment would be great.

1466 Dr. {Chernew.} First let me say, Go Blue.

1467 The {Chairman.} Yes. Absolutely.

1468 Dr. {Chernew.} Having been in Michigan for 15 years
1469 but--

1470 The {Chairman.} We lost a basketball guy this week. I
1471 don't know if you heard.

1472 Dr. {Chernew.} I think the IPAB is yet an unknown
1473 quantity. I think in its best it could be supportive of all
1474 the things that one does here and at its worst it could
1475 create problems that you discussed, and I think the challenge
1476 like much of aspects of the ACA is how to implement the
1477 proposals. What you have heard here around the table about
1478 payment reform I think is a stunning consensus about both the
1479 problems of the SGR. I heard from the chairman and the
1480 others who spoke and the notion that reforming payment is
1481 going to have some basic principles, and you mentioned some.
1482 The others mentioned the transition and stuff, and I would
1483 like to think that the IPAB can be used as a tool to backstop
1484 if problems arise in those, but I certainly think that if one
1485 isn't careful in various ways there would be concerns.

1486 And so like most things the devil is going to be in the
1487 details and how to make it work is a bigger question than one
1488 can address in the time that we have here.

1489 The {Chairman.} Anybody else like to comment?

1490 Dr. {Williamson.} Our coalition has opposed the IPAB
1491 for a number of reasons, some have been stated. We have
1492 concerns about the fact that it is comprised of non-elected
1493 officials with minimal accountability and the fact that its
1494 recommendations would automatically become law if the
1495 Congress didn't act within a fairly short period of months.
1496 So our coalition has opposed that entity.

1497 Dr. {Wilson.} Thank you, Mr. Chair. The AMA from the
1498 start has said that this--the Affordable Care Act is a big
1499 step forward to health system reform, but it is just a step,
1500 and there is some challenges associated with it. There are
1501 things that were left out, and that is medical liability
1502 reform as well as a fix for the Medicare physician payment.
1503 And there is some things in the bill that we have problems
1504 with, and one of them is the Independent Payment Advisory
1505 Board, the IPAB. As it is presently structured. We do not
1506 support it.

1507 Our concern is and maybe this would be a good place to
1508 float this, and that is 20 years from now we might be sitting
1509 here, some of us, talking about how to correct the problems

1510 associated with it. So it is not impossible that it could
1511 serve a function, but as presently constituted we could--we
1512 see it basically another target for physicians to meet,
1513 potential double jeopardy with an SGR as well as the
1514 pronouncements from this body.

1515 So we believe significant changes need to be made.

1516 The {Chairman.} Great. I know my time has expired. I
1517 just want to add the Tort Reform is also on our short list of
1518 getting things done.

1519 So thank you very much.

1520 Mr. {Pitts.} The chair thanks the gentleman, and now
1521 recognizes the distinguished gentleman from Michigan, the
1522 Ranking Member Emeritus, Mr. Dingell, for 5 minutes for
1523 questions.

1524 Mr. {Dingell.} Mr. Chairman, I thank you for your
1525 courtesy, and I would like to direct my attentions to Dr.
1526 Wilson, Dr. Goertz, and Dr. Hoyt, and I would like to do this
1527 against the background of getting their helpful and necessary
1528 advice on how we will proceed to solve a problem that is
1529 going to cost more every year.

1530 Now, gentlemen, like all of you I believe we have to
1531 change or repeal the seriously-flawed SGR formula. Each of
1532 you seems to be in agreement that a 5-year stability period
1533 is needed for Medicare physician payments to allow providers

1534 to plan ahead as well as to allow demonstration projects of
1535 different payment models.

1536 Is a 5-year stability period an adequate amount of time
1537 to phase out SGR and for physicians to prepare for a new
1538 payment system? Yes or no? In other words, is 5 years
1539 enough time to do the job?

1540 Dr. {Wilson.} Well, Mr. Chair--

1541 Mr. {Dingell.} If you want to quality that I will be
1542 glad to receive that for the record.

1543 Dr. {Wilson.} I will quality it. We think the 5 years
1544 because we do think we are going down a different road. This
1545 is going to be a challenge. It will not be easy.

1546 On the other hand, we don't want an indefinite period of
1547 time. We think there is an urgency about moving forward, and
1548 we also believe that as things come--

1549 Mr. {Dingell.} Doctor, I hate to be discourteous, but I
1550 have got a lot of questions. If I get yes or no, I will get
1551 through them.

1552 Dr. Goertz, Dr. Hoyt?

1553 Dr. {Goertz.} We would commit to a 5-year period to do
1554 everything possible to make the transition.

1555 Mr. {Dingell.} Dr. Hoyt.

1556 Dr. {Hoyt.} I would agree.

1557 Mr. {Dingell.} All right. Now, we have heard from many

1558 of you about the need for demonstration projects. How many
1559 demonstration projects would be necessary to determine the
1560 effectiveness of a new system? Starting with Dr. Wilson.
1561 Just horseback answer.

1562 Dr. {Wilson.} Thank you, Mr. Chair--Congressman. The--
1563 it depends on how they work out.

1564 Mr. {Dingell.} True.

1565 Dr. {Wilson.} And if we are fortunate that the first
1566 project works out, then we are there, and that is why we are
1567 doing demonstration projects. We don't know how it is going
1568 to turn out.

1569 Mr. {Dingell.} The other two panelists, please.

1570 Dr. {Goertz.} Well, I would posit to you that at least
1571 for the elements that I am talking, have referred to, the
1572 patients in a medical home, I think there are more than
1573 enough demonstration projects that already show the benefit
1574 of that. Now, if you are talking about overall change, I
1575 think you are going to have to have enough demonstration
1576 projects that represent all the regions of the country, all
1577 the demographic variations that are appropriate, but I don't
1578 think that has to be an onerous number.

1579 Mr. {Dingell.} Thank you. Doctor.

1580 Dr. {Hoyt.} And I don't know the number, but
1581 particularly in surgery we would need demonstration projects

1582 to fulfill the needs of surgeons practicing in already
1583 integrated health systems like Geisinger or Kaiser. Then we
1584 have 55 percent of our members that are still practicing in
1585 solo or small group practice, and solutions for them are
1586 needed as well.

1587 Mr. {Dingell.} Thank you. Now, the same panelists, if
1588 you please. I introduced in the prior Congress H.R. 3961.
1589 That included reforms that may offer some solutions to the
1590 current payment problems. As you are well aware, next
1591 January Medicare physicians are facing a 29.5 percent cut if
1592 the SGR problem is not addressed.

1593 Do you have any that H.R. 3961 would have prevented the
1594 29.5 percent cut we are expecting in January? Yes or no?

1595 Dr. {Wilson.} Yes.

1596 Mr. {Dingell.} Doctor?

1597 Dr. {Goertz.} Yes, it would have definitely helped.

1598 Mr. {Dingell.} Doctor?

1599 Dr. {Hoyt.} Yes.

1600 Mr. {Dingell.} One of the proposed reforms included in
1601 H.R. 3691 or rather 3961 was creating two categories of
1602 physician services; one for evaluation management and
1603 preventative services and the second to cover all other
1604 services. Primary and preventative services would be
1605 permitted to grow at GDP plus 2 percent while other services

1606 would be allowed to grow at the rate of GDP plus 1 percent.

1607 Do you think this is a good idea? Yes or no?

1608 Dr. {Wilson.} That is one of the challenges of
1609 prescriptive formulas and that is to know that you got it
1610 right, and I think the answer would be I do not know.

1611 Mr. {Dingell.} Thank you, Doctor.

1612 Doctor?

1613 Dr. {Goertz.} We certainly ascribe to the rebalancing
1614 that the primary care elements would have done. The overall
1615 I don't know also.

1616 Mr. {Dingell.} Now, we have a whole series of problems
1617 here, one of which is we are putting target limits on all
1618 kinds of services being paid for by Medicare. Should we
1619 limit spending targets to physician services, or should we
1620 cover all other kinds of services? Starting with Dr. Wilson,
1621 if you please.

1622 Dr. {Wilson.} Thank you. I think if we are going to
1623 have targets, then they should include everyone.

1624 {Voice.} Microphone.

1625 Dr. {Wilson.} I am sorry. I think if we are going to
1626 have targets, they should include the health system in
1627 general. I think what we are understanding dealing with the
1628 SGR that targets are not a very effective way to do what we
1629 want to do.

1630 Mr. {Dingell.} Thank you. Dr. Goertz.

1631 Dr. {Goertz.} Unless you consider the overall
1632 healthcare system, you can't make it efficient.

1633 Mr. {Dingell.} I note, Mr. Chairman, I am over my time.
1634 Thank you for your courtesy.

1635 Mr. {Pitts.} The chair thanks the gentleman and
1636 recognizes the distinguished vice chairman of the
1637 subcommittee, the gentleman from Texas, Dr. Burgess, for 5
1638 minutes.

1639 Dr. {Burgess.} Thank you, Mr. Chairman. So much to
1640 ask. We always do reserve the right to submit questions in
1641 writing. I will not get through the list of things in front
1642 of me, and I know that these are not yes or no questions.

1643 Dr. Wilson, Dr. McClellan, whoever feels most
1644 comfortable answering this or both of you, actually, Dr.
1645 McClellan, your old boss at Department of Health and Human
1646 Services, Mike Leavitt, had a demonstration project that the
1647 physician group practice demonstration project that now has
1648 moved into the ACO realm, and many of us were somewhat
1649 excited about the concept of ACOs, and a lot of the Medicare
1650 payment reform perhaps could have been tied to the ACO. But
1651 then a couple of weeks ago we got the rule out of the Center
1652 for Medicare and Medicaid Services, with which you are
1653 intimately familiar, and it was almost unreadable and

1654 certainly unworkable, so now that everyone knows what a
1655 unicorn is, I don't think any exist in practice, do they?

1656 Dr. {McClellan.} Well, as you know, the regulatory
1657 process involves stats and especially in new areas like this
1658 one there are going to be lots of comments on whatever the
1659 agency puts out first, and I have heard some statements
1660 recently from some of the leadership at CMS that they are
1661 definitely listening closely to the comments, and they want
1662 to address on the issues that have been raised about the
1663 proposed regulation.

1664 I don't think that like many of the other ideas that we
1665 have talked about here today, though, that we are just
1666 talking about unicorns in terms of doing reforms and payment
1667 that support physician leadership and improving care and
1668 lowering costs. There are a number of ACO-like programs in
1669 existence now. Dr. Chernew talked about the Massachusetts
1670 Blue Cross Alternative Quality Contract. That has a lot of
1671 new kinds of support for physicians for the kinds of delivery
1672 reforms that we have talked about. Dr. Hoyt talked about a
1673 lot of experience with Episode and statements that have
1674 helped surgeons.

1675 Dr. {Burgess.} Let me interrupt you for a moment
1676 because I know you know so much about this, and I am going to
1677 ask you to respond to part of this in writing, but under the

1678 rule that came out I don't know that they could exist, and
1679 perhaps they could respond to me in writing about whether or
1680 not their programs could continue to exist.

1681 Dr. Wilson, you talk a little bit about physician
1682 leadership, and this is going to be so critical. Whatever
1683 evolves as the answer to this conundrum it is going to take
1684 physician leadership, and what are you doing now as the head,
1685 the consummate insider of organized medicine in the free
1686 world? What are you doing to recruit that physician
1687 leadership?

1688 We all know whatever it is doctors don't like anything
1689 moving in their cage, we don't like change, but when it
1690 happens, it is going to take champions within the profession
1691 to lead that change.

1692 How are you preparing for that?

1693 Dr. {Wilson.} Well, thank you, Congressman. I assume
1694 that means in addition to praying. The AMA is actually
1695 devoting a great deal of its resources to trying to provide
1696 information to physicians through papers on this subject,
1697 through webinars, through information on our website, through
1698 seminars around the country to help physicians understand
1699 what an ACO might look like and understanding that the
1700 definition is fluid and that what is in the private sector
1701 may look different than that in the Medicare sector.

1702 So we are committed to that. Just the week before last
1703 I did a webinar just looking at the proposed rules. So we
1704 think that is an important part of what the AMA needs to do,
1705 and I would just state--

1706 Dr. {Burgess.} Let me just interrupt you for a second.
1707 That would include other payment models other than just the
1708 ACO?

1709 Dr. {Wilson.} Absolutely. Absolutely, and I would just
1710 say that as I have gone around the country and looking at
1711 physician organizations, they are onboard and trying to do
1712 that as well. So they are--this is a big job, there are a
1713 lot of people who are involved, and we think it is important,
1714 and we agree with that.

1715 Dr. {Burgess.} Well, and I would just point out, I
1716 mean, I have already gotten some criticism, the twitter
1717 verse, for acknowledging that there were so many doctors on
1718 the panel. We had never had doctors on the panel when we
1719 were doing healthcare reform. I just do need to point that
1720 out, and I thought we needed you when we were doing
1721 healthcare reform, but there is not a day that goes by that I
1722 don't hear from some doctor or some group who has some idea
1723 about--I dare say you can't go into a surgery lounge anywhere
1724 in the country where this problem wouldn't be solved within
1725 15 minutes with time for coffee.

1726 Now, Dr. or Mr. Miller and Dr. Chernew, I need to ask
1727 you in what limited time I have left, both of what I heard
1728 you describe what you were proposing, I will admit getting a
1729 very cold sensation because it sounded so much like
1730 capitation under the HMO model of the 1990s.

1731 How are each of you different from capitation?

1732 Mr. {Miller.} Well, it is different from capitation in
1733 a number of critical ways. First of all it is risk adjusted
1734 so that you don't get penalized for having sicker patients.
1735 There are limits on the amount of risk that you would take.
1736 So if you get a usually expensive patient, you don't end up
1737 having to pay for that all out of the same amount of money.
1738 That gets covered, and there are quality bonuses attached to
1739 it so that you don't end up being rewarded for delivering
1740 low-quality care.

1741 And I think that when we talk to physicians about this,
1742 I was just in Colorado this past weekend, had 100 doctors, we
1743 actually had them sort of be inside the payment model, and to
1744 talk about how they would change care because of the greater
1745 flexibility that they would have, and at the end we said, so,
1746 which would you rather be in? These new payment models or
1747 the existing payment model, and it was about 99 to one people
1748 said I would like to be in the new payment model because of
1749 the opportunities it gives me to be able to deliver better

1750 quality care.

1751 Dr. {Burgess.} Mr. Chernew, just very briefly.

1752 Dr. {Chernew.} I would just add--

1753 Dr. {Burgess.} All right. Are you finished your
1754 answer? All right.

1755 Dr. {Chernew.} Apparently.

1756 Mr. {Pitts.} Did you have something--

1757 Dr. {Burgess.} I was just wanting Dr. Chernew to
1758 respond to the issue of capitation.

1759 Dr. {Chernew.} A 5-year--I agree with everything Dr.
1760 Miller said and the 5-year duration of the contract makes a
1761 big difference, because if you are effective in lowering
1762 costs, they can't come in the next year and just lower and
1763 lower your capitation rate. The rates always go up, the
1764 capitation. I think that is an important fact.

1765 Mr. {Pitts.} Okay. Thank the gentleman and now
1766 recognize the distinguished ranking member of the full
1767 committee, the gentleman from California, Mr. Waxman, for 5
1768 minutes.

1769 Mr. {Waxman.} Thank you very much, Mr. Chairman. I
1770 know we try to be liberal on time, and I will try to stay
1771 within the 5 minutes, but knowing the President I am sure I
1772 could go over.

1773 I have always been a supporter of allowing managed care

1774 choice for Medicare beneficiaries. My district, Kaiser
1775 Permanente, Kaiser Health Plan and Permanente Medical Group,
1776 have been leaders in providing high-quality care at a
1777 reasonable cost.

1778 In many cases, however, managed care gets out of
1779 control, loses its bearings, patients have been denied
1780 necessary treatments and care, has been rationed by some
1781 private plans.

1782 Dr. Chernew, I want to address this question to you
1783 because your testimony describes the alternative quality
1784 contract of Blue Cross Blue Shield Massachusetts is pursuing.
1785 Can you tell whether and how that model guards against the
1786 incentives for doctors that deny needed treatment to their
1787 patients?

1788 Dr. {Chernew.} Very briefly there is--the rates are set
1789 so that they don't go down so no organization is forced to
1790 reduce access to care. The rates go up at a slower rate than
1791 they otherwise might have. There is the quality bonus system
1792 that protects against care which includes outcome measures as
1793 well as process measures, includes patient experience
1794 measures, as well as just process measures, and our
1795 preliminary evidence suggests, in fact, the quality has risen
1796 under the AQC, and again, it tends to be a more doctor-
1797 oriented system where the doctors have autonomy to do what

1798 they were trained and want to do as opposed to insurer micro-
1799 managing the care. The doctors have much more flexibility as
1800 Mr. Miller emphasized than you might have in other systems.
1801 So I think it is a very doctor-leadership friendly design.

1802 Mr. {Waxman.} In Medicare, of course, we are pursuing
1803 some similar projects in the form of accountable care
1804 organizations and other shared savings arrangements. Can you
1805 draw any lessons for Medicare from the Blue Cross Blue Shield
1806 Massachusetts experience to date?

1807 Dr. {Chernew.} I do think there is a lot of
1808 similarities. I think some of the advantages that Blue Cross
1809 has had is, for example, you have to choose a physician,
1810 designate a physician. I think that is similar to the
1811 contracting that Dr. Williamson mentioned. You have to pick
1812 a physician that helps--it works. There is an up side and
1813 down side risk as some of the ACL regulation gets out, so I
1814 do think there are broader lessons in the AQC, the
1815 performance measures, but we would have to have a longer
1816 conversation to go into all the things. But there are
1817 parallels, and I do think it speaks well of where some of the
1818 innovations are going.

1819 Mr. {Waxman.} Many of the physician groups that
1820 responded to our letter, bipartisan letter, seeking comment
1821 asked that Medicare allow physicians to choose from a menu of

1822 options for different payment models in the future. Do you
1823 agree that Medicare needs to be able to deal with physicians
1824 and hospitals in a more personalized, specific way, less of a
1825 one-size-fit-all approach?

1826 Dr. {Chernew.} I do think that multiple approaches will
1827 be useful. I think they have to be structured in a way to
1828 avoid aspects of selection across the different programs, but
1829 subject to those caveats I think there is unlikely to be a
1830 one-size-fits-all solution.

1831 Mr. {Waxman.} As we look at the ways to change the
1832 incentives in order to truly fix the payment system, we have
1833 to be sure we do no harm the quality of care in the process
1834 and hopefully rebuild incentives that actually improve the
1835 quality of care.

1836 So Dr. Miller, I was very interested in your ideas on
1837 regional health collaboratives. During my time as chairman
1838 of the Oversight Committee, separate committee from this one,
1839 one of the most striking things we learned was about--was a
1840 project in Michigan that was implementing a checklist to
1841 reduce healthcare-associated infections. Many people took
1842 away from that the idea that we ought to have checklists, but
1843 what we also heard and maybe more importantly at this hearing
1844 was the importance of people coming together to improve care.
1845 The checklist was only a tool to allow for collaboration at

1846 the local level.

1847 MedPAC has recently begun a discussion about ways to
1848 improve quality of care. They are contemplating changes to
1849 the Medicare Quality Improvement Organizations and heard
1850 testimony from a regional health collaborative.

1851 Dr. Miller, do you think that the QIOs should be
1852 significantly modified to allow for more entities to
1853 participate, and can these collaboratives play a more direct
1854 role in payment reform aside from the critical role of
1855 improving quality?

1856 Mr. {Miller.} Well, I think the collaboratives are
1857 already doing around the country things that we want to see
1858 happen. They are measuring and reporting on quality long
1859 before Medicare was doing that. They have been working to
1860 work with both hospitals and physicians to help them be able
1861 to restructure the way they deliver care. Pittsburgh
1862 Regional Health Initiative in Pittsburgh was doing those
1863 infection reduction projects back in the 1990s.

1864 What everybody kept running into was the problem that
1865 the way the payment system was structured actually either
1866 didn't support the care changes that they had found would
1867 work or would penalize them for doing that, and so that is
1868 why we now see a number of the collaboratives around the
1869 country that are working on payment reform efforts and have

1870 brought together the commercial health plans and Medicaid
1871 plans to agree on different approaches to payment. The
1872 biggest thing that is missing is Medicare being at the table.

1873 I think the QIOs in a number of communities, some of the
1874 QIOs are operating as regional health collaboratives, and I
1875 think that in other cases they are working together. I think
1876 there is plenty to be done to be able to improve the way the
1877 healthcare system works and rolls for everybody. I think the
1878 issue is to have that local focus and to be able to have the
1879 kinds of improvement customized to what are the specific
1880 problems and the specific needs in that particular community,
1881 and that is what we don't have right now is a good system for
1882 being able to support that local customization.

1883 Mr. {Waxman.} Thank you. Thank you, Mr. Chairman.

1884 Mr. {Pitts.} The chair thanks the gentleman and
1885 recognizes the gentleman from Kentucky, Mr. Guthrie, for 5
1886 minutes.

1887 Mr. {Guthrie.} Thank you very much, Mr. Chairman. I
1888 guess, Dr. McClellan, I will ask you this since you were at
1889 CMS in the 2000s. I have been looking at the Sustainable
1890 Growth Rate. I got elected 2 years ago, so I am new at this,
1891 and I don't like to go back and say, well, there is a problem
1892 in the past. We have to fix it, but it would be kind of nice
1893 to know since we are trying to come up with a new system,

1894 were you there when the Sustainable Growth Rate was designed?
1895 Because looking at the map of it, it ties, essentially ties
1896 it to the gross domestic product, which even the gross
1897 domestic product drops. People don't quite go into the
1898 positions, so it seemed like a bad model to begin with, and I
1899 don't know if--did people come together and say, you may not
1900 have been here, but just history of it, this was the right
1901 thing to do and now we are here 10, 12 years later going, we
1902 have to do something different?

1903 Because my question gets to whatever we do is going to
1904 have to save costs in the system, and so whatever system we
1905 have it going to save the costs of at least the growth.
1906 Right now it is cut, it is not trying to slow growth, it is
1907 cutting, which is wrong, but I just want to know the history
1908 of the SGR and why you think it was supposed to work and
1909 didn't.

1910 Dr. {McClellan.} Well, I will try to give you a brief
1911 history. I wasn't there back in the days of the Balanced
1912 Budget Amendment or Balanced Budget Act that established the
1913 SGR more than a decade ago. It was driven exactly as you
1914 said, by concerns about rising costs in the Medicare Program
1915 and the need to find a way to take costs out, and you know,
1916 unfortunately, the traditional thing that we do when we can't
1917 figure out the direct way to save money while improving care

1918 is when all else fails, just cut the payment rates, and that
1919 is what was built into the formula.

1920 So I wasn't here when that started. I was here 5 years
1921 ago at CMS as you mentioned when this subcommittee was also
1922 having hearings about the challenges of reforming the SGR,
1923 and I think what has happened in the 5 years since is a
1924 couple of things.

1925 One is the concerns about rising costs and the
1926 sustainability of the Medicare Program have increased a lot,
1927 along with the cost about the affordability of our healthcare
1928 system overall, and the second is we have a lot more evidence
1929 and a lot more leadership from physicians as has come up
1930 repeatedly today on ways to do it better so that you don't
1931 depend on crossing your fingers that some statutory formula
1932 is actually going to be implemented, and you do depend on the
1933 people who are in the best position to do something about
1934 this problem, and that is physicians.

1935 So the steps that we have talked about today, I think it
1936 is time to begin implementing them to move away from the SGR
1937 and save money at the same time.

1938 Mr. {Guthrie.} I agree, agree completely. I just
1939 wanted to kind of figure--we were sitting here a dozen years
1940 ago saying this is going to fix the problem, but I guess
1941 people must have thought even when they did it, this really

1942 isn't going to fix the problem. So when you do--things come
1943 as gimmicks, and this is not going to work. You have got to
1944 have sustainable changes into that.

1945 The thing on quality of care, a lot of times we talk
1946 about teachers, and they say, we want to be paid for the
1947 quality of instruction and how do you measure it. I mean,
1948 the measurables come into play because the teacher says,
1949 well, if I am in a school with a certain demographic, then I
1950 may--and I am with a school of a different demographic, I am
1951 being compared to each teacher. And so, I mean, how do you--
1952 because if you have a less-healthy population you are
1953 treating, you are going to have less outcome just by nature
1954 than if you have a healthy group.

1955 So how do you determine--anybody want to talk? How
1956 about Dr. Hoyt?

1957 Dr. {Hoyt.} Yeah. I think that is a great question,
1958 and the way you do that is, first of all, through statistical
1959 risk adjustment of patient population so you are comparing
1960 apples to apples, physician to physician, practice to
1961 practice.

1962 Mr. {Guthrie.} Another formula?

1963 Dr. {Hoyt.} And then secondly, you really need to pick
1964 matrix that are going to be relevant to improving the patient
1965 care process, and I think by having leadership models like

1966 people have talked about we are actually training leaders to
1967 become qualitologists or quality leaders in organizations by
1968 having these inter-State collaboratives so that we share best
1969 practice. And then what you individually do with the
1970 database is you array against a particular complication,
1971 let's say surgical infection, all of the providers. That can
1972 be hospitals or that could be an individual physician, and
1973 what you then get is the performance of all those providers
1974 across that complication. You are going to have some
1975 outliers that are doing well, some outliers that are doing
1976 poorly.

1977 What happens is those people get together, and they
1978 improve, and that is the affect we are trying to get to.

1979 Mr. {Guthrie.} I only have 30 seconds, but the surgical
1980 infections is what the hospital is doing there. What about
1981 some of the behaviors that--what the patient brings to it
1982 like someone who is pregnant. So--

1983 Dr. {Hoyt.} That needs an additional--

1984 Mr. {Guthrie.} And I know you want to incentivize
1985 having better prenatal care, but are there doctors that that
1986 is what you want to do is say you kind of really manage that.
1987 A lot of times it will be different for different physicians
1988 based on the way their patient populations react. And how do
1989 you account for that?

1990 Dr. {Hoyt.} Well, I think that is an additional
1991 strategy. You know, in my field, trauma, the way we do that
1992 is you work on road traffic safety initiatives, you work on
1993 gun control or whatever because you are trying to go upstream
1994 from the problem, and every aspect of medicine has
1995 preventative areas that are essential.

1996 Mr. {Pitts.} The chair thanks the gentleman and
1997 recognizes the gentlelady from California, Ms. Capps, for 5
1998 minutes for questions.

1999 Mrs. {Capps.} Thank you all for being here. I have
2000 long been a supporter of fixing the SGR problem. It is an
2001 issue that causes difficulty for providers and consumers
2002 alike. In addition, providers who are able to keep their
2003 patients healthier and lower overall costs are often
2004 penalized even more.

2005 But the conversation often stops at the crisis point.
2006 How do we make it to the next fix and rarely moves onto one
2007 where we can discuss our vision for healthcare system in the
2008 future and how to get there. That is why I thank Chairman
2009 Pitts and Ranking Member Pallone for engaging in this
2010 important topic today, and I have two--an idea to bring
2011 before Dr. McClellan and Mr. Miller.

2012 There has been so much talk about the role of doctors in
2013 the healthcare system, but if we are really going to move to

2014 a more comprehensive prevention focused system of care, I
2015 believe it is important to acknowledge the role that other
2016 healthcare providers bring to the table in keeping our Nation
2017 healthy, including nurses, nurse practitioners, physicians'
2018 assistants, and many new kinds of models of delivering care.

2019 This hearing and many before it have drawn our attention
2020 to the needs to move away from volume-based medicine and
2021 toward a more holistic model where the rewards are for
2022 providing great care for a patient rather than a lot of tests
2023 and procedures. As a nurse I can tell you that nurses and
2024 nurse practitioners get that. In previous hearings we have
2025 heard about how many successful programs--we have heard about
2026 some successful programs, for examples, the Guided Care
2027 Program at Johns Hopkins and how they rely on nurse managers
2028 or nurse practitioners to provide the complex services that
2029 frail Medicare and Medicaid patients often need. In
2030 addition, nurses have patient education skills that can help
2031 to manage chronic diseases for many people.

2032 So, Dr. McClellan, will you talk briefly about the
2033 possibilities for nurse practitioners, physicians'
2034 assistants, and other non-physician practitioners in some of
2035 these new care models like medical homes or accountable care
2036 organizations, please? Then I will turn to you--

2037 Dr. {McClellan.} Every single one of these reforms has

2038 involved more reliance on other health professionals. I
2039 can't think of any, not medical homes, not these episode-
2040 based programs, improve surgical outcomes and reduce
2041 complications, not programs for palliative and supportive
2042 care for patients with complex illnesses. They don't rely
2043 much more than we have in the past on nurse practitioners,
2044 nurses, pharmacists, and other allied health professionals in
2045 delivering care. And that gets back to the core problem we
2046 have been talking about today, which is that Medicare's
2047 traditional fee-for-service program doesn't do much to pay
2048 for these other forms of care in order to target these
2049 services to the right patients, though, you need physicians
2050 working with these other health professionals making
2051 decisions. You need more flexibility for them to lead, and
2052 that is hopefully where these payment reforms will take us.

2053 Mrs. {Capps.} And so that is one of the areas where you
2054 want to see us go forward.

2055 Dr. {McClellan.} Absolutely.

2056 Mrs. {Capps.} Okay, and of course, underlying all of
2057 this is the shortage of primary docs, and everyone is fixated
2058 on that. There are--we need more incentives for people to
2059 rise to those kinds of primary care services from these other
2060 professions as well. I am seeing you nod so I think you
2061 agree.

2062 Dr. {McClellan.} I think so, and just to go back to the
2063 example in Massachusetts that Dr. Chernew was talking about,
2064 one of the features of that alternative quality contract is a
2065 lot more resources for primary care doctors to coordinate
2066 care, and some of them who I have talked to said they feel
2067 this is more like concierge's medicine almost. They are able
2068 to really spend the time managing the patients' problems and
2069 aren't being reimbursed just on a short, you know, 5-minute
2070 visit basis.

2071 Mrs. {Capps.} Good. Okay. Maybe Mr. Miller, and if
2072 there is time, Dr. Chernew, you may want to chime in, too.

2073 Mr. {Miller.} I organized and ran a project in
2074 Pittsburgh over the past 3 years focused on reducing hospital
2075 readmissions for patients with chronic disease. We made a
2076 lot of changes in various procedures, but the most important
2077 single thing that we did was that we hired two nurses to work
2078 with those chronic disease patients to help them, educate
2079 them to go into their homes to figure out what they needed to
2080 be able to manage their care better. We had to use a
2081 foundation grant locally to pay for them because they could
2082 not be paid for by--

2083 Mrs. {Capps.} There is no funding stream right now.

2084 Mr. {Miller.} My instructions to the nurses when we
2085 hired them was your job is to keep 13 people out of the

2086 hospital in the next year because that will actually pay for
2087 your salary, and they beat that target by a significant
2088 amount. We reduced readmissions by 44 percent in the course
2089 of 1 year, and we ended up having to lay off one of those
2090 nurses at the end because there was no way to continue her
2091 under the current healthcare payment system. In the other
2092 case, fortunately, the hospital was willing to pick her up to
2093 put her on salary to continue to do that work to help the
2094 patients stay out of the hospital.

2095 Mrs. {Capps.} Great example. So the results are pretty
2096 short-term.

2097 Mr. {Miller.} The results at quick, they are dramatic,
2098 and the intervention is very simple. It is simply--it is a
2099 perfect example of something where the current payment system
2100 does not pay for that. Now, whenever you do pay for it, you
2101 want to have them focusing on a specific target--

2102 Mrs. {Capps.} Right.

2103 Mr. {Miller.} --that will actually save you some money
2104 and not have that nurse diverted into doing all kinds of
2105 other things that might be desirable but will not save the
2106 program money. That is why whenever we did the program we
2107 said the focus is specifically on keeping, reducing
2108 readmissions of patients, and they were able to do that, and
2109 it was actually a very empowering thing for the nurses and

2110 for the physicians to be able to have that resource that they
2111 could use for their patients and be able to use it for the
2112 patients that they knew needed help but that they didn't have
2113 the time to be able to provide for them.

2114 Mrs. {Capps.} And I have run out of time, but I will
2115 look for your written testimony, Dr. Chernew. If you would
2116 like to submit--if you want to zero in or boar in on the way
2117 that this impacts in the Massachusetts Program as well, I
2118 would appreciate that.

2119 I will yield back.

2120 Mr. {Pitts.} The chair thanks the gentlelady and now
2121 recognizes the gentleman from Louisiana, Dr. Cassidy, for 5
2122 minutes for questions.

2123 Dr. {Cassidy.} Dr. Wilson, I am also a member of the
2124 AMA, and I like all your suggestions except that I don't see
2125 how we pay for them. In fact, one of the--I was disappointed
2126 as many members of the AMA were in the AMA support of PPACA
2127 because frankly the low-hanging fruit of savings in Medicare
2128 didn't go to sure up Medicare or to fix the SGR. It went to
2129 create another entitlement, which arguably is going to make
2130 our situation worse.

2131 So do you have any--I don't see inherent in your
2132 testimony now that the savings for Medicare have been used
2133 outside of Medicare how we pay for this.

2134 Dr. {Wilson.} Well, one of the challenges of the whole
2135 healthcare system is that the costs are multi-factorial, and
2136 we have not in this hearing because it is not a part of this
2137 hearing talked about the biggest driver for cost in this
2138 country in healthcare, we spend 78 percent of what we spend
2139 on healthcare on chronic disease. And so--and most of that
2140 preventable. So that is another area we need to be involved
2141 with.

2142 The area of tort reform CBO has suggested that a cap of
2143 \$250,000 on non-economic damages would reduce the federal
2144 budget by \$54 billion over the coming years. So we think
2145 they have a variety of things in this legislation that will
2146 start to address that, and that is where we need to look, but
2147 it is a variety of things. There are parts of this
2148 legislation that look at the whole area of simplification,
2149 administrative simplification, insurance forms, things that
2150 don't contribute to health--

2151 Dr. {Cassidy.} Let me interrupt just because I have
2152 such limited time. I always say, though, anything that
2153 creates according to the CBO enumerable boards,
2154 bureaucracies, and commissions does not decrease
2155 administrative costs.

2156 But Dr. Chernew, now, I am very interested in what you
2157 described Blue Cross doing in Massachusetts. But on the

2158 other hand, Massachusetts, which is kind of a forerunner of
2159 PPACA, has the highest, I mean, literally, the highest
2160 private insurance premiums in the Nation, and so my concern
2161 is that, again, the forerunner of PPACA has resulted in the
2162 highest private insurance premiums in the Nation. So how has
2163 the program you described, which is incredibly intriguing,
2164 thwarted that, contributed to that? I mean, it seems kind of
2165 a discordance where you have high premiums and yet you have
2166 what is on paper seems like an effective intervention.

2167 Dr. {Chernew.} Right. I am not prepared to defend all
2168 of Massachusetts and the differences of Massachusetts
2169 healthcare. We could discuss it at greater length, but I
2170 think the easy answer to your question is the AQC wasn't
2171 designed initially to save money in the first years. As I
2172 mentioned in response to an earlier question, it doesn't
2173 lower the amount of money that any physician group gets paid,
2174 and in fact, the physician groups are more efficient. A lot
2175 of that is captured by the physicians. It is not captured by
2176 the plan.

2177 The goal of the AQC has been to give physicians the
2178 power to control that trend through say, for example, a very
2179 primary care center the way Dr. Goertz described, and so the
2180 evaluations of what it is going to do are ongoing but
2181 ultimately its impact on spending and trends are specified in

2182 the 5-year trajectory and relative to what had been projected
2183 in Massachusetts, which had been growing at about the same
2184 rate, it was designed to save money off of trend, not to
2185 lower fees.

2186 And so in the end what matters is how much you allow
2187 the--

2188 Dr. {Cassidy.} Is there an initial indication that it
2189 is saving money on the trend?

2190 Dr. {Chernew.} There has only been 1 year of experience
2191 so--

2192 Dr. {Cassidy.} And then let me ask you another because
2193 I have such limited time. Now, the medical loss ratio, is
2194 that 15 percent in Massachusetts?

2195 Dr. {Chernew.} I am not aware of what the medical loss
2196 ratio is in Massachusetts.

2197 Dr. {Cassidy.} And the only reason I ask that is
2198 because clearly there is an informational infrastructure
2199 required of the insurance companies.

2200 Dr. {Chernew.} Yes.

2201 Dr. {Cassidy.} Now, on the other hand if you have high
2202 premiums, again, if you have the highest in the Nation, 15
2203 percent of something high gives you something pretty high.
2204 Fifteen percent in a lower State which doesn't have this sort
2205 of precursor PPACA which may be lower, that absolute dollar

2206 is less.

2207 Can you incorporate this with an artificial medical loss
2208 ratio of 15 percent?

2209 Dr. {Chernew.} I agree with the premise of your
2210 question that there is going to be some spending that is not
2211 countered in the medical loss ratio that is very important to
2212 control spending, and you want to make sure that medical loss
2213 ratios don't impede your ability to innovate, and if that is
2214 the gist of your question, I agree with you.

2215 Dr. {Cassidy.} Okay. Fantastic. Dr. McClellan, now, I
2216 got to tell you, I see my New England Journal medicine
2217 article which shows that ACOs and these demonstration
2218 projects which are picked to succeed, that they typically
2219 don't succeed in terms of saving money, and when everybody
2220 says we are going to save money with ACOs and yet the best
2221 analysis from the best demonstration project show that they
2222 don't, how can we hang our hat on this, particularly after
2223 that incomprehensible rule put out by CMS?

2224 Dr. {McClellan.} Well, setting aside the rule I think
2225 the New England Journal you are referring to summarized the
2226 experience under a demonstration program that we started
2227 while I was there, and what it found was that out of the ten
2228 groups that participated every single one of those physician
2229 groups significantly improved the care for their

2230 beneficiaries. They led to significant overall savings in
2231 Medicare costs, and five out of the ten got to levels of
2232 savings of 2 percentage points per year, which is in the kind
2233 of realm that would make Medicare--

2234 Dr. {Cassidy.} Now, if I may quote, ``It seems highly
2235 unlikely that the newly-established, independent practices
2236 would be able to average the necessary 20 percent of return
2237 on their investment.'' I am quoting from the article. ``The
2238 main investment of,'' I could go on, but it actually disputes
2239 a little bit your assertions.

2240 Dr. {McClellan.} Well, I think what the article is
2241 pointing out is that for physicians to change their practices
2242 in ways that improve care takes an investment upfront, and if
2243 all they are getting is this shared savings on the backend,
2244 that by itself may not be enough, and that is essentially one
2245 of the core concerns that people have raised about the
2246 proposed regulation, and I agree.

2247 We need to be looking at reforms that give enough
2248 support upfront to enable the kinds of backend savings to
2249 bend the cost curve. What we are seeing in a lot of the
2250 private insurers who have implemented ACOs is a combination
2251 of approaches. They don't just like pick one and do that for
2252 5 years and then wait and do something else. They are trying
2253 to comprehensively work with providers to solve this problem.

2254 So they do something like medical home payments upfront
2255 as we talked about before, more resources for primary care.

2256 Dr. {Cassidy.} Let me interrupt. The chairman has been
2257 very generous, but we are already a minute, 20 over. I
2258 appreciate that. I would appreciate your complete response--

2259 Dr. {McClellan.} I would be delighted to follow up with
2260 you.

2261 Dr. {Cassidy.} --and I would like to submit for the
2262 record something that Dr. Goertz would agree with from Q
2263 Alliance regarding the direct medical home for the record.

2264 Mr. {Pitts.} Without objection so ordered.

2265 [The information follows:]

2266 ***** COMMITTEE INSERT *****

|
2267 Mr. {Pitts.} Thank--the chair thanks the gentleman and
2268 now recognizes the gentlelady from Wisconsin, Ms. Baldwin,
2269 for 5 minutes for questions.

2270 Ms. {Baldwin.} Thank you, Mr. Chairman, and I also want
2271 to extend my gratitude to the panel for being here and also
2272 to add my comments to those who mentioned earlier that it is
2273 great to see the bipartisan leadership of this subcommittee
2274 and full committee working together on this critical issue.

2275 As we talk today about the importance of repealing the
2276 Sustainable Growth Rate, we also have to focus on replacing
2277 the Medicare Fee-For-Service Payment System with a model that
2278 has some better incentives aligned rewarding quality,
2279 controlling costs, and I would like to sort of add the new
2280 layer of incenting us to involve patients as partners in
2281 their healthcare, something I haven't heard a lot about, but
2282 of course, we have a panel of physicians, and I am sure later
2283 in this session as we dig down in this issue that we will
2284 hear from patient groups and that role, too.

2285 We are all representatives, we all represent certain
2286 geographical areas of this country, and as such we tend to
2287 follow closely what is happening in our home turf. I happen
2288 to represent South Central Wisconsin in the U.S. Congress,
2289 and I think based on what I have learned from some of my home

2290 State practitioners, there is a lot we can learn from what is
2291 going on in the State of Wisconsin.

2292 Providers there have been at the forefront of adopting
2293 innovative models that have demonstrated high quality and
2294 value. They have proved that implementing a system where
2295 there is a high level of integration and where doctors are
2296 responsible for managing patient populations can produce high
2297 quality and low cost care.

2298 I guess I want to focus a little bit on one such
2299 delivery model that has produced successful outcomes in
2300 Wisconsin, and Dr. Goertz has talked about it extensively in
2301 his testimony, the patient-centered medical home. That model
2302 focuses on the productive roll a primary care physician can
2303 play in providing and coordinating care, and we know how
2304 important the primary care field is in improving healthcare
2305 outcomes. They recommend preventative measures, help
2306 patients manage chronic conditions, and keep patients out of
2307 high-cost emergency room settings.

2308 I know all of you know that in a medical home model the
2309 practice-based care team takes collective responsibility for
2310 a patient's ongoing care, and this team coordinates the
2311 patient's care across care settings and fields and maintains
2312 a personal relationship, the patient, with their personal
2313 care physician.

2314 One system in my district, Dean Health System, has
2315 tested the patient-centered medical home model, and when
2316 establishing this model, they hit an initial roadblock which
2317 was basically finding that the fee-for-service model and
2318 Medicare, i.e., rewarding volume, is inherently contradictory
2319 to the patient-centered medical home model. This model
2320 relies on primary care providers carrying out and providing a
2321 significant number of tasks that improve quality and enhance
2322 efficiency, but these tasks are not reimbursable through the
2323 relative value unit-based compensation model.

2324 What Dean did instead was to establish its own
2325 reimbursement model to ensure sufficient reimbursement for
2326 this primary care model. Their innovative approach has
2327 really paid off. The quality of care in the systems medical
2328 homes has improved notably, and these models have achieved
2329 considerable improvements in efficiency measures.

2330 Today all of Dean's pilots have been certified by the
2331 National Committee for Quality Assurance. But, furthermore,
2332 there has been great patient feedback in terms of their
2333 happiness and satisfaction with this model. Their perception
2334 of access and satisfaction are higher for these patients who
2335 receive care through their medical home model.

2336 But perhaps the most notable achievement is that by
2337 embracing these innovative models Dean has achieved

2338 significant cost savings. Overall the system saw medical
2339 costs increase by only 2 percent in 2010, compared to the
2340 national average of 10.5 percent. Also, their pharmacy costs
2341 did not increase at all in 2010, while pharmacy costs across
2342 the Nation increased 9 percent last year.

2343 The successes that they had and other providers in
2344 Wisconsin have achieved would not have been possible in this
2345 sort of fee-for-service construct. For this reason up to
2346 this point the medical home model has really been limited to
2347 the private sector to the greatest extent.

2348 So, Dr. Goertz, could you elaborate a little bit on how
2349 moving away from the fee-for-service model and expanding the
2350 patient-centered medical home to public payers like Medicare
2351 could help realize the goal of providing this high quality
2352 care for lower costs but also this increased potential of
2353 involving patients in managing and in partnership with their
2354 physicians and nurses in managing their own care?

2355 Dr. {Goertz.} Thank you for that question. One of the
2356 interesting things about the patients in the medical home is
2357 when we evolved that in the early 2000s, we took in a lot of
2358 information from patients themselves about what they wanted
2359 and designed it, and to the chagrin of our members we
2360 designed it without caring about how it was going to be paid
2361 for. And then we turned around and said, how are we going to

2362 pay for this model that we designed to give the care for
2363 patients the way we know it can be done and still have the
2364 resources to run the practices.

2365 So my response is the commercial payers and the models
2366 that they have already put in place show it works, but it
2367 takes looking at the entire spectrum where costs are laid in
2368 the system, and until you allow us to look at the entire
2369 panorama of where costs are, you are never going to fix it.
2370 You just can't, and that--the patient-centered medical home
2371 seeks to have the patient get the care where they need it by
2372 the right people in the team without regard to those other
2373 pieces, and it seeks to involve the patient in how care is
2374 given.

2375 Mr. {Pitts.} The chair thanks the gentlelady and
2376 recognizes the gentleman from Pennsylvania, Dr. Murphy, for 5
2377 minutes for questions.

2378 Mr. {Murphy.} Thank the panel. It is good to see some
2379 of you here again.

2380 Back in the 1990s when I was a State Senator I authored
2381 and we passed into law, actually got bipartisan support, a
2382 Patient Bill of Rights Law, and much of that was dealing with
2383 at that time the problems of managed care, where we found out
2384 it was more about managing money from people outside the
2385 doctor's office and with insurance companies than it really

2386 was about managing care.

2387 So I am wondering, Mr. Miller, if you could elaborate a
2388 little bit more on this. You and I have had conversations in
2389 the past, but if you could give, and I apologize I couldn't
2390 do some of this before. I had run into other things. Give
2391 me an example or two of how this actually works and we make
2392 sure the incentive is not to not provide services because the
2393 breakdown before of managed care was if somebody had a pool
2394 of money in their account, they kept that money by not
2395 providing care.

2396 Could you tell us how it actually works to make sure
2397 they are providing better care?

2398 Mr. {Miller.} Well, in several ways. First of all, I
2399 think that it is important that this be controlled by
2400 physicians, not by health plans, and I think that is really
2401 the promise of whatever the unicorn ultimately looks like
2402 when you talk about accountable care organizations is that
2403 those really need to be controlled by the healthcare
2404 providers, the physicians, the nurses, et cetera, not by
2405 outside health plans. So that is number one because I think
2406 they will be very reluctant to deliver poor quality care.

2407 The second thing is to actually have good measurement of
2408 the quality of care so that they know how they are doing and
2409 the public knows how they are doing, and that is happening in

2410 a number of communities around the country that are reporting
2411 on the quality of care so that patients can make good
2412 choices.

2413 I think the second thing, third thing is that there
2414 needs to be choices about where patients can go which is why
2415 it is very important to not have requirements and regulations
2416 that only limit this to being very large organizations or
2417 that encourage consolidation of entities into one large
2418 monopoly but to be able to let small practices be able to
2419 participate in this particular fashion.

2420 And I think that is what we--there are models like that
2421 around the country where physician practices are taking
2422 capitation payments, risk adjusted or otherwise, and are
2423 delivering very high-quality care to their patients, and they
2424 are in control.

2425 Mr. {Murphy.} As this becomes an issue, I know one of
2426 the battles we had was the issue of any willing, qualified
2427 provider, and I always felt that if you eliminated people
2428 from being able to--providers from being able to compete by
2429 quality for service, they were out of the loop, and those--
2430 once they had locked in a contract, it was actually a
2431 disincentive for them because they didn't have the
2432 competition anymore. Is that what you are referring to by
2433 allowing patients actually to have some choices?

2434 Mr. {Miller.} Yes. That is right, and patients having
2435 choices based on both what the cost and the quality of the
2436 care is rather than either being locked into a particular
2437 provider because of what an insurance company determines or
2438 essentially having no choice because of the nature of the
2439 organization and the community. So to have a maximum number
2440 of opportunities to choose their provider I think helps to
2441 support that.

2442 Mr. {Murphy.} I mean, this is an area that dealing with
2443 actual disease management is such a huge issue in healthcare
2444 in America, and yet I am still amazed that the way that
2445 Medicare and Medicaid work, designed in 1965, and I would
2446 venture to guess that none of us as healthcare providers
2447 would want to brag to our patients, by the way, I bought no
2448 equipment since 1965, haven't read a single medical journal,
2449 or been to continuing education credits from 1965, and proud
2450 of it, but that is how our system works. You only get paid
2451 if you poke, prod, push, pull, or pinch someone but not if
2452 you make them better.

2453 A secondary I just want--this whole panel can help. I
2454 think it is the absurdity, so I am correct in understanding
2455 that if someone is on Medicare, and a physician is taking,
2456 you know, balanced billing, and they say to the patient, you
2457 know, look. I understand you are low income. I will just

2458 take whatever Medicare pays me, and I will leave it at that.

2459 They are not allowed to do that? Is that correct, panel?

2460 Dr. {Williamson.} That is correct. That is correct.

2461 Mr. {Murphy.} So as a doctor I am saying, you know, I
2462 am just going to waive this. Here. You baked a pie for me,
2463 good enough, thank you, Mrs. Smith. You can walk away. Then
2464 that doctor is committing a crime?

2465 Dr. {Williamson.} Civil and criminal penalties. Yes,
2466 sir.

2467 Mr. {Murphy.} And how big is the penalty?

2468 Dr. {Williamson.} I don't have that number. I am
2469 sorry.

2470 Mr. {Murphy.} But it is big. Civil and criminal
2471 penalty.

2472 Dr. {Williamson.} It gets the attention of doctors.

2473 Mr. {Murphy.} And if a doctor also says, you know, I
2474 think I can do this better by managing, by making calls to
2475 you, making sure you are taking your medication. It is like
2476 75 percent of prescriptions aren't taken correctly from
2477 beginning to end. If a doctor decides to have a nurse in the
2478 office manage that call and take care of those things and
2479 actually keep that person out of the hospital but doesn't
2480 even bill for that providing a service, does this also go
2481 under the category of they are doing something illegal? They

2482 are providing a service and care without billing for it?

2483 Dr. {Goertz.} That is not illegal. You just don't get
2484 any compensation for helping the patient.

2485 Mr. {Murphy.} Oh, well, that is--okay. But it still
2486 comes down to so if--it is absolutely amazing, and Mr.
2487 Chairman, I hope we get more into this, because the Medicare
2488 and Medicaid Systems in my mind are so hopelessly outmoded
2489 that the old tool, when everything looks like a hammer,
2490 everything--when the only tool is a hammer, everything looks
2491 like a nail, and all Congress knows how to do is giveth and
2492 taketh away. We spend a dollar, we take away a dollar.

2493 But on this issue to have spent nearly almost half a
2494 century of time using the same system without fixing this is
2495 preposterous, and I believe it is imperative to the
2496 physicians' abilities to work on these things to change the
2497 system.

2498 So I hope we can get back to this in the future. Thank
2499 you.

2500 Mr. {Pitts.} The chair thanks the gentleman and
2501 recognizes the gentleman from New Jersey, Mr. Lance, for 5
2502 minutes for questions.

2503 Mr. {Lance.} Thank you, Mr. Chairman. Good afternoon
2504 to this distinguished panel. Following up on Congresswoman
2505 Baldwin's questioning which I found very interesting, Mr.

2506 Miller, in your testimony to do mention the accountable
2507 medical homes as being a type of transition payment system,
2508 and in your comments you discuss developing specific targets
2509 for reducing utilization of healthcare services outside the
2510 physician practice.

2511 How would these targets be developed, and are they ready
2512 to be employed in the near term?

2513 Mr. {Miller.} Yes. In fact, the State of Washington
2514 and the Puget Sound Health Alliance have been working on this
2515 and are implementing that program this month where a group of
2516 small primary care practices around the State have done that.

2517 Now, getting there was a challenge because, first of
2518 all, you have to have the data to be able to determine what
2519 your current rates of ER visits and hospitalizations are, and
2520 that was a real challenge to primary care practices to even
2521 think about it because they don't have that data right now.
2522 Surprising enough it was even difficult for some of the
2523 health plans to deliver that data to them, but once we were
2524 able to get it, it made clear that there were fairly high
2525 rates of emergency room utilization for non-urgent reasons.

2526 And so the idea was to give the primary care practices
2527 some flexible resources that they could use to hire a nurse,
2528 to have longer office hours, et cetera, and to--and we
2529 calculated that with the kinds of reductions, just to take ER

2530 visits, the kinds of reductions in ER visits that many of the
2531 medical home programs that Dr. Goertz talked about have
2532 achieved, that they would be able to save more money for the
2533 health plans and the amount of flexible resources that they
2534 were getting upfront.

2535 So a number of practices have signed up to do that this
2536 year through the payment, and the challenge locally was to
2537 get eight different health plans and Medicaid to agree, and
2538 Medicare is not at the table.

2539 Mr. {Lance.} And in your judgment why is that the case?
2540 Why is Medicare not at the table?

2541 Mr. {Miller.} Because Medicare does not have a payment
2542 model now that would support that. In fact, Washington
2543 applied to be in the multi-payer advanced primary care
2544 demonstration and was not selected. And so they will be
2545 actually, they will be saving Medicare money because they
2546 will do it for all of their patients, not just their Medicaid
2547 and commercial patients, but they won't get the money to be
2548 able to support that at the level that they really need.

2549 Mr. {Lance.} Thank you. In your remarks, Dr. Chernew,
2550 in your prepared remarks you state, and I am quoting now,
2551 ``Just to give one example, a colonoscopy performed in a
2552 physician's office costs Medicare on average about half of
2553 the cost if it is performed in a hospital outpatient setting.

2554 This largely reflects different treatment of the technical
2555 fee for providing the service, which may be justified, but it
2556 is difficult to assess the appropriate fee differential, if
2557 any because case mix and other factors are hard to observe.''

2558 Could you elaborate for me a little bit on that?

2559 Dr. {Chernew.} Sure. So fee-for-service systems are
2560 incredibly unwieldy, and ours is particularly unwieldy, and
2561 the amount you get paid for something depends on where it is
2562 done, because, remember, there is payments to the physician,
2563 but there is also payments to a facility. And so if you move
2564 the service from one setting to another setting, in some
2565 cases the physician is getting both the professional and the
2566 technical fee, and in other cases the physician is just
2567 getting the professional part. The technical part is going
2568 somewhere else, but those technical fees aren't fixed. It
2569 differs based on what is in the physician fee and what is in
2570 say the hospital setting. And so there is differences, and
2571 that is just one example of where the difference is.

2572 It is easy to say that, well, we should set them the
2573 same, technical should be the same, and what people in the
2574 hospital would tell you is, yes, but the patients that we are
2575 seeing in the hospital have a whole series of other
2576 comorbidities, it is more difficult to treat them for one
2577 reason or another. Our technical fee, albeit higher, is

2578 justified because of some aspect of the patient or the care
2579 we deliver that is different than the care that is delivered
2580 if you are doing the same procedure in a physician's office.

2581 If you knew what that cost difference was, if someone
2582 came down from on high and told you this was what the cost
2583 difference was, you might be able to manage that reasonably
2584 well.

2585 Mr. {Lance.} So we have a responsibility working
2586 together on a bipartisan capacity with experts such as the
2587 distinguished panel here to try to overcome that to make it
2588 less expensive.

2589 Dr. {Chernew.} So my view is we will be hopelessly
2590 mired in the morass of fee management if we stay for too long
2591 in a basically fee-for-service system.

2592 Mr. {Lance.} Yes.

2593 Dr. {Chernew.} And so moving away from the system in my
2594 view is a long-run solution. We have to mitigate the
2595 problems in the short run no doubt, but I am not a believer
2596 in the government's ability or anyone's ability to
2597 micromanage these crazy fee schedules all that well.

2598 Mr. {Lance.} Thank you, and I hope we not hopelessly
2599 mired in the system. Thank you very much, Mr. Chairman.

2600 Mr. {Pitts.} The chair thanks the gentleman. That
2601 concludes the first round of questions, and we will go now to

2602 follow up. I will yield first to Dr. Burgess for questions.

2603 Dr. {Burgess.} Thank you, Mr. Chairman.

2604 Dr. Goertz, if I could ask you because this has come up
2605 several times on, I think Dr. Wilson mentioned the 78 percent
2606 of the people in Medicare who suffer from chronic disease.
2607 So the universe of people that are dual eligibles and I think
2608 Dr. Williamson said he would exclude those from the direct
2609 contracting, but honestly, that may be the group where you
2610 want to focus the direct contracting.

2611 If you provided each of the dual eligibles with a
2612 concierged physician, a navigator, a facilitator that could
2613 be with them through all this, maybe a doctor, maybe a nurse
2614 practitioner, we could argue about that, but it seems like
2615 that is, you know, Willie Sutton used to rob banks because
2616 that is where the money was. I mean, Dr. Berwick has told us
2617 this is where the money is. Dr. Wilson reaffirmed today that
2618 this is where the money is. Eighty percent of Medicare,
2619 which is a lot, is spent by 20 percent of the patients.

2620 What do you think about that?

2621 Dr. {Goertz.} Our organization is in favor of any
2622 innovative model that addresses coordination and information
2623 sharing among all the team members who need to take care of
2624 that patient.

2625 Dr. {Burgess.} But here is the problem. Mr. Miller

2626 told us that Medicare has no payment model for that type of
2627 activity. Is that--did I understand that correctly?

2628 Dr. {Goertz.} In our opinion it does not.

2629 Dr. {Burgess.} So really all the smart people at the
2630 table if you will tell us how to construct that demonstration
2631 project where we can demonstrate that level of savings, I
2632 mean, I will be happy to take that to Dr. Berwick and spend
2633 some time with him and see if we cannot either
2634 administratively or legislatively make that change happen
2635 because, I mean, truly that is the low-hanging fruit that we
2636 should be talking about. Is that not correct? Does anybody
2637 disagree with that?

2638 So, again, we have offered a challenge to the panel
2639 assembled here today. Help us craft that as a, whatever you
2640 want to call it, demonstration project or whatever, and let's
2641 see if we can do so in a way. We have got to be careful
2642 because Dr. McClellan worked very hard on the physician group
2643 practice demonstration project with Secretary Leavitt, and
2644 now, of course, we have got a series of rules that are
2645 unworkable.

2646 So it is, there is a problem in our system, and we have
2647 all identified it, but this is one that I would be anxious to
2648 work with you all on this and even, you know, Dr. Williamson,
2649 I thank you for bringing the idea forward that, okay, we

2650 would separate this group of patients out of direct
2651 contracting, but really if we are going to save the money, we
2652 won't call it direct contracting because that upsets too many
2653 people, but let's help that group of patients navigate the
2654 system and spend dollars more efficiently. That is where we
2655 could perhaps do the most good, not on the margins of the
2656 people who might, in fact, be in a direct contracting type of
2657 world.

2658 Yes, sir.

2659 Mr. {Miller.} I just say quickly, the models that we
2660 talked about can help with that, but it is also an example of
2661 how you can't have one size fits all, because some of those
2662 patients who need much more intensive help need to have a
2663 payment model that supports that, and it may be a lot of
2664 money for different things than they are getting now with the
2665 opportunity to save a lot of money on the other side.

2666 And there has been a lot of attention recently, for
2667 example, the Boeing model on the West Coast has focused on
2668 some of those highly-complex patients, project in New Jersey
2669 is focused on those kind of patients and showing very
2670 significant savings.

2671 But you also have to have some very significant reach
2672 change in the way care is delivered and a payment model to
2673 support that.

2674 Dr. {Burgess.} Yes, and I would not quarrel with that.
2675 You know, one of the things that I have heard over and over
2676 again today when Ms. Capps was in here talking about nurse
2677 practitioners, very frustrating. I mean, again, Dr.
2678 McClellan and Secretary Leavitt working on the Medicare
2679 Advantage Program in the mid 2000s, which we, of course,
2680 robbed in the Patient Protection Affordable Care Act and now
2681 given a waiver, but this was the whole idea if I remember
2682 correctly. It was a disease-management care coordination,
2683 electronic health records, you do all these things in return
2684 for perhaps a little bit more reimbursement in the Medicare
2685 Advantage System.

2686 Dr. McClellan, do I recall that system correctly?

2687 Dr. {McClellan.} Yes. There have been a number of
2688 steps to try to get even specialized Medicare Advantage Plans
2689 or dual eligibles and people with complex illnesses, and
2690 those programs can work, but you are right. This is the
2691 population that could benefit the most from well-coordinated
2692 care and has the most fragmented payments. So it is a lot of
2693 obstacles to overcome.

2694 Dr. {Burgess.} Well, could we use that leverage and
2695 pivot, you know, perhaps our discussion of SGR reform to
2696 actually get to a more sensible system for those patients
2697 that are involved with spending the most money in the

2698 Medicare System? I mean, would that not be a correct
2699 approach to take?

2700 Dr. {McClellan.} I agree, and I think it, again,
2701 highlights the importance of this effort focusing on clear
2702 opportunities to improve care for particular kinds of
2703 patients, particular types of medical care and recognizing
2704 that the physician payment system can make a big difference
2705 in that, but there are other changes that are going on and
2706 other opportunities in Medicare today to reinforce and
2707 support those changes through steps like the measures used in
2708 the Medicare Advantage Program and the way the Medicare
2709 Advantage Program is set up.

2710 So those are all feasible.

2711 Dr. {Burgess.} Well, let me just say just as a wrap-up,
2712 Dr. Wilson, I really want you to concentrate on the
2713 maintenance of professionalism within our profession. As we
2714 see more of these things develop, ACOs, whatever the system
2715 is, there is an inherent danger for the doctor not to be the
2716 advocate for the patient, and historically we know that is
2717 correct relationship for the doctor to have with the patient.
2718 The health plan can't advocate for the--adequate advocate for
2719 the patient, the hospital can't be an adequate advocate. It
2720 has to be the physician. There has to be the maintenance of
2721 the professionalism within the profession, and I thank you

2722 for taking on that task.

2723 Mr. {Pitts.} The chair thanks the gentleman. We are
2724 voting on the Floor. We are going to try to wrap this up.

2725 I will recognize Mr. Pallone for follow up and then Dr.
2726 Gingrey.

2727 Mr. {Pallone.} I just wanted to ask either Dr. Chernew
2728 or Dr. Miller, you can both respond if you want, the idea
2729 that Medicare should abdicate its responsibilities to protect
2730 seniors from exorbitant cost sharing in the name of private
2731 contracting, the idea that Medicare shouldn't place limits on
2732 the cost of care has been floated in a bill that was
2733 introduced by Representative Price and supported by some
2734 physician witnesses before the committee.

2735 The idea of unlimited balanced billing, of course, is
2736 not new, but it is one of the oldest requests of providers in
2737 Medicare to be able to charge whatever you want. But I want
2738 talk about the beneficiary impact. We don't have any
2739 beneficiary representatives on the panel here today, which is
2740 a shame, but I note that ARP in a letter strongly opposes
2741 efforts to increase beneficiary costs through private
2742 contracting. As I understand it this idea of balanced
2743 billing is not something that is very common in private
2744 sector networks.

2745 So maybe I will ask Dr. Chernew, in your work observing

2746 private health plans have you noticed a trend towards
2747 allowing physicians to bill enrollees in network, whatever
2748 they like, and if Mr. Miller wants to respond, too.

2749 Dr. {Chernew.} I have not noticed that trend, and I
2750 will save longer responses if you want.

2751 Mr. {Miller.} I think that the key thing is that there
2752 is no one change that is either desirable or necessary that
2753 will fix the system, that multiple things have to be done
2754 simultaneously, and that keeping the current fee-for-service
2755 structure and simply trying to fix it with one change may not
2756 do the kind of thing that you want and may lead to other
2757 kinds of problems.

2758 I do think that it makes sense, though, that patients
2759 have more sensitivity to the cost of services and that
2760 physicians and providers not be constrained as to whether
2761 they can deliver care based on what Medicare decides to pay
2762 them.

2763 So mechanisms that would enable them to set the right
2764 price as Dr. Chernew said earlier, as well as what the
2765 payment structure is, are going to be very important. But I
2766 think that you have to have a comprehensive set of reforms
2767 that changes the way the payment is made as well as what the
2768 patients' responsibility is.

2769 Mr. {Pallone.} I mean, I just wanted to mention, you

2770 know, choices beneficiaries would be forced to make in this
2771 situation because they are just overwhelming. I asked my
2772 staff to look at what a patient would need to consider by way
2773 of prices and in negotiation with a physician over a course
2774 of several treatment options for prostate cancer, for
2775 instance, and just to read a few, and maybe I will enter it
2776 into the record, extensive prostate surgery which there are
2777 five variations listed for Medicare with prices ranging from
2778 \$1,100 to \$1,700, removal of prostate, three variations
2779 ranging from \$900 to \$1,100, intensity modulated radiation
2780 therapy, seven--\$567 per dose, but the number of doses
2781 required varies significantly from person to person. The
2782 dose plan for that therapy, \$400 to \$2,100. I mean, just to
2783 give you some examples.

2784 Dr. Chernew.

2785 Dr. {Chernew.} I guess what I would say broadly is the
2786 concern that I would have with these types of programs for
2787 starters--actually, let me say for starters, I believe in
2788 markets. I am an economist. I like markets as much as the
2789 next guy, in fact, probably more so. I am concerned in this
2790 case about market power. I am concerned that while I believe
2791 consumers can drive down prices for iPads, I am not so sure
2792 they can do that in healthcare for some of the reasons that
2793 you say.

2794 In Ann Arbor there was a situation where the faculty, I
2795 have been told anecdotally lobbied to get dental coverage for
2796 routine care. It was \$60. They got the coverage for \$60 per
2797 visit. The prices went up to \$120.

2798 So I think if there is competition, you can solve these
2799 problems. I am not so sure there always is, and you have to
2800 be worried about. I think it is particularly hard in the
2801 Medicare population because you have a lot of people, at
2802 least like my grandparents, that are cognitively impaired,
2803 and so there is a concern about their ability to do some of
2804 these things, and obviously there is issues of disparities.

2805 My biggest concern would be that it would give you all
2806 frankly a path to keep Medicare rates lower than they
2807 otherwise would be, and I think that you shouldn't have an
2808 excuse for under-funding Medicare, and I worry that this
2809 might give you that excuse.

2810 But on the other hand I haven't studies this particular
2811 issue, and I don't have a particular position on it, but I do
2812 have the concerns that I outlined going forward in such a
2813 way.

2814 Mr. {Pallone.} Thank you. Thank you, Mr. Chairman.

2815 Mr. {Pitts.} The chair thanks the gentleman, and we are
2816 running out of time. Dr. Gingrey, you are recognized for
2817 questioning.

2818 Dr. {Gingrey.} Mr. Chairman, thank you very much, and I
2819 will try to get right to it.

2820 Dr. McClellan, I have got a letter in my hand that was
2821 actually sent to the House GOP Doctors' Caucus, April 15,
2822 2011, subject, Reforming the Medicare Physician Payment
2823 System. The letter advocates new payment model options,
2824 including pay for performance, bundle payments to groups of
2825 physicians, or even blending elements of multiple models.
2826 The letter states that allowing Medicare to create multiple
2827 care models is important because there is no one-size-fits-
2828 all payment model that will achieve physicians and
2829 policymakers objectives for improved care and affordability.
2830 I am kind of quoting from the letter.

2831 What are your thoughts on the value of multiple care
2832 models as a solution to the SGR problem?

2833 Dr. {McClellan.} Well, Dr. Gingrey, you heard today
2834 there are a lot of models that can help support better care.
2835 I think what unifies them is not the jargon but the fact that
2836 they all can be linked to specific, meaningful steps to give
2837 patients better care that the surgeons have identified, the
2838 primary care physicians have identified, that all of these
2839 leaders from Madison have identified. And by focusing the
2840 reforms that this committee undertakes on actually achieving
2841 those improvements in care, I think we can target them more

2842 effectively.

2843 I would emphasize that that not only means leadership
2844 for physicians on identifying specific kinds of payment
2845 reforms but especially leadership on identifying how they can
2846 make care better by changing the payments because Medicare
2847 doesn't support all this now, and then accountability for
2848 doing that. You know, the quality impact, we have talked a
2849 lot about measures, and the cost impact, too, and that is a
2850 challenge, but we know so much more than we did a few years
2851 ago about this. There is so much more physician leadership
2852 now on these questions and especially with so many physicians
2853 in the House hopefully we can have--

2854 Dr. {Gingrey.} Yes. We got 21 now.

2855 Dr. {McClellan.} Right.

2856 Dr. {Gingrey.} Yes. I saw--I will stick with you just
2857 for a second, in your opinion does the solution to the SGR,
2858 Sustainable Growth Rate, lie simply in reforming how
2859 providers are paid, or do you believe a review of how
2860 Medicare benefits are structured, whether--we have talked
2861 about concierge care, even the private contracting I know has
2862 come up a number of times this morning might help bring about
2863 meaningful reform in physician payments.

2864 Dr. {McClellan.} Benefit reforms would really help and
2865 would emphasize that a lot of these private sector

2866 implementations of payment reforms go along with benefit
2867 reforms to actually save beneficiaries money by giving it
2868 more financial support to stay with their meds, to take their
2869 meds, to stay out of the hospital.

2870 Dr. {Gingrey.} Well, I know Dr. Williamson also talked
2871 about that in his testimony, and, Todd, I will go to you on
2872 this. You cite the benefits of private contracting within
2873 Medicare including the ability for the physicians to charge
2874 seniors less than they pay today in their out-of-pocket
2875 costs. As a medical provider of neurology why can't you
2876 charge a poor senior less than the Medicare-required rate?

2877 Dr. {Williamson.} We would subsequently be subsequent
2878 to penalties, criminal and civil as I said, and you know, I
2879 can tell you doctors want to do that a lot, but they can't.
2880 That is one thing that we frequently hear from our practice
2881 managers is you can't do this.

2882 And, you know, our premise is that doctors and patients
2883 should be free to define the value of their interaction. You
2884 know, the government has the responsibility to fulfill its
2885 promise to Medicare recipients. It was suggested earlier
2886 that private contracting might get the government a pass to
2887 not fulfill that promise. That is not what the Medicare
2888 Payment Empowerment Act is about. It wouldn't change any of
2889 the existing benefits that patients now have under Medicare.

2890 What it would allow is patients to have the option, if they
2891 could afford and they chose to, to spend their own money on
2892 their medical care, and it would not require them to forego
2893 their Medicare benefits if they want to see a doctor outside
2894 the Medicare System as they have to do now, which we think is
2895 wrong. And we think it is wrong for a doctor to have to opt
2896 out of Medicare for 2 years if he or she provides care and
2897 accepts payment for that care to a Medicare patient.

2898 Dr. {Gingrey.} I had another part to that, but Mr.
2899 Chairman, I know we have got about a half a minute left on
2900 the vote, so I will yield back and just say thank you to all
2901 seven of our witnesses. You all have been fantastic today.
2902 We really appreciate it. Thank you.

2903 Mr. {Pitts.} The chair thanks the gentleman.

2904 This has been an excellent hearing, excellent testimony,
2905 and I think we have taken a big step today in moving beyond
2906 previous discussions of the deficiencies of the Sustainable
2907 Growth Rate System to an examination of the kind of payment
2908 and delivery system we need and how to get there.

2909 First of all, I want to thank all of the groups that
2910 responded to the committee's bipartisan letter asking for
2911 their suggestions. Their input has been very valuable, and I
2912 want to thank this distinguished panel of experts who took
2913 the time to testify here today in an effort to help solve

2914 this difficult but extremely important problem.

2915 I want to remind the members that they have 10 business
2916 days to submit questions for the record. I ask that the
2917 witnesses all agree to respond promptly to those questions.

2918 With that the subcommittee is adjourned.

2919 [Whereupon, at 12:58 p.m., the Subcommittee was
2920 adjourned.]