

****THIS TESTIMONY IS EMBARGOED UNTIL
2:00PM MAY 12, 2011****



**MEDICARE PHYSICIAN PAYMENT:
WE GET WHAT WE PAY FOR—HOW CAN WE GET WHAT
WE WANT?**

Stuart Guterman
Vice President, Payment and System Reform
Executive Director, Commission on a High Performance Health System
The Commonwealth Fund

Invited testimony
Way and Means Committee
Subcommittee on Health
U.S. House of Representatives
Hearing on “Reforming Medicare Physician Payments”
May 12, 2011

I would like to thank Karen Davis, John Craig, Anthony Shih, Cathy Schoen, Barry Scholl, Mark Zezza, and Rachel Nuzum for their helpful comments and suggestions.

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Thank you, Chairman Herger, Congressman Stark, and Members of the Subcommittee, for this invitation to testify on Medicare physician payment. I am Stuart Guterman, Vice President for Payment and System Reform at the Commonwealth Fund. The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Fund carries out this mission by supporting independent research on health care issues and making grants to improve health care practice and policy.

The Congress faces a challenging dilemma in considering Medicare physician payments: on the one hand, Medicare spending is rising at a rate that threatens the program's continued ability to fulfill its mission; on the other, the sustainable growth rate (SGR) mechanism, which is intended to address that problem, produces annual reductions in physician fees that are equally difficult to accept. This dilemma arises from the underlying mismatch between the primary cause of rising spending, which is the volume and intensity of services provided by physicians, and the focus of the SGR, which is to set the fees that physicians receive for each service they provide. Because the SGR neither controls the volume and intensity provided by the individual physician—and, in fact, may create an incentive to increase volume and intensity to offset reductions in fees or fails to adjust—nor adjusts fees selectively where volume growth is of concern, it does not address the underlying cause of physician or total spending growth. It is also important to remember that, although physician services account for only about 20 percent of total Medicare spending, physicians are instrumental in ordering tests, medications, referrals to other providers, and admissions to hospitals and other facilities; therefore, any discussion of physician spending also must take into account its effect on the system as a whole.

Determining how much to pay physicians certainly is an important issue, but of at least equal importance is determining how to pay physicians so that the Medicare program gets the best care possible for its beneficiaries. While the payment amount may have an effect on beneficiaries' access to physician services, the payment mechanism (as well as other

tools) can be used to make sure that the quality and appropriateness of medical care is maximized, so that beneficiaries' health status is enhanced and the Medicare program gets the most for the money it spends. In fact, there is evidence that, at least given the current state of the health care system, improved quality and reduced cost may both be achievable, and we can, at least in a relative sense, have our cake and eat it, too.

In this testimony, I will first discuss Medicare physician payment and some issues related to the SGR mechanism and the problems associated with it. I then will discuss the imperative for Medicare to become a better purchaser of health care, rather than remaining merely a payer for health services, and suggest some areas on which initiatives in this direction should focus. Finally, I will briefly discuss some of the promising initiatives that currently are underway in both the public and private sectors, and offer some opinions as to how they might be used to improve the Medicare program and the health care system in general.

THE SGR: ITS RATIONALE AND ITS FAILURE

Physicians are unique among Medicare providers in being subject to an aggregate spending adjustment. By contrast, Medicare facility-based services now are paid through prospective payment systems that set a price for a bundle of services. In these systems, the provider is free to make decisions about the volume of services provided to the patient and prices paid for services and supplies, but the payment for the bundle is fixed.

Physicians are unique in their role in determining the volume of services they can provide. Physicians are the gatekeepers and managers of the health care system; they direct and influence the type and amount of care their patients receive. Physicians, for example, not only can control the frequency of office visits for each patients, but also can order laboratory tests, radiological procedures, and surgery.

Moreover, the units of service for which physicians are paid under the Medicare are frequently very small. The physician therefore may receive payment for an office visit and separate payment for individual services such as administering tests and interpreting x-rays—all of which can be provided in a single visit. Contrast this with the hospital, which receives payment for each discharge, with no extra payment for additional services or days (except for extremely costly cases).

Further, once a physician's practice is established, the marginal costs of providing more services are primarily those associated with the physician's time. That means that any estimates of the actual cost of providing physician services are extremely malleable, because they are largely dependent on how the physician's time is valued. Even at that, there is no routinely available and auditable source of data on costs for individual physicians or even practices, such as there is for hospitals via the Medicare Cost Report.

Attempts to Control Spending by Adjusting for Volume and Intensity

In an attempt to control total spending for physicians' services driven by increases in volume (the quantity of services provided) and intensity (the mix of services), Congress in the Omnibus Budget Reconciliation Act of 1989 established a mechanism that set physician fees for each service and tied the annual update of those fees to the trend in total spending for physicians' services relative to a target. Under that approach, physician fees were to be updated annually to reflect increases in physicians' costs for providing care and adjusted by a factor that reflected the volume of services provided per beneficiary. The introduction of expenditure targets to the update formula in 1992 initiated a new approach to physician payments. Known as the volume performance standard (VPS), this approach provided a mechanism for adjusting fees to try to keep total physician spending on target.

The method for applying the VPS was fairly straightforward, but it led to updates that were unstable. Under the VPS approach, the expenditure target was based on the historical trend in volume and intensity. Any excess spending relative to the target triggered a reduction in the update two years later. But the VPS system depended heavily on the historical trend in volume and intensity, and the decline in that trend in the mid-1990s led to large increases in Medicare's fees for physicians' services. The Congress attempted to offset the budgetary effects of those increases by making successively larger cuts in fees, which further destabilized the update mechanism. That volatility led the Congress to modify the VPS in the Balanced Budget Act of 1997, replacing it with the sustainable growth rate mechanism in place today.

Like the VPS, the SGR method uses a target to adjust future payment rates and to control growth in Medicare's total expenditures for physicians' services. In contrast to the VPS, however, the target under the SGR mechanism is tied to growth in real (inflation-

adjusted) gross domestic product (GDP) per capita—a measure of growth in the resources per person that society has available. Moreover, unlike the VPS, the SGR adjusts physician payments by a factor that reflects cumulative spending relative to the target.

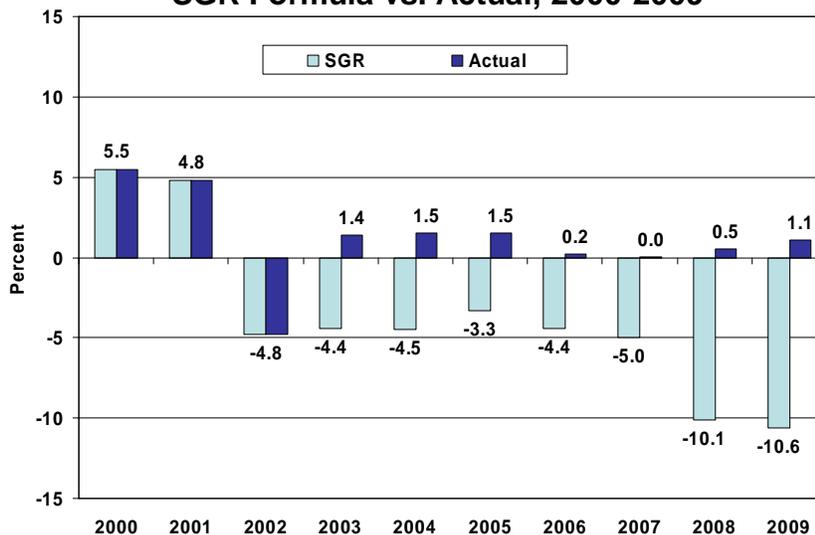
Policymakers saw the SGR approach as having the advantages of objectivity and stability in comparison with the VPS.¹ From a budgetary standpoint, the SGR method, like the VPS, is effective in limiting total payments to physicians over time. GDP growth provides an objective benchmark; moreover, changes in GDP from year to year have been considerably more stable (and generally smaller) than changes in the volume and intensity of physicians' services.

Problems with the SGR Mechanism

A key argument for switching from the VPS approach to the SGR mechanism was that over time, the VPS would produce inherently volatile updates; but updates under the SGR formula have proven to be volatile as well. From 1998 through 2001, that volatility was to the benefit of physicians: with strong economic growth, the increase in fees in the first three years the SGR formula was in place was more than 70 percent greater than the increase in the cost of practice (as measured by the Medicare Economic Index, or MEI) over the same period.

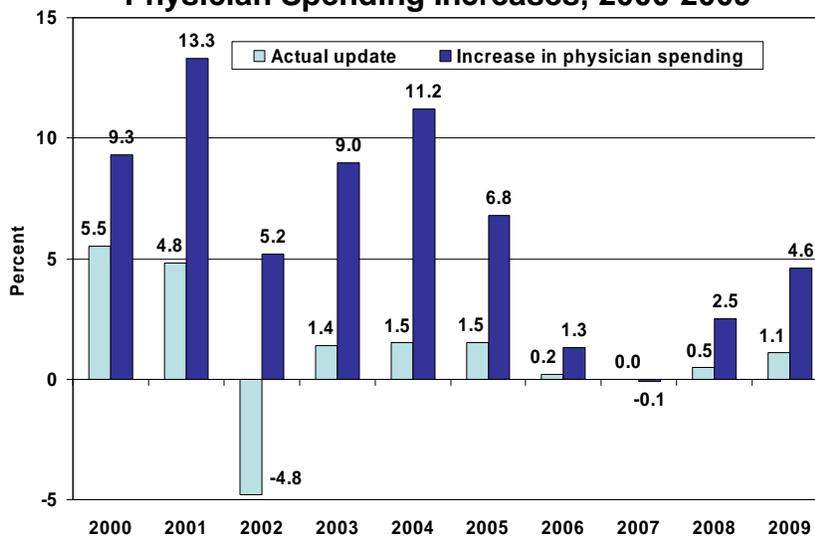
The pattern since then has been considerably different. In 2002, Medicare physician fees were reduced for the first time, by 4.8 percent; in succeeding years, the Congress has wrestled with a succession of negative updates produced by the SGR formula (Exhibit 1). Since 2002, reductions in physician fees have been avoided through a series of temporary measures—without addressing the widening gap between Medicare physician spending and the SGR target or its underlying causes (Exhibit 2). They have only postponed and exacerbated the cuts mandated by the SGR formula: in January 2012, when the latest measure expires, physician fees will be reduced by almost 30 percent unless there is Congressional action.

**Exhibit 1. Medicare Physician Fee Updates:
SGR Formula vs. Actual, 2000-2009**



Source: J. Hahn, "Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System." Congressional Research Service, August 2010.

**Exhibit 2. Medicare Physician Fee Updates and
Physician Spending Increases, 2000-2009**



Source: M.K. Clemens, "Estimated Sustainable Growth Rate and Conversion Factor for Medicare Payments to Physicians in 2011." Centers for Medicare and Medicaid Services Office of the Actuary, November 2010.

As the SGR hole gets deeper, it becomes harder to deal with: the Congressional Budget Office (CBO) estimates the ten-year cost of even a 10-year freeze of physician fees at

\$298 billion relative to current law. Moreover, this would cost Medicare beneficiaries billions of dollars in higher premiums and copayments under Medicare Part B (the Supplementary Medical Insurance that covers physician and other ambulatory care services). This large cost—and the concomitant increase in the federal budget deficit—has made it difficult for Congress to confront the SGR problem directly. Instead, Congress has postponed taking on the real problem by breaking it into smaller pieces.

The extra spending still occurs, however, whether it's one year at a time or in ten-year chunks. So, leaving the SGR mechanism in place:

- Threatens to reduce payment rates across-the-board, for every service, every specialty, and every area of the country, regardless of appropriateness, quality, and productivity;
- Maintains incentives for each physician to increase volume and intensity;
- Does not address the undervaluation of primary care services in the physician fee schedule or the overvaluation of more specialized services;
- Leads to increasing gaps between Medicare and private payment rates;
- Undermines the credibility of the Medicare program with physicians;
- Hinders the provision of incentives to improve care; and
- Fails to control Medicare spending growth.

The SGR therefore preserves all of the unfavorable aspects of fee-for-service payment while making health care improvements more difficult: it's hard to provide effective rewards for effective and efficient health care when the baseline is a 30 percent cut in physician fees.

THE NEED FOR CHANGE AND THE ROLE OF PAYMENT REFORM

The problem of rapidly rising health care spending is not unique to physician services and it is not unique to Medicare nor even to the public sector.² Excess cost growth—that is, the growth in spending per person—drives not only federal and state and local budget deficits, but also places an increasing burden on businesses and households.

Despite high and rapidly rising health care spending, the U.S. health system fails to deliver the kind of performance the nation should be able to expect. There is vast room

for improvement on an array of dimensions, including access and quality as well as efficiency.³ To accomplish that objective—to have a health system that consistently delivers appropriate, effective, and efficient care that produces good health at good value—requires fundamental reforms in the financing, organization, and delivery of health care.

Payment Innovation: A Key Component of Health Reform

Our health care delivery system is fragmented. Even when individual services meet high standards of clinical quality, there is often poor coordination of care across providers, services, and settings, as well as poor communication among providers and patients and their families. The focus is on high-cost, intensive medical interventions rather than high-value preventive and primary care. Most importantly, there is often a vacuum of accountability for the total care of patients, the outcomes they achieve, and the efficiency with which resources are used.

The way the nation pays for care fuels this fragmentation. The fee-for-service payment mechanism that typifies the U.S. health system emphasizes the provision of health services by individual providers rather than health care that is coordinated across providers to address the patient's needs. It undervalues primary care and preventive care, rewards volume and intensity, and does not recognize value, neglecting and even punishing providers' efforts to coordinate and improve care and failing to support the infrastructure required to make those efforts successful. As a result of these misplaced incentives, U.S. health spending continues to rise disproportionate to the value we receive for that spending—and threatening to exceed our ability to continue to afford it. If we are to achieve improved access, enhanced quality, and slower cost growth, the health care delivery system must be reformed, in a way that emphasizes coordinated, appropriate, and effective care, accountability for patient outcomes and population health, and more diligent stewardship of the nation's health care resources.

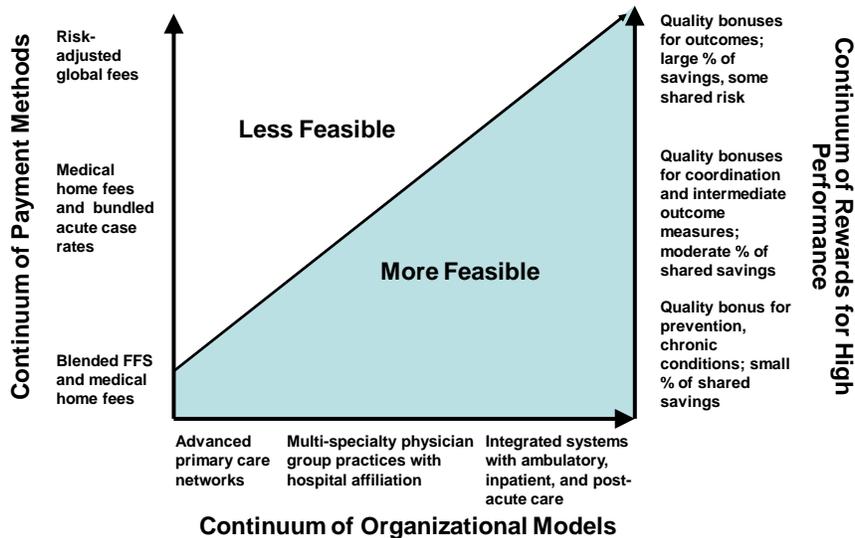
Changing the way health care is organized and delivered requires a change in the way it is paid for—moving from fee-for-service payment to alternative mechanisms that would align financial incentives with system goals, and enable and encourage providers to consider their patients' needs in a broader context, collaborate to provide the care that they need, and take mutual responsibility for patient outcomes and cost.

Payment, Organization, and Performance

Although payment reform is desirable, it cannot be carried out without recognizing the diverse array of organizational models that make up the health care delivery system and the differences in the environments in which those organizations operate. Provider organizations vary widely in size, scope, and degree of integration—and in the degree to which they may be willing or able to assume broader clinical or financial accountability for their patients’ care. Currently, traditional fee-for-service Medicare—like most other payers—recognizes only independently practicing physicians, hospitals, and other individual service providers for direct payment. Moving away from the adverse incentives provided by the current system toward alternative payment approaches and organizational models—such as the bundled payment approach and accountable care organization model specified in the current legislation—must recognize that health care delivery may be configured differently in different areas. This means that payment and health care delivery reform must provide an array of payment approaches that apply to providers in the context of their current organizational structure, while at the same time establishing rewards and requirements that both encourage high quality and value and provide incentives for those organizations to move toward increased integration.

There is a strong interaction between payment methods and organizational models (Exhibit 3). Payment approaches can range from the current fee-for-service system to more bundled approaches, to global payment that covers all of the health care provided to each patient during a year; organizational models can range from small practices and unrelated hospitals to groups of providers in a single-specialty or multi-specialty practice, to fully integrated delivery systems. The more integrated the organization, the more feasible it is to expect it to take responsibility for a larger bundle of patient care. The availability of more sophisticated—and more substantial—rewards for high performance for organizations that can deliver more effective and efficient care can be used to provide an incentive to move toward more coordination and accountability and away from the fragmented delivery system that patients currently face.

The Relationship Between Payment, Organization, and Performance



Source: S. Guterman, S.C. Schoenbaum, K. Davis, C. Schoen, A.-M.J. Audet, K. Stremikis, and M.A. Zezza, *High Performance Accountable Care: Building on Success and Learning from Experience* (New York: The Commonwealth Fund, April 2011).

As payment changes, those who deliver care will be able to innovate in response to the new incentives they face. The right incentives can encourage providers to work together, either in formal organizations or in less formal relationships, in ways that enable them to take broader responsibility for the patients they treat and the resources they use—and benefit from doing so. As organizational arrangements evolve, payment methods can be adjusted to encourage and reward increasing levels of accountability, with continuous development and improvement over time—but even over time, different payment approaches and organizational models may be required in different areas and different circumstances to accomplish the goals of health reform.

If we want to move most physicians and providers to accept new payment models, the rewards for doing so must not only be large enough both to offset any perceived loss of revenue involved in moving away from fee-for-service payment and the potentially substantial costs involved in reorganizing the delivery system. This can be accomplished by increasing the amount of quality and value-based awards in the new payment models and by decreasing the desirability of fee-for-service payment by curtailing increases in those payments over time.

SOME PROMISING ORGANIZATIONAL AND PAYMENT MODELS

Previous work by the Commonwealth Fund’s Commission on a High Performance Health System indicates that organized and accountable health care delivery holds significant potential for transforming the U.S. health care system.⁴ Among the organizational models that could be used to encourage improved health care delivery are:

- *Advanced primary care practice networks with infrastructure support and associated specialist referral networks*—groups of primary physicians that can take responsibility for a full range of primary care services and function as medical homes for their patients;
- *Multispecialty physician group practices*—groups of physicians that can take responsibility for a range of care needed by their patients; and
- *Health care organizations with functionally integrated ambulatory, inpatient, and post-acute care services*—networks that include not only ambulatory care providers but also inpatient care facilities, offering and being responsible for the full continuum of care.

Several alternative payment options could be used in the context of these organizational models, including:

- *Primary care medical home fees*, any of several methods for paying primary care providers that encourages them to coordinate their patients’ care. Blue Cross Blue Shield of Michigan and Community Care of North Carolina are two organizations that have used such payment methods with success.
- *Bundled acute case rates*, which cover a range of services related to treatment for a patient during a specified time interval around an acute care event, like a hospital admission. Geisinger Health System in Pennsylvania uses this method.
- *Global fees*, a payment rate that covers all the health care provided to an individual during a specified time interval. Examples of organizations using global fees include HealthPartners in Minnesota, Intermountain Healthcare in Utah, Blue Cross Blue Shield of Massachusetts, and Kaiser Permanente in eight regions around the country.

While organizations receiving partial capitation or global fees share in both savings and financial risk, Medicare might mitigate the risk of being accountable for high-cost

patients through reinsurance or stop-loss provisions, especially for cases in which the ACO does not directly provide the full range of services. The key is to encourage and support providers to take responsibility for the care their patients need, while protecting them from the risk of high costs that is beyond the control of the provider.

Rewards for Provider Performance

Rewards for excellence would be awarded to providers who perform well and show improvement on relevant sets of performance metrics. The magnitude of these rewards could be set for each type of provider organization to correspond to the level of integration, to provide a graduated incentive to providers to integrate care and assume accountability for a broader continuum of care. In addition, in the case of models involving shared savings or shared risk, those payments could be explicitly tied to attainment of performance criteria.

Beneficiary Rewards and Responsibilities

For physician group practices, hospital systems, and integrated delivery systems to assume accountability for care of a defined set of patients, it is important that Medicare beneficiaries be encouraged to designate a physician practice as their primary source of care, and failing that to be auto-enrolled in a practice based on quality and utilization patterns so that they can benefit from more effective and efficient care. Historically, Medicare beneficiaries have used multiple sources of care.⁵ It will take time to encourage all beneficiaries to establish a relationship with an enduring long-term source of care, but such a designation is important both to encourage enrollment in group practices selecting the new payment choices—and to encourage greater accountability for care even among physicians that continue to participate independently in the current Medicare payment system.

Lower premiums and reduced deductibles and coinsurance could serve as inducements to beneficiaries to enroll with more integrated provider organizations, engage in management of their conditions, and utilize services within the designated medical practice or system of care. In exchange for these financial inducements, beneficiaries would be expected to use services within the designated practice or delivery system or on referral to providers for selected services under contract to the practice or delivery system. Beneficiaries enrolling in group practices, hospital systems, and integrated delivery systems would formally agree to have all relevant clinical information shared

with all providers involved in their care. Beneficiaries would benefit not only from financial inducements but from greater assurance that their care is being coordinated, meeting guidelines, and being monitored in the aggregate for higher quality.

Supporting Improved Provider Performance

For physician practices, hospital systems, and integrated delivery systems to improve their performance on agreed-upon metrics, it is important that Medicare provide timely periodic reports to providers on their own performance and performance compared to relevant benchmarks. Rewards for high performance on quality and coordination, as well as efficiency, should be made as soon as possible after the period to which they apply, to keep clear their connection to the actions that produced them and strengthen the incentives that they are intended to provide.

Although improved health information systems should enable providers to monitor the conditions and progress of their patients, Medicare should make every effort to supplement that information as necessary for organizations to track care outside their own systems and address the underlying causes for avoidable utilization such as non-essential emergency room visits.

Encouraging Provider Participation

Under the approach described here, physician group practices, hospital systems, and integrated delivery systems would receive positive incentives for participation, including more favorable payment updates and individual financial rewards for high performance on specified metrics. Providers would have more flexibility to provide services that benefit their patients—some of which are not included under the current payment system. In addition, financial incentives for Medicare beneficiaries to enroll with participating physician group practices and delivery systems should increase the market shares of those organizations, a particular benefit for early adopters.

With improved coordination of care and the elimination of unnecessary and duplicative services, spending growth—and therefore the growth in provider revenues—should slow relative to current projections; however, while the trajectory of Medicare spending would be lower under the proposed approach than under the current system, Medicare outlays—and provider revenues—would still be expected to increase over time in absolute terms,

as the demand for care is fueled by the aging of the baby boomers and the increased capacity of the health system to provide beneficial services.⁶

The traditional fee-for-service payment system, however, continues to provide strong incentives for fragmented care and overutilization. Explicit disincentives for non-participation in alternative models of organization and payment could help transform the delivery system more rapidly.

PAYMENT INITIATIVES TO ALIGN INCENTIVES AND CONTROL COSTS

The need for change in how health care is paid for has been recognized for several decades. Initiatives have been developed in both the public and private sectors that aim to change the incentives embedded in fee-for-service payment and provide a base on which to build wide-reaching payment reform:

Medicare has constructed mechanisms for collecting and reporting data on the quality of care offered by hospitals, nursing homes, home health agencies, and dialysis facilities, and is preparing to develop a similar mechanism for physicians. Medicare also has been testing models for rewarding high-quality performance by hospitals and physicians, and is beginning to test value-based purchasing models for nursing homes and home health agencies. In addition, Medicare has been testing models for improving coordination of care among different types of providers, as well as several models of broader system redesign.

Medicaid programs in more than half the states have pay-for-performance mechanisms in place, and many more have plans to adopt such mechanisms. Several states have implemented payment reform initiatives to improve access and coordination; some are actively supporting delivery system reform including patient-centered medical homes and accountable care organizations.⁷ In addition, the Secretary of Health and Human Services (HHS) has begun an initiative to align incentives in Medicare and Medicaid around the establishment of medical homes in conjunction with community health services.

Many initiatives in the private sector are aimed at improving quality and efficiency, as well as pursuing alternative approaches to payment and encouraging greater coordination among various providers responsible for the treatment of patient populations.

Although there are some links among these initiatives, however, they generally are not connected or coordinated—suffering from the fragmentation that many of them are intended to reduce. Efforts should be made to align the efforts taking place across the health care sector so that the benefits of successful initiatives can be shared by all.

The Center for Medicare and Medicaid Innovation

Perhaps the most noteworthy recent development from the perspective of payment reform is the establishment of the new Center for Medicare and Medicaid Innovation. The Innovation Center is to pilot innovative payment and delivery system models that show significant promise for maintaining or improving the quality of care in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP), while reducing program costs.

While these pilots are voluntary and not necessarily expected to apply to providers across-the-board, they provide a mechanism for identifying, developing, implementing, testing, and spreading innovative approaches to health care financing and delivery that can help improve health system performance. The underlying philosophy is one of rapid development and spread of innovative payment and delivery models—much as such innovation transformed American agriculture into a highly productive sector of the U.S. economy in the mid-1900s.⁸ Emulating that approach will require the ability to move quickly, learn as one proceeds, and try multiple strategies rather than focusing on a single model.

The success of the Innovation Center—and any attempt to develop innovative approaches to health care financing and delivery—is dependent on its ability to identify and act on promising strategies and be flexible enough to adapt to contingencies as they arise. Success in this endeavor will require a new innovation strategy, including:⁹

- **National models of payment innovation**—An array of national models of payment innovation should be developed and implemented to accomplish the objectives of payment and system reform. These should include variations on the payment models discussed above, with payment conditional on quality reporting, and rewards should be available for high performance on quality, patient experience, and efficiency.

- **Payment innovations proposed by states and private entities**—“Ground-up” as well as “top-down” approaches should be developed by encouraging and approving promising models developed by and with states and/or private sector entities. Medicare traditionally has played a lead role in developing and implementing new payment policies, including the diagnosis related group and resource based relative value scale payment systems. However, there are many initiatives currently being pursued by other public programs, state governments, and the private sector. CMS should pursue coordinated initiatives, including those developed and led by states or private sector entities, and actively encourage states to propose multi-payer payment reform initiatives.
- **Multi-payer approaches**—Medicare should join with other federal and state health programs, as well as private payers, in adopting these payment models for participating providers. New initiatives that involve Medicare, Medicaid, CHIP, state employee health plans, and private insurers can be expected to have a greater impact on provider behavior and should receive priority. This should provide more consistent incentives, reduce provider administrative burden, and more rapidly diffuse promising models throughout the health system.
- **“Innovation With Evidence Development”**—CMS has developed an approach to coverage determinations that it has termed “Coverage With Evidence Development,” under which Medicare may cover a promising item or service under the condition that the patients using the technology participate in a registry or clinical trial. This approach provides beneficiaries access to promising treatments while continuing to monitor their effectiveness and safety. This same philosophy should apply to the development and implementation of new models of payment and health care delivery—a type of “Innovation With Evidence Development.”
- **Transparency**—The process for selecting, developing, and implementing Medicare payment initiatives should be based on criteria that are well understood by potential participants. Making the process more transparent would help safeguard its integrity and allow for better and more timely decision-making. This would involve both establishing an explicit set of criteria for identifying and selecting new initiatives for development and allowing more open discussion of the policy changes of interest and their potential impacts.

- **Information and assistance**—Establishing appropriate incentives may not be enough to ensure success in achieving delivery system reform. Payers can assist providers by organizing or financing community-level shared resources such as health information exchanges to support clinical decision-making and facilitate coordinated care; 24-hour, seven-day coverage for after-hours care so patients can obtain the care they need when they need it; technical assistance with care redesign and quality improvement; and chronic care nurses to help patients with chronic conditions manage them. Collaboration among payers and providers in each community to provide these services can increase the probability of success while increasing system-wide efficiency and effectiveness.
- **Rapid data feedback**—Rapid data feedback and assessment will allow payment models to continue to evolve as experience is gained with them. Initiatives should be continuously monitored, and bellwether measures should be developed that allow preliminary evaluations to help indicate directions not only for the development of new pilots but also for changes in existing ones. Participating providers would also benefit by knowing where they are performing well relative to other providers, and where they might most appropriately focus their improvement efforts.
- **Sufficient authority**—Efforts must be made to simplify the approval process for testing payment innovations. Increasing transparency, as described above, and establishing clear lines of accountability would go a long way toward reducing the need for a lengthy and burdensome process as a protective mechanism against inappropriate proposals designed to advance the interests of specific institutions or geographic areas. Sufficient authority should be vested in the Secretary of HHS in consultation with the Administrator of CMS to make the decisions—including negative decisions—but holding her or him publicly accountable for those decisions.
- **Ability to “escape gravity”**—Both the Innovation Center and the providers, patients, and other payers who participate in the innovation process must focus on the need to be willing to try new approaches, even if they involve some risk. To be sure, CMS has a responsibility to protect both the fiscal and the policy integrity of the programs for which it is responsible and providers are justified in expecting fair and reasonable payment for their efforts, but Americans also have a right to expect a high

performance health system, and the outcome of failure to act—continuing on a path that is fiscally unsustainable—is not a viable option.

- **Translating Pilots Into Policy**—In addition to the identification, development, and testing of new approaches to payment and delivery, a more explicit process for translating what we learn from the pilots implemented by the Innovation Center into new policy is crucial. The Secretary of HHS has the authority to continue or expand a pilot, but making the process more transparent would help considerably, as this would allow more open discussion of policy changes of interest and a clearer understanding of their potential impacts. The requirement in current law that the Secretary submit a bi-annual report to Congress is one way of providing a regular vehicle for reporting the findings from the Center’s initiatives. Periodic Congressional hearings on potential improvements, involving testimony from HHS/CMS and the Medicare Payment Advisory Commission, also would help make the end-point of the process more visible.

CONCLUSIONS

Efforts are being made throughout the health care sector to improve care and control costs. The speakers you will hear on this panel represent a variety of approaches to achieving the goals we all have for our health system.

To date, efforts to increase value have centered on: developing appropriate measures of quality and efficiency; collecting data on provider performance according to those measures; establishing mechanisms for reporting those data so that payers, users, and providers can use them to make appropriate decisions and indicate, facilitate, and implement required improvements; and determining and operationalizing the criteria and methodology for financial incentives at the margin to achieve high performance. The next phase should be aligning the financial incentives not only at the margin but presented by the underlying payment mechanism to encourage and reward accountability and performance—in particular, higher quality and more coordinated and efficient care.

A flexible approach to calibrating payment rates and performance incentives, as well as disincentives for non-participation, will need to be followed, learning as experience is

gained, with rapid turnaround of programmatic information and monitoring of utilization and savings.

We face great peril if our health system continues on its current course of high cost and suboptimal performance, especially as other countries surpass us in improving mortality and other indicators of high quality care. In our very large and mostly privately owned and operated health care delivery system, changing payment incentives is one of the few tools available for inducing higher performance. The framework presented here shows how Medicare, using payment incentives could lead the nation to higher health system performance and yield great benefits for individuals, providers, and society as a whole.

NOTES

¹ Physician Payment Review Commission, Annual Report to Congress, 1997.

² Congressional Budget Office, The Long-Term Budget Outlook, June 2010 (revised August 2010).

³ The Commonwealth Fund Commission on a High Performance Health System, Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008, The Commonwealth Fund, July 2008.

⁴ A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, Organizing the U.S. Health Care Delivery System for High Performance, The Commonwealth Fund, August 2008.

⁵ H.H. Pham et al., “Care Patterns in Medicare and Their Implications for Pay-for-Performance,” New England Journal of Medicine 356, no. 11 (2007): 1130-1139.

⁶ In one study, a set of options to improve health system performance and reduce spending growth was estimated to save \$1.6 trillion in national health expenditures between 2008 and 2017—but even after that large “reduction,” annual health spending was still expected to grow by almost 80 percent over the 10 years. See C. Schoen et al., Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending (New York: The Commonwealth Fund, December 2007).

⁷ N. Kaye and M. Takach, Building Medical Homes in State Medicaid and CHIP Programs, National Academy for State Health Policy, June 2009.

⁸ Atul Gawande, “Testing, Testing.” *The New Yorker* December 14, 2009.

⁹ S. Guterman, K. Davis, K. Stremikis, and H. Drake, “Innovation in Medicare and Medicaid Will be Central to Health Reform’s Success.” *Health Affairs* June 2010 29(6):1188-1193.