Chairman Brady Announces Hearing on Developing a Viable Medicare Physician Payment Policy

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Chairman Brady Announces Hearing on Developing a Viable Medicare Physician Payment Policy

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:06 a.m. in Room 1100 Longworth House Office Building, Hon. Kevin Brady [chairman of the subcommittee] presiding. Advisory

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*Chairman Brady. Good morning, everyone. The subcommittee will come to order. I want to welcome everyone to today's hearing on addressing the broken Sustainable Growth Rate formula by which the Federal Government reimburses our local doctors for treating Medicare patients. While this is our third hearing, the SGR has been the focal point of the first two, as well.

The first hearing was on redesigning the Medicare benefit package to make it more rational and responsive to seniors and Medicare patients. In that discussion, we heard that solving the SGR problem is key to maintaining a strong Medicare program.

The second hearing was on the Medicare Payment Advisory Commission recommendations for improving the various payment systems. In that discussion we heard that now is the time to repeal the SGR. I couldn't agree more with both of these sentiments. We need to repeal the SGR so that seniors continue to have access to their local doctors.

Physicians are understandably frustrated. In our communities we are witnessing firsthand how the current broken system is forcing doctors to rethink their future with Medicare, consider closing their private practices, or joining up with a hospital. And who can blame them? The SGR is a major contributor to an unhealthy system, and it needs to change this year.

We need to reform the physician payment system to reward high-quality care to patients and value to health care. The current fee-for-service payment system treats all services the same, and fails to take into account the quality of the care provided or how efficiently that care was furnished. This needs to change too.

Building on the subcommittee's efforts in the 112th Congress, Chairman Dave Camp and I joined with our counterparts on the Energy and Commerce Committee to engage with physician organizations and other stakeholders on how best to achieve this goal. These stakeholders have provided extensive feedback on two iterations of the proposal that would first repeal the SGR, provide a period of payment stability, then reward quality and value by using metrics that physicians believe in. And then, finally, allowing physicians to voluntarily opt for alternative payment models if they better meet their needs.

This hearing enables the subcommittee to hear from a few of the many organizations that provide a constructive response to these proposals. The subcommittee will benefit from their experience and insights.

The hearing also provides the subcommittee the opportunity to hear some perspectives that complement the voice of the physician, especially organizations. These perspectives help us understand that the payment system improvements we envision for Medicare can be accomplished.

More importantly, this hearing will help the subcommittee roll up its sleeves and get on with the hard work of developing a viable physician payment reform policy. And crafting this policy need not be a partisan exercise. While we certainly have our differences, permanently fixing the SGR this year is a shared goal. I am pleased that the Majority and the Minority jointly selected the witnesses we will hear from shortly. This is an important step in the effort to find a bipartisan policy solution. My hope is that we continue to collaborate as we talk to physicians on an ongoing basis.

While finding the money to pay for an SGR replacement policy remains a challenge, the most recent Congressional Budget Office SGR repeal estimate surely helps. Using its new Medicare spending projections, CBO estimates that freezing Medicare physician payments at their current level over a 10-year period would cost $138 billion. This is significant reduction from its $243 billion estimate for the same policy just a few months before.

I do look forward to working with my friends on the other side of the aisle when we start talking about how to pay for the SGR solution. We will eventually have to go down that hard road, not only to pay for it, but also to address our spending problems. But let's put that aside for now.

Let's work together as Republicans and Democrats engaged with the physicians and other stakeholders to get the payment reform policy right. The goal is not a perfect policy, but a good, sound policy. Let's craft when the bill is on the momentum of the dialogue that continues here today, and takes advantage of the more favorable CBO cost estimate. Together let's get it done this year.

Before I recognize Ranking Member McDermott for the purpose of an opening statement, I ask unanimous consent that all Members' written statements be included in the record.

[No response.]

*Chairman Brady. Without objection, so ordered. I now recognize Ranking Member McDermott for his opening statement.

*Mr. McDermott. Thank you, Mr. Chairman. I think you were looking over my shoulder. You wrote my speech and read it.

[Laughter.]

*Mr. McDermott. This Committee has been wrestling with the need to reform Medicare's physician payment system for more than a decade. But for a variety of reasons, Congress has not yet been able to send a proposal to the President. We may have a rocky road ahead, but I hope this year we can succeed. We can't afford not to.

The Sustainable Growth Rate Formula is fundamentally broken. As Congress acted to override the formula's cuts, the hole has been dug deeper every year. And, let's be honest, no one ever expects that we are going to cut 30 percent in fees. But the uncertainty promotes profound discomfort and instability in the system.

It is patently unfair to ask physicians or others paid under the fee schedule to live with the sword of Damocles hanging over their head year after year after year. And I understand we can't just repeal it and move to an unrestrained inflationary debate -- or update. But the SGR's threat has dampened physician spending, even if it has been a series of dysfunctional changes, often last-minute efforts to avert disaster.

Instead, we need to replace it with a sensible policy that reflects a more modern care delivery system. We need a policy that rewards quality, not quantity. We need a policy that gives incentives for teamwork, coordinated care, with strong primary care components. We need a policy that helps promote getting the right care to the right patient at the right time. More than anything, we want provider accountability.

Now, let's be clear -- and I know it as well as anybody on the panel -- this is a difficult set of objectives. They won't be accomplished with one fell swoop. They are not going to be. There is no silver bullet in this business. But it is the time to take some steps forward in this challenge. We don't have to start over; we can build on what works and what is already working out there in some places. We should use physician expertise to develop measures, but we must have an accountable public actor as the ultimate arbiter.

Looking at the -- among other things, makes it clear that we can't afford to yield such critical decision-making to unaccountable or self-interested private organizations. There is too much at stake. The cost is still high, but it is lower than it has been in years. And the cost of inaction and more patches will be higher still over time.

I am pleased the chairman seems to want to work together on this replacement policy. As he said, the choice of the witnesses was doing jointly, which was really a revolutionary experience in the House of Representatives. I don't know if it went on in any other committee ever before, but it is a good step. Next will be drafting. We hope we can do the drafting together.

The chairman's outlines are a good start. But without some detail, we will have to find out where the common ground is. It is like being invited to go to three cities in Europe. I would like to know which city we are going to before I sign up totally for the trip. But I am very much involved in wanting to go on a trip.

Now, given the bipartisan interest in this, I want to acknowledge that paying for this endeavor will likely be the cause of the most controversy and potential disagreement. It will be difficult, if not impossible, for me and many other Democrats to support a package that is financed by shifting costs onto beneficiaries, especially given that there are other offsets that are available.

This policy could be entirely financed by ending a windfall that was created by the Congress for big PhRMA when we enacted the Medicare Part D. Again, the average Medicare beneficiary has a household income of $22,500. No one should ever forget that. And the average physician income, on the other hand, is about $180,000. I won't support Robin Hood in reverse, especially when people have paid into the program for deficits -- for decades.

But I thank the chairman for holding this hearing. But more importantly, I show -- I thank him for showing an interest in a bipartisan approach. The Medicare program and the nation will be better for it. And I think that today's testimony -- I am looking forward to it because it is a good start. Thank you.

*Chairman Brady. Great. Thank you. Today we will hear from five witnesses: Dr. David Hoyt, executive director of the American College of Surgeons; Dr. Kim Allan Williams, the past president of American Society of Nuclear Cardiology; Dr. Charles Cutler, the chair and the board of regents, American College of Physicians; Dr. Frank Opelka, vice-chair, consensus standards approval committee with the National Qualify Forum; and Dr. Patrick Courneya, health plan medical director for HealthPartners.

Thank you all for being here today and I look forward to your testimony. You will all be recognized for five minutes for the purposes of providing your oral remarks, and we will begin questioning after that.

Dr. Hoyt, we will begin with you.

*Dr. Hoyt. Thank you, Chairman Brady, Ranking Member McDermott, and members of the committee. I am David Hoyt, the executive director of the American College of Surgeons. On behalf of the more than 79,000 members of the college, I am pleased to be here today to discuss the reform of Medicare physician payment system, and to highlight some challenges moving forward that are described in greater detail in the college's February and April letters that have been submitted for the record. The college appreciates the committee's continued commitment to address the complex problems facing Medicare's physician payment system, and applaud your work in inclusiveness.

In our February letter, the college outlined our value-based update, VBU, proposal to reform physician payment -- the physician payment system. We believe that any new payment system must be based on the complementary objectives of improving outcomes, quality, safety, and efficiency, while simultaneously reducing the growth in health care spending. The VBU proposal is based on the college's 100 years of experience in creating programs to improve surgical quality and patient safety, such as the National Surgical Quality Improvement Program, or NSQIP.

We have learned that measuring quality improves patient care, increases the value of health care services, and reduces cost. The savings gained are a direct result of improving quality outcomes.

We agree with the joint commission proposal that a full repeal of the SGR and a period of payment stability are prudent first steps in reforming the system, while longer-term reforms are developed, tested, and phased in over several years. The college believes that the phase one period of payment stability should be for five years. If we were to move to a value-based system, it is imperative that we make sure the payment models and the quality measures, which will serve as the backbone of the new system, are properly aligned, and that will take some time. The college urges Congress to provide statutory payment rates tied to inflation during the period of stability. Such stability will allow physicians to make necessary capital investments in their practices to move to a value-based system.

In phase two of the joint proposal, the college believes that the most critical component to successfully establishing a base payment rate tied with a variable rate is that it incentivizes high-quality care and does not just function through a withhold. Providers willing to take on the risk based on performance associated with the variable rate must first see a starting base rate at an appropriate level to cover the work and expenses required to provide the necessary care. We believe that the base rate should be based on the market value at the end of five years of stability. The college further believes that once the starting base rate is appropriately determined, subsequent base rates should account for the increased cost of providing care by increasing with inflation.

It is crucial that the variable rate not only require a level of risk by physicians that may result in a reduced payment, but it is -- also contains a level of reward that -- with increased payment for those physicians who achieve the highest quality care. The cost savings we have seen through our quality programs are in the money saved by the improved outcomes. We believe that a variable rate should be determined as to whether a physician meets a specific performance threshold. For a new system to flourish, we must encourage those high performers to share their techniques with those who do not meet the performance threshold. Whether a physician experience is an increase or a decrease from the base rate should be determined by performance, compared to standards or thresholds.

We would like to emphasize that a zero sum budget-neutral scoring methodology for the variable rate could significantly hamper collaborative care, the sharing of best practice amongst providers, and hinder our ability to recognize all the possible savings.

In our century of experience, the college has learned that the real cost savings are best realized from coordinated care. Numerous elements of the committee's proposal relative to performance measurement are strictly specialty or service-based. In contrast, our VBU proposal, which centers on clinical affinity groups,

breaks down the silos of physician care. The CAGs, which have collective quality and performance measures, are designed to be inclusive of multiple specialties working in concert to treat the patient.

In developing quality and performance measures, the college believes that we must be able to provide sufficient measures representing all specialties. The committee's proposal on measure development could lead to potential conflict between measures that go through the NQF process and those that use the proposal's suggested non-NQF process. The college recognizes that there are challenges with the NQF approval process, but that -- that have led to frustration among specialties and physicians. However, with the possibility of multiple entities approving measures, there exists the real possibility the physicians could be compared with each other, while not pursuing the same measure set. Alternative measure sets need clear evidence of effectiveness if they are to be used.

Finally, the college believes it is incumbent upon every physician and health care provider to commit to being a responsible steward of the nation's health care resources. Physicians and other providers will work together to achieve cost savings with -- and those savings cannot be constrained by the current financing silos of the Medicare program. As physicians work to bring costs down, those savings should be accessible to those who are achieving the savings, whether in parts A, B, C, or D.

We appreciate the opportunity to address the second draft of the joint proposal, and look forward to working as partners in forging a new patient-centric, quality-based health care system. Thank you very much.

*Chairman Brady. All right. Thank you, Dr. Hoyt.

Dr. Williams, we will reserve five minutes for your discussion.

*Dr. Williams. Thank you, Chairman Brady, Ranking Member --

*Chairman Brady. Can you get that microphone, Doctor?

*Dr. Williams. Got it.

*Chairman Brady. Thanks.

*Dr. Williams. Thank you, Chairman Brady, Ranking Member McDermott, and other distinguished members of the Ways and Means Health Subcommittee. We thank you for the opportunity to testify on behalf of American Society of Nuclear Cardiology, otherwise known as ASNC. ASNC is a leader in education, advocacy, and quality for the field of nuclear cardiology that was founded in 1993, and represents about 4,600 physicians, technologists, and scientists worldwide dedicated to the science and practice of nuclear cardiology. My name is Kim Allan Williams. I was formerly president of ASNC, and am currently a member of the health policy steering committee.

ASNC and many other specialty societies are encouraged very much by the committee's solicitation of physician input on the SGR repeal and the development of alternative reimbursement and delivery models. This partnership is very likely to lead to legislation that reflects the intricacies of clinical practice and advances best practices. To that end, I would like to propose that we talk a little bit about clinical data registries.

ASNC was involved very much in the development of appropriate use criteria, in partnership with several other organizations, in order to reduce the number of inappropriately ordered and performed tests. Decision support tools such as guidance on the proper use of stress protocols and tracers are important initial steps in quality imaging, and ASNC will continue to collaborate in the development of decision support tools to assist referring physicians and nuclear cardiology professionals.

To further assure appropriateness and patient-centered imaging, ASNC is currently establishing the groundwork for a cardio-vascular-imaging registry. This will begin with nuclear cardiology, but hopefully it will be expanded to further -- other modalities in cardiac imaging in the future. This is a natural progression of prior quality initiatives such as clinical application guidelines, imaging procedure guidelines, physician certification, laboratory accreditation, and the appropriate use criteria.

We do envision that the imaging registry will be a major instrument in allowing the development of a robust set of clinical performance metrics of interest to private payers, as well as Medicare and Medicaid, and other policy matrix. These metrics may add further weight to the reality that medical imaging is good medicine, and inform proper reimbursement and performance incentives. Advances in medical imaging really have changed the way that physicians take care of patients on a daily basis. And integrating medical technology into care plans can save costs by lowering the amount of wasteful and ineffective invasive testing and treatments.

As stated, the -- our hope is that ASNC can develop the groundwork and define initial quality metrics. The initial phase of the registry development hopefully is going to be the end of 2013, first quarter of 2014, and will be focused on data collection and foundational performance metrics that relate to radiation safety and dose protocols, timeliness of reporting of test results, and clinical indications, most importantly. The registry results will be focused on building the resources related to implementation of patient-centered imaging protocols and reporting of appropriate use.

In subsequent phases in 2015 and 2016, ASNC intends to develop the capability to follow the patient through the continuum of care. Partnerships with other registries in the field of cardiology will assist this initiative. We can track adherence to appropriate use criteria and the result in treatment decisions, such that the cardio-vascular-imaging registry may illustrate that nuclear cardiology does affect downstream cost in a positive way through more appropriate selection of patients who need invasive and further therapies.

We expect that the metrics that we develop will be -- enable Congress and CMS to engage ongoing clinical improvement initiatives and, with this data, effectively tie reimbursement to these initiatives. Credit should be given for quality improvement initiatives that are already in place and ongoing, not just for new initiatives each year.

And there should be broader, ongoing recognition for achieving and maintaining board certification, lab accreditation, performing laboratory quality assurance, and participation in registries such as the one proposed by ASNC. These are integral quality activities, and we would hope that annual metric updates would not ignore these ongoing quality measures simply by looking for new initiatives less related to quality. Financial incentives should be provided to physicians who participate in registries, receive feedback, and address any quality deficiencies that are discovered.

In terms of the reward for clinical improvement of activities and pay for performance, we embrace the methodology that rewards the specialty's advancement in care and quality improvement activities, and we are -- we expect that in a system of fee for service, provided that that continues, ASNC would propose that physicians are awarded with the highest levels of -- when they have the highest levels of performance, an increment above the baseline fee schedule, and with negative updates for those who are not performing and not participating and not improving. So we are actually in favor of that concept.

In terms of the stability of the physician reimbursement, the SGR framework, we applaud all of the efforts to try and rework this in such a way that there are not shocks to the system of physicians and their businesses. And we really want to try and replace this with quality measures that can be very much cost savings.

*Chairman Brady. Great. Doctor, thank you very much for your testimony.

Dr. Cutler?

*Dr. Cutler. My name is Charles Cutler. I am chair of the board of regents of the American College of Physicians. The college represents 133,000 internal medicine physicians and medical student members. I am a full-time primary care internist in a multi-specialty group practice in Norristown, Pennsylvania.

The college wishes to thank subcommittee Chairman Brady and Ranking Member McDermott for convening this hearing. We also thank Chairman Camp and Energy and Commerce Chairman Upton for proposing a bold plan for Medicare payment reform that holds the promise of breaking a decade-long impasse on the SGR repeal.

We thank Representative Schwartz for her leadership in sponsoring, along with Representative Heck, the Medicare Physician Payment Innovation Act. This bill, which we support, has a similar approach as the Campton-Upton [sic] proposal and merits strong consideration.

The college believes that the Camp-Upton plan has four key elements needed to create a viable Medicare payment system: it repeals the SGR; it stabilizes payments; it phases in value-based models; and provides multiple pathways for physicians to participate in efforts to improve quality and effectiveness. We request that the committee consider adding the following five policies to the chairman's proposal.

First, establish annual positive baseline updates for all physicians for at least the next five years, with a higher update for evaluation and management services.

Second, create opportunities for physicians to qualify for additional incentive updates on a graduated scale for participating in a CMS-approved or deemed value-based initiative starting in 2014.

Third, create a process by which CMS could deem a private sector initiative to qualify physicians for graduated incentive payments.

Fourth, we support rigorous standards for deemed programs to ensure that they improve quality and effectiveness.

And fifth, enable practices that have received independent recognition as patient-centered medical homes, to qualify for the graduated incentive program. Thousands of physician practices providing care to tens of millions of privately-insured patients have achieved accreditation as patient-centered medical homes. Extensive data demonstrates their effectiveness. Yet Medicare's support for this model is mostly limited to several hundred practices participating in Medicare's comprehensive primary care initiative.

These practices are paid their usual fee-for-service payment plus a monthly risk-adjusted care coordination payment for each patient, plus the opportunity for shared savings. In return, they agree to be evaluated by a robust metrics -- set of metrics. But even for these practices, traditional fee-for-service remains the single largest part of their Medicare payment.

Medicare payment policies should also recognize the far-greater number of recognized patient-center medical-home practices that are delivering high-quality, coordinated care to all of their patients, including Medicare practices which, nonetheless, receive no support from Medicare, other than the usual fee-for-service payment. Related, the NCQA has a new medical home neighborhood accreditation program for specialty practices that meet standards related to the coordination of care, creating a pathway for non-primary-care specialists potentially to qualify for incentive payments. The bottom line is patient-centered medical homes have the track record to be scaled up and support by Congress now.

Finally, following five years of stable and positive payments during which physicians could qualify for additional, value-based incentive payments, Congress could set a date by which time physicians would be in a new payment model or a deemed program, or be subject to reduced annual payment updates with hardship exceptions excluded.

We believe the most effective approach, however, is to create positive incentives for physician-led models that, when supported by an improved payment system, will enable physicians to deliver better and more effective care. Thank you for listening today.

*Chairman Brady. Thank you, Dr. Cutler.

Dr. Opelka?

*Dr. Opelka. Thank you, Chairman Brady and Ranking Minority Member McDermott and committee members, for inviting me to participate in today's hearing on behalf of the National Quality Forum. My name is Frank Opelka, and I am the vice-chair for the NQF's consensus standards approval committee, the CSAC, which I will chair coming this July. The CSAC oversees measure endorsement and the NQF. My day job is the executive vice president for health at Louisiana State University and associate medical director of the American College of Surgeons.

The NQF was founded in 1999 as a non-profit, non-partisan organization with members spanning all of health care, beginning with specialty society physicians, patient advocates, hospitals, businesses, and more. The NQF has two main roles: to convene its members to endorse performance measures, and to recommend to HHS, which measures best fit within the various CMS payment programs.

I am here today because, without the NQF, we would have hundreds of measures from specialty societies, from health plans and others, bombarding physicians and hospitals with a sea of their favorite but very different measure preferences, making it untenable for me or for my hospital to report meaningful measures to help patients. Just imagine the confusion of five different measures for heart attack, one from each major health plan, or one from those associated specialties caring for the heart disease, or different measures for the same surgical operation. Which measure would we choose to report? Which result should a patient use?

Mr. Chairman, we commend you and the entire committee for undertaking the critical task of reforming physician payment and for placing quality at the center. To focus on quality will only work if the measurement tools are themselves high fidelity. To have an impact, quality measures must first have physician input to establish the highest medical and scientific standards. That is why over 400 physicians volunteer alongside experts from hospitals, patient advocates, and business groups, joining together to total over 850 individuals volunteering to serve on NQF committees.

Mr. Chairman, the measurement work of the NQF is predicated on delivering results that improve care, work toward affordability, and inform patients. Some examples of NQF-endorsed measures have, as noted in a CDC report, helped promote 58 percent reduction in central line infections between 2001 and 2009, saving more than 6,000 lives and estimated $1.8 billion in cost. The NQF measures and physician groups across Wisconsin worked to lower cholesterol and improved breast cancer screening when compared to other physician groups outside the NQF across the tri-state region. NQF measures added in reducing mortality rates in 650 hospitals using the endorsed safe practices of the NQF. NQF-endorsed perinatal measures promoted a limit on newborn deliveries prior to 39 weeks, reducing the need for newborns in ICUs by 16 percent in 27 hospitals.

So, what does the NQF mean to me? The NQF takes measured developers and takes their measures and convenes specialty society experts, along with patients and business groups, to assess measures for their importance to patients, for their scientific properties, for their feasibility for the burden of implementation, and the meaningfulness to the end users: physicians, hospitals, and patients.

Of the measures proposed, 70 percent are approved, with over 700 measures now in the measure library; 27 percent of those measures now are patient outcome measures. Rigorous standards are needed so that we don't misclassify physicians or hospitals, or create a misinformed market about providers. Improvement, quality, reduced cost, and informed patients deserve this rigorous NQF endorsement.

For me, ensuring an NQF endorsement process allows for rapid inclusion of all interested parties, and avoids the confusion of 1,000 flowers blooming if too many efforts crowd the measure space and lack coordination.

I seek your continuing support for this rapidly-emerging science of health care performance measures with the standards set by the NQF. The process is well balanced with experts led by specialty society physicians and input from business groups and patient advocates. The NQF continuously redesigns its processes with strong guidance from the medical profession, from those patient advocates, businesses, and from CMS. The NQF is the most assured means for coordinating all the voices and transforming our national health care through measure endorsement, avoiding creating confusion from competing standards.

Thank you for the opportunity to provide testimony to Ways and Means Committee. I am happy to answer your questions and elaborate further on any points I have made during my testimony.

[The prepared statement of Dr. Opelka follows:]

*Chairman Brady. Thank you.

Dr. Courneya?

*Dr. Courneya. Good morning, and thank you, Chairman Brady, Ranking Member McDermott, and the members of the House Ways and Means subcommittee. I am Dr. Patrick Courneya, medical director for HealthPartners Health Plan in Minneapolis, serving Minnesota, Wisconsin, and the surrounding states, as well as the national network.

We are a nonprofit, consumer-governed health care organization serving more than a million patients and more than 1.4 million health plan and dental members. We have nearly 50,000 members who are Medicare patients, and one of the nation's few five-star Medicare plans. While we operate a care-delivery system, more than 60 percent of our health plan members get their care from our contracted network, which includes groups of all sizes.

We appreciate the opportunity to lend our perspective on this important issue. I also wish to thank the Alliance of Community Health Plans for helping to bring our work in this regard to your attention.

At HealthPartners we share the broad goals outlined in the SGR repeal and reform proposal. And we strongly support the shift from fee-for-service to value-based payment. And we applaud the bipartisan effort in Congress to achieve it.

In particular, we agree that three phases, those three phases outlined in the proposal, provide a sensible, workable framework for developing a viable physician payment system for Medicare.

Over the past two decades, we and other organizations in Minnesota have used a similar sequence to achieve meaningful progress toward performance-based payment reform in our state. Minnesota is known for having large, multi-specialty care systems and large, not-for-profit health plans. We sometimes hear that what works in Minnesota's market and its structure could not work in other markets. We believe strongly that is not the case. The elements of Minnesota's payment reform are replicable and scalable and provide a real-world example for the rest of the country, including Medicare. And, because much of the piloting of this work is complete, and powerful tools are already established, we suggest that broader implementation could produce results even faster than they have in our state.

I would like to illustrate with a brief example from my own personal experience. I am a health plan medical director, but I am also a board-certified family physician with 25 years of clinical experience. By instinct I see performance-based payment through the lens of a 13-physician family practice clinic in

Minneapolis that I once helped to run. Our small practice served a broad range of patients, from affluent middle class to first-generation Hmong, Somali, Eritrean, and Korean immigrants. We accepted a broad range of insurance coverage, including Medicare and Medicaid.

In the 1990s, as we sought to prove our value against larger systems, we responded to the early cost and quality transparency initiatives emerging in Minnesota. At that time, using a paper-based system, and supported by bonus payments from health plans and a local health-plan-sponsored quality collaborative, our small clinic was able to perform as well as or better than the largest groups in our market on clinically-important quality measures. We learned just how much improvement is possible if the market signals are right and support is present.

It was an example of a small clinic system serving a diverse population competing on a level measurement playing field with the big systems, and doing well. And still today, some of our market's best performers are small, primary-care groups. More important, in the past four years these same groups have sustained or improved quality performance while working with new total-cost-of-care payment models that drive attention to resource use in an environment of accountability for quality.

The sequence, quality and experience first, followed by focus on efficient resource use, is the right pathway. In our example, our communities would not really accept a focus on cost until we could demonstrate the ability to improve quality on measures of acknowledged importance to patients and clinicians. Second, until clinicians had the skills and experience in quality improvement, they would not be able to develop the confidence that they could effectively manage costs as these new payment models unfolded.

As a health plan during the course of 20 years, and in collaboration with our contracted provider community, HealthPartners has used a wide variety of tools to support this transition to payment models that focus on improving quality and aligning payment to reward those who deliver high quality most efficiently.

The proposal sequences the transition from current Medicare payment models to a similar permanent solution that rewards value instead of volume, and, given the scope of Medicare, this transition could reinforce the welcome transition already underway in the commercial health care finance system.

In short, the precedent is there, the tools are available, and the opportunity for Medicare and the nation's entire health care system is enormous. We are pleased to support this important, thoughtful work.

Thank you again for the opportunity to appear here today.

*Chairman Brady. Doctor, thank you very much. We are joined, I should note, by Representative Black and Representative Schwartz. Thank you both for your interest.

Reading through the testimony -- I appreciate you getting it to the committee well in advance so we could study it -- it seems to be clear that you are convinced we can base payments on quality measures, that getting those measurements right is very important, the collaborative approach in which, you know, a physician who is isolated is going to have more trouble than one that is in a system that gives them timely feedback so they can -- need to make the adjustments to quality of care, and that it is important that, as we create this formula, we not only reward physicians for improving the quality of care, but we also reward them for maintaining a high level quality of care, going forward.

Let me start with my first question, Dr. Courneya. And I say to all of you I like the process that we have taken here, where we continue to share the framework of where we want to go, seek input from you in two different rounds of input. I hope that is working for physician organizations. I think it is going to create a better product at the end of the day.

Dr. Courneya, you have been doing this for 20 years. Your own experience, 13-physician practice. So that would translate to many of our communities. One of my concerns is heaping another round of quality indicators and paperwork and bureaucracy on top of physicians who are not only struggling with a dramatic increase in paperwork and overhead, separate quality indicators from private insurance, as well. A lot of bureaucracy with electronic medical records.

Can we achieve this without adding more burdens on to local physicians? And your experience at HealthPartners, have you focused on the key indicators that matter, rather than a laundry list that may have various value?

*Dr. Courneya. Boy, we sure have tried to. And I think one of the consequences of an engaged and collaborative approach to doing this is that the provider organizations in our community, in our marketplace, have held us accountable to a commitment as health plans in our market to use those agreed-to measures, not create the kind of confusion that can occur with HealthPartners, Blue Cross Blue Shield and Medica and others in our marketplace have little variations on the same general principles.

We have agreed, as a market, on things like comprehensive diabetes measures, where actually achieving the goals and the clinical targets for those patients is the objective. But we all use those same measures as the foundation for any quality improvement incentives that we put in place.

We also think it is important to have both process measures, those things that indicate whether or not you are, on a day-to-day basis, reliably delivering care in the ways that we know are clinically and scientifically sound, but also outcomes measures that are reflective of what is important to patients, as well.

*Chairman Brady. And that varies, I understand, looking at the graph you sent us, that varies by type of medical care provided. Is that right?

*Dr. Courneya. That is correct.

*Chairman Brady. Good. Did physicians within the practice -- do they have practices where they tend to focus on one or two of those types of medical conditions, versus a broad range that would require you to keep up with just a laundry list of indicators?

*Dr. Courneya. Well, you know, it has evolved, actually. As a primary care physician, we don't really have the luxury of focusing on just one topic, although, as we phased this in, we did get our feet wet, we got our skills up to speed, based on, in our case, diabetes measures. Because we could create systems that reliably sustained performance on diabetes, we could then move on to other things like cardiovascular disease preventative services, and actually manage a pretty long list, but do so in a way where the systems that supported us in doing that worked well. And we did that in a system that didn't have a big, multi-specialty thousand-member physician group to do it.

*Chairman Brady. I am not a fan of Washington picking out a regional model, injecting it full of bureaucracy, and deeming it for the reset of the country. But clearly, your experience shows that there is the foundation in place that we can learn from. Is your belief that we can take approaches like yours, and put them in place in Medicare in a reasonable time frame?

*Dr. Courneya. Yes, I think this is a nice combination of a privately-developed but collaborative approach to doing this work. And we do think that one of the real values of that is that provider groups could look to the health plans who were driving towards a consistent signal in terms of clinical quality, and the kind of incentives that they put in place, and take the risks to make the changes that they needed to drive towards better performance on those selected measures. Anything that CMS can do in those regions -- and I think that those regions exist all across the country -- to reinforce those signals without interfering with some of that work that is going on, would be a delightful translation of that work into improving quality for the patients who are served by CMS and Medicare.

*Chairman Brady. Great. I also -- actually, I have a boatload of questions for all of you. But for the sake of time, let me yield to Dr. McDermott.

*Mr. McDermott. I suspect the chairman and I and all the committee have a boatload of questions.

All of you have said, one way or another, that we are going to be involved with the fee-for-service system for quite some period of time. It is not going to go away with a snap of the finger. And we all know that. So, the question is, how do we make a transition that makes sense in the delivery of health care, as well as fiscal sense to the United States Congress who is paying for it? That is really the trouble, or that is the balance that we are struggling for.

And I would like to hear from you, because we look at all these things and we look at how fee schedules have been developed since 1992 -- prior to that, Medicare was fee-for-service, you send in your fee and we will send you whatever -- then we put in the fee schedule. And since then, we have had this continual question about how much we are paying. And I would like to hear from you what you think are the best measures by which you decide how much you pay.

Now, we heard a little bit about the quality -- National Quality Forum. And the question of whether somebody should set a standard outside and it be applied nationwide, or is it something that we let everybody decide on the basis of whether the patients like what they -- what is the quality standard you are going to use that will make the most sense in trying to pay on the basis of quality, rather than quantity?

Because treating a diabetic patient is somewhat different than treating a patient -- a pediatrician who teaches a mother how to be a new mother and breastfeeds and all those things that go on in a pediatric office is not the same as adjusting the amount of sugar that a endocrinologist does. So how do you set measures that make real sense? I would like to hear all your ideas, starting with you, Dr. Courneya. You have been trying it.

*Dr. Courneya. Yes. Actually, one of the things I would like to say about the NQF endorsement process: that tends to turbo charge our work, because that lends credibility to the providers in our community, so that that is an important part. Total cost of care measure that we have in our marketplace is one example of that, and that has been a really powerful engagement tool.

I do think that we need to have the flexibility to be able to understand that different broad categories of providers will have different focus areas where the quality metrics are most important. And so, for instance, in pediatric clinics, those kinds of measures that reflect effective management of the common conditions in pediatrics, the preventative services that they provide, whereas with family medicine it is going to be a different suite of measures. But they are all relatively short in number. And for each individual specialty, they can be manageable. And we have done that, and we have seen it happen in our marketplace.

I also think it is important -- before we can go and give attention to total cost of care, as I said in the statement, we need to be able to credibly prove that we are paying attention to clinical quality in measures that are meaningful. We also have to pay attention to issues of access and satisfaction.

The truth is that it is only through establishing a long-term relationship with my patients that I am going to have the kind of opportunity to have a real impact on their health over time. And both clinical quality and satisfaction are part of what cements that relationship over time. And it is important to recognize.

*Mr. McDermott. Are the data that you get right now from -- or that Medicare makes their decision, is it good data? Do you think we are gathering the right data?

*Dr. Opelka. Well, so --

*Mr. McDermott. It is open to all of you, so jump in.

*Dr. Opelka. So from the National Quality perspective, we have been moving across different data streams. Beginning with claims data, it is at least a start to get a certain aspect of performance measurement on the table. But as you move through different payment systems, you have to map the different -- the quality metrics and the goals within that system to different sets of measures.

As we are moving in the NQF and we look at what is happening with clinical data, rather than claims data, with clinical registries, rather than non-registry-based data, we move the performance measurement system into a much more robust system. And so, moving from a claims-based system for performance measurement in the real clinical data drives much higher fidelity in the performance measurement world. And then, if that maps to a payment system, we push those together.

*Dr. Hoyt. Yes. I would like to speak to this from the standpoint of a surgeon trying to participate in quality assessment for payment, but all of the other things that they need to participate in. And what we found is that registry data is critical. Claims data is probably inadequate for a lot of the things that, ultimately, they need to participate in.

And, for example, the joint commission requires that you demonstrate that you have ongoing practice performance assessment. That is a standard. And to be able to do that, you need to individually credential each physician every two years and a cycle in between. Maintenance certification for board certification requires now submission of data based on your practice that is reflective of your actual practice, and your qualification to then sit for subsequent examination is based on that kind of data. PQRS, or performance data that could be quality linked, also needs registry data.

So, what we are doing to anticipate that and, really, to your question, Chairman Brady, in terms of how to sort of lessen the burden for physicians, we are trying to collect data that can be used for all of these things, so that in the context of practice, a physician is collecting patient data that is relevant to all the regulatory and payment things that they participate in. And it is actually very straightforward.

So, we have developed, for instance, a physician or a surgeon-specific registry that allows multiple things to be achieved at the same time. And it makes it, then, very straightforward.

*Chairman Brady. Great. Thank you. Mr. Johnson?

*Mr. Johnson. Thank you, Mr. Chairman. Dr. Courneya, is Medicare and Medicaid paying you when you send in a request?

*Dr. Courneya. Yes, they are.

*Mr. Johnson. Are they really? All the time?

*Dr. Courneya. Well, as far as my business office tells me.

*Mr. Johnson. Okay. I am especially interested in your assessment that small practices could do well in your payment system. Could elaborate on this point and give some examples?

*Dr. Courneya. Sure. That -- you know, that is an important issue to me, personally. I grew up in northern Minnesota, a small community. And so, it is really important to me that solutions that might work in a population-concentrated area can find a way to translate into small group practices or individual practices. In fact, in our marketplace, some of the top performers in clinical quality are actually those who are single, solo practitioners, which is, to me, a refreshing signal that we are getting it right.

The way it works, actually, for us, is that those folks in those environments are as engaged in the collaboration around clinical quality and learning from others in the marketplace about how to change the way they practice. And by supporting them in those transitions from the current model practice to an alternative payment model, we have seen really important improvements.

I think that those small communities, those one or two-physician practices, are actually the ones most burdened by the current fee-for-service model in some ways, because the only way their business can get any payment for work that they do is for them to be on the treadmill, running as fast as they can. And any alternative ways of delivering those care -- that care that they may see, they can't do because the payment model isn't flexible enough to let them do that.

So, we actually think that these kinds of payment models, supported with the kind of infrastructure and the kind of transitional support that we have used in our marketplace, can really have an impact, both in inner city, concentrated areas as well as rural communities. And we have seen it working.

*Mr. Johnson. I am impressed by what HealthPartners has done to evolve its payment system to support and reward quality of care. I appreciate the description of how you have done it and how it works for small physician practices. I realize your system must work for physicians for you to have come this far. But I would be interested in hearing your thoughts on what a contract physician would say if asked about his or her experience with HealthPartners.

*Dr. Courneya. Well, there is a couple of things. First, let me reflect back on what I first said back in the early nineties, when some of this stuff started to march out.

I wasn't terribly happy, to be honest. The idea of transparency around my performance implied that maybe I wasn't performing as well. What is worse was, when we did actually do that measurement, I found out that I wasn't, our clinic wasn't, and, in fact, the general community wasn't performing as well as they thought they should. So the early reaction is very similar to many of the things that we have heard.

Right now, I am actually quite proud of the fact that I think that we, as a health plan, have really very positive, productive relationships and, in fact, have worked very hard to make sure that financial performance around our contracts reflect a shared set of objectives and a shared stake in success. So, I think that, after that time of collaboration, we have had good success.

*Mr. Johnson. Well, what did you change to make it better?

*Dr. Courneya. Well --

*Mr. Johnson. Because you said you weren't satisfied with it.

*Dr. Courneya. Me, as a physician? Well, first of all, when I saw that we weren't performing as well as we could, we started to actually track and understand our patients. All we had was a spreadsheet and a paper record. And we used very simple tools to track and follow up on patients after they had left the office, and help support them.

One of the things that is important -- was important for me to realize, is that sitting in an exam room as a physician, the plan that I gave them may not necessarily translate into something that they can actually do. So we got much more involved in making sure that when we were recommending, we were giving them support to actually be able to execute on. So, by extending our relationship to our patients to that period of time between the visit, we were able to make a big difference in the quality outcomes. And we did so with very simple approaches.

I am very excited about the way things are evolving right now, because I feel as if the tools to be able to do that in service to our patients are just exploding now, and it is a very exciting time for that, I think a real opportunity for us to be able to demonstrate improved quality at the same time we can pay attention to the thoughtful use of the resources.

*Mr. Johnson. Great. Thank you, sir. Yield back.

*Chairman Brady. Thank you. Mr. Kind?

*Mr. Kind. Thank you, Mr. Chairman. I want to thank you for holding yet another, I think, very important hearing. I want to thank the panelists for your testimony today.

Dr. Courneya, I have been through your facilities in Hudson and New Richmond, and I commend the work that is being done there. It seems as if you have been quite successful in being able to marry up the quality and the cost metrics, trying to drive for better outcomes at a better price. And listening to your opening testimony, too, it sounds as if you believe this is sustainable and can be transferred, broad based, throughout the system. It is not just something unique that you are doing, but something that is translatable to other areas. Is that true?

*Dr. Courneya. Yes, yes. We think so quite strongly. In fact, one of my favorite examples is in western Wisconsin. I was on the board of directors for the Osceola Medical Center for several years and got to know folks there and over in Amery, Wisconsin, as well. And as a part of a collaborative framework, a number of the critical-access hospitals got together and decided on how they would serve their communities with a cancer treatment center that was a shared resource. What that did is it created a resource for treating cancer patients that was shared, that did not duplicate the investment unnecessarily, and produced a rural solution to a very real problem that was disrupting the lives of those patients in ways that was unnecessary.

So, I think that is a great example where the model, focused on efficient use of resources and high-quality care, can really have an application --

*Mr. Kind. I would love to follow up with you on that. I am co-chairing the Rural Health Care Caucus with Kathy McMorris Rodgers, too, and I think the unique needs that exist in rural America, too, is something we can't neglect in that.

But, Dr. Opelka, NQF. Is that becoming the standard? Are people looking to your organization as the standard bearers as far as quality measurements and outcomes? And how are you getting the buy-in?

*Dr. Opelka. Yes. The value of the NQF is the rigor of making sure we don't misclassify. That is the biggest risk when you get in this performance measurement business. If the measures aren't adequately tested and they are put out there and we misclassify a physician or we misclassify a hospital, we misdirect patients.

So, it has been a rigorous process, it has been an evolution. We have been getting faster at how we do it, which is making the standard more usable, friendlier. But it is really that dedication to the science and the rigor, so that we avoid misclassification. And we have seen it from measures that have not gone through the process where they end up with creating a misguided end result.

*Mr. Kind. Sure.

*Dr. Opelka. So we are wedded to that as a standard.

*Mr. Kind. And I didn't hear anyone on the panel mention the value-based modifier. It is a work in progress right now through CMS. It will be fully implemented by 2017, so it is just around the corner here. Does anyone have any thoughts as far as what is gong on with the value modifier? Concerns with the direction that it is taking right now?

[No response.]

*Mr. Kind. The physician-based value modifier. Dr. Cutler, do you know what --

*Dr. Cutler. Sure, I know about it. The ACP is not really prepared to object to it at this point. Our position is that payment reform should move towards team-based care. So the value-based modifier would not really be necessary if we could get to more of a team-based care model.

*Mr. Kind. Right, yes. Anyone else have any thoughts on a physician-based modifier? Dr. Hoyt?

*Dr. Hoyt. Yes. I think, you know, the context is ultimately what will be selected to be the component measures that judge one specialist versus another specialist, or primary care versus, you know, team care might be appropriate for primary care.

*Mr. Kind. Right.

*Dr. Hoyt. In some circumstances. But for a surgeon it might be your surgical infection rate, your DVT prophylaxis measurement, your compliance with bundles of safety in a hospital, so a very different kind of measure set. I mean we see that as really the prototype for how this whole quality linked to payment would actually exist.

*Mr. Kind. Right.

*Dr. Hoyt. And the details of the VBU are still, you know, being worked out, but the concept is to link quality measures to payment, and that is, I think, the --

*Mr. Kind. I couldn't agree with you more. You know, we see -- from CBO just a couple of months ago, the recalculation of the cost in SGR, they might be fleeting, because they are going to do another recalc this month, I believe. So we will see where they end up. We will see where they end up with all of that.

But it seems that we have got to change the incentives so it is value-based, not volume, so that we are paying physicians based on the quality of work, and not how much work they ultimately do.

And, Dr. Courneya, I believe your physicians are salary-based. Is that correct?

*Dr. Courneya. You know, actually not.

*Mr. Kind. Oh, no?

*Dr. Courneya. In our medical group it used to be that way, partly as a consequence in the change in the way payment occurred over the 1990s and into the 2000s. We did go to a production-based compensation. We do have -- a substantial portion of that compensation, though, is related to clinical quality outcomes, and we drive that into our culture quite deeply.

I do think that we can align the incentives properly, we can create a situation where we have shared objectives and shared trajectories, whether we are payer or providers or patients who we are responsible for.

And I do think, also, that as long as the signals are directionally consistent, as long as the measures are parsimonious in terms of not driving providers crazy, we can create strong, directional market signals that can make a big difference and will actually create an opportunity to transform the way we pay for care over the course of the --

*Mr. Kind. I would love to follow up with you and see how you are accomplishing that, because -- and also how much risk the physicians are actually taking on themselves.

*Dr. Courneya. Yes.

*Mr. Kind. But, Mr. Chairman, I see my time has expired. Thank you.

*Chairman Brady. Thank you. Mr. Roskam?

*Mr. Roskam. Thank you, Mr. Chairman. Mr. Chairman, we have three colleagues on our committee who have one thing in common, and that is they went into medicine as physicians when medicine was attracting the best and the brightest. That is Dr. Price, Dr. McDermott, and Dr. Boustany. I kind of have a lot of fun lumping the three of those together, and they are not sure if that is a compliment. I mean it as a compliment.

But teasing aside, I come from a family with three siblings who are physicians. And what I have observed is that the joy of going in to medicine has been -- largely been ground out, basically, by these larger systems. And it is incumbent upon us, if we are going to be dealing with the physician shortage that is looming, we have got to figure out a way to bring the joy of medicine back into medicine, and to bring the buoyancy in that sense of healing, as opposed to check the box and feeling very defensive about the whole environment.

There is one statistic that I think it is important for us to be mindful of, and that is provided to us by the Association of American Medical Colleges. And they project that we are going to be facing a physician shortage in 2020 -- which is just around the corner -- of at least 91,000 physicians. And that is going to grow in another 5 years, 2025, to 130,000 physicians.

Dr. Courneya, can you give the committee a perspective of you, as a physician and the physicians that you are interacting with, on two issues that are sort of looming? One has been sort of well litigated, no pun intended, and one is upon us: that is, defensive medicine, to the extent that it actually drives your behavior and has an adverse impact on the doctor-patient relationship; and if the tort liability system were somehow changed, would that create a better system? Is it overstated? Is it understated? Can you give us your perspective, as somebody who is treating patients?

And the other is, how significant is the Independent Payment Advisory Board that is going to be coming in with the Affordable Care Act? Can you give us your perspective?

*Dr. Courneya. Sure. A couple of thoughts. First of all, just on the best and brightest, I have the great pleasure of actually meeting a lot of the new folks coming in. Still attracting them, and that is really exciting.

*Mr. Roskam. That is good.

*Dr. Courneya. I think one of the things that has ground joy out of medicine is that treadmill that everybody is on that is in response to the way the market is set up as it exists right now with fee-for-service payment.

With regards to the medical liability, you know, that is also something that seems to me to be varying, based on the marketplace. In our own marketplace, liability is not really a very big issue. And so, speaking to it from our experience, all I can say is that it is not a big part of what is on the table. I can't speak to the way that affects people emotionally in other marketplaces. I know it does. And I know that even in our marketplace, it is in the back of our mind.

One thing I would say, though, is that in our experience, well supported with information, physicians with the time to have conversations with their patients actually feel a lot less concerned about that. And I think also that patients feel a lot less concerned about that, as well. It is really the rapid pace and the situation that we are in right now, where we don't have the time to understand the patient's needs, from their perspective, so that when we come up with a plan for care it is properly matched to those needs.

With regards to the IPAB, you know, I think there is a broader question about having available information. And this really comes from my perspective as a family physician. There are so many treatments out there that I don't have good information to sit down with my patient and make decisions about which ones are the most efficient, the most effective, and match them best. So, regardless of the source of information, I think we do need, whether it is a result of private or public effort, we do need information about how things work, one compared to the other.

As far as the specific solution, I think it is more general direction that I am most interested there.

*Mr. Roskam. Dr. Williams?

*Dr. Williams. Thank you. I would like to comment on the concept of defensive medicine. As an imager, it has long been discussed that there are unnecessary tests that are being done in the name of defensive medicine, where folks are afraid that if they tell a patient, for example, who comes in and asks for a test that, no, it is really not indicated, that if something bad happens to that patient, that they will get sued. And so this has been scored by CBO, multiple millions of dollars, and that has been going on for quite a while.

We are, as the American Society of Nuclear Cardiology as well as the American College of Cardiology, are both in favor of indemnification of physicians for following guidelines that are accepted. That is, if we are able to use the appropriate use criteria and be able to tell that patient or the physician who is ordering a test that this test is really not indicated and we are okay with that, then we really shouldn't have to pay the penalty on the other side for following good guidelines. So we are very much in favor of that.

*Mr. Roskam. Thank you. I yield back.

*Chairman Brady. Great. Thank you. Mr. Blumenauer?

*Mr. Blumenauer. Thank you, Mr. Chairman. I very much appreciate the range of opinions presented here today. And actually, the certain coherence about it, in terms of looking forward to something that is a more coherent and effective way to reward effective practice of medicine. I think this is something that we need to continue pushing forward on. I have my own personal bias, that the cost of this is overstated, because every single year we kick it down the road. We are never going to implement the cut to the SGR unless there is a breakdown in the system. So I am, at some point, hopeful that we can wipe the slate clean and move forward with you.

I would like to begin, if I could, Dr. Courneya, your -- because I come from a community in metropolitan Portland, Oregon, where I think the practice patterns are very similar to what you enjoy in your service territory and particularly in metropolitan Minneapolis.

Your comments about the difference it makes for people to be able to communicate and understand that -- in each case I get the sense that a lot of people in the medical profession are harried, they don't have the time they want, which leads, perhaps, to default testing for whatever reason. It is one of the reasons that I personally have been on a crusade for the last five years to have the Federal Government pay physicians or other medical professionals to talk to patients that face end-of-life situations and their families, so they know what they are getting into, and that their wishes, regardless of what they may be, are enforced.

I am curious to have your observations about how much time is going to be necessary to be able to make this transition using some of the indications that you have, and others that we are working on, to be able to make that transition from volume to value.

And maybe, Dr. Courneya, if you could start, and other observations about what the time frame -- how quickly could we do this right?

*Dr. Courneya. Again, I will reflect back on some experience in the 1990s, partly to make a point. Again, at that time, with nothing but a paper-based system and a spreadsheet, within five years we were clearly performing on multiple measures at a level that was consistent with our biggest competitors in our marketplace. So we were able to do that with very basic tools and attention to the process, and also with a mental framework that distributed the work for doing that stuff to a broad team, so it reinforces the comments that we have heard earlier about team-based care, making a lot of those conversations more possible.

In the context that we are in right now, particularly because many markets in this country have learned how to do that, and given the tools that we have available now that are much more robust than we had back then, I do think that that three-to-five-year time line to building the skills, to be able to demonstrate the ability to deliver on quality, and setting the stage for delivering on quality, sustaining that performance, and then giving good attention to resource use, is possible.

*Mr. Blumenauer. Within the context of the Affordable Care Act. Other observations, gentlemen? Dr. Hoyt?

*Dr. Hoyt. Yes, I would like to comment, because I think to really accelerate the pace of what you are asking for, we really need to invest in information systems. And I don't mean the electronic medical record, per se. I mean data registries, data to physicians. And we need to then incentivize, in addition to individual physician behavior, we need to incentivize collaboration, or physicians working together to common solutions, that come out of the data that they examine. Those two elements are really the two major features that lead to change.

And so, if you can invest in them and incentivize them that is what we are seeing with our registries and our collaborators. So that when you can get a group of physicians, a group of hospitals to work together, they have data that they can review together, they will come together and share and move toward a best practice, they do it automatically.

*Mr. Blumenauer. Doctor --

*Dr. Hoyt. And the biggest inhibition is the finances behind that.

*Mr. Blumenauer. Dr. Cutler, did you want to comment?

*Dr. Cutler. I would just add it is the position of the ACP that -- the American College of Physicians -- there are hundreds of practices, thousands of doctors, that have now incorporated team-based care, the patient-centered medical home, into their practices. Those practices, because of the team-based nature, can provide the services that you speak about. The physicians have the time to talk to the patients

about the complex nature of their illnesses. And other members of the team can also supply medical information to them. So, there are enough practices, in the view of the ACP, that we could begin implementing these programs and incentives right now.

There are so many different fits that some are ready to go, some are two-third ready to go, some are one-third ready to go. And it is our belief and part of our testimony that as soon as 2014, we could roll out these systems, rewarding folks who are more mature in the market at a higher percent than those who are halfway there, and still allow enough time for the small practices and the practices that have not become team-based over the next four to five years to develop those team-based models.

*Mr. Blumenauer. Thank you. Thank you, Mr. Chairman.

*Chairman Brady. Thank you. Dr. Price?

*Mr. Price. Thank you, Mr. Chairman. And I want to join those who are commending the chairman and our staff for putting together this hearing. I think this is extremely important. And I want to commend all of the panel members. As a fellow physician, it is a hard time for docs out there taking care of patients. And I want to commend each of you for what you are doing to try to improve the system and move it in a positive direction for patients.

Language is important. And a number of folks have used the word "reimbursement" for what CMS does to physicians caring for Medicare patients. I would suggest that the SGR formula is not a reimbursement formula. It is a payment system. And it often times doesn't cover the costs of providing the care. So we are not reimbursing docs for a thing; we are paying them for something, and sometimes it works and often times it doesn't.

I want to just touch on a different topic, but Dr. Williams mentioned utilizing especially society guidelines as an affirmative defense in a court of law to end the practice of defensive medicine. We have been working on this for a number of years. And thank you for that note, and look forward to continuing to work with each of you on getting us to a system where we can end the practice of defensive medicine, which I believe -- and others -- wastes hundreds of billions of dollars.

I think it is always important we talk about patients when we are talking about health care. And patient access to care right now is being compromised, I would suggest, because of the system. One in three physicians in this country who are eligible to see Medicare patients have decreased or limited the number of Medicare patients that they see. One in eight physicians who is eligible to see Medicare patients no longer sees any Medicare patients. This is a system that is broken and is in dire need of fixing.

So, I want to concentrate on two specific issues. One is flexibility and two is the transition time that each of you -- I think at least four out of five of you -- talked about. Dr. Hoyt and Dr. Cutler, I would like you to comment on -- I think there need to be some pressure valve outlets for docs in the system right now, because it is so -- often times so onerous and oppressive. One of those is patient-shared billing, or balanced billing, or private contracting, voluntarily, outside of the system, and still allowing physicians to stay in Medicare and patients to stay in Medicare. Is that something that ACS and ACP support? Dr. Hoyt?

*Dr. Hoyt. Well, I would say that we support it as something that needs to be explored in greater detail, just as you suggest. And, you know, I think it may be the right model for certain kinds of care. It may be the right model for certain physician elements. But it is just not clear, and so --

*Mr. Price. More flexibility --

*Dr. Hoyt. -- I think to talk about it broadly, rather than looking -- and study it in context that would be the appropriate way to do it.

*Mr. Price. Dr. Cutler?

*Dr. Cutler. My answer is similar. The ACP does support the concept. We would like it tested, initially. And we want to determine that patients are protected --

*Mr. Price. Understand the --

*Dr. Cutler. -- in a way --

*Mr. Price. Yes, you know, I appreciate. And we look forward --

*Dr. Cutler. -- that patient care wouldn't be compromised.

*Mr. Price. -- to working with you on that, yes.

*Dr. Cutler. But thank you.

*Mr. Price. Let me talk about -- Dr. Williams?

*Dr. Williams. Just one quick comment, an inner city doctor from Chicago and now Detroit, working in safety net hospitals, that balanced billing would actually help us, because there are certain patients who would be able to pay the balance and would help us take care of the people who are really not able to pay at all. And it may not be the intent of the Medicare system to do that, but it certainly would help us.

*Mr. Price. Thank you, thank you. Now let me switch to the transition, because we -- most folks have talked about a period of time of transition. I think five years, as many of you have stated, is an important period of time. During that transition, though, I hope that it is not just a period of time to then impose another formula that again doesn't work. Shouldn't we get the quality measures, and all of those things, correct? Shouldn't that be our goal during that time of transition? Dr. Courneya, maybe?

*Dr. Courneya. I think the work on the quality goals is an important first step in getting the skills necessary to know that you can grapple with problems like that. So, you know, that has to be a particular point of attention.

But I think perhaps balance too, by the fact that in the commercial market some of these shared savings and other alternative forms of payment are beginning to unfold, that the five-year time frame is one that matches pretty well with what is unfolding in the marketplace well right now.

And so, the idea of being able to pay attention to a resource use and grapple with that issue is one that, because of what is going on in the private insurance marketplace, physician groups are beginning to build the skills to do that, and they are being able to see the value of both that broad view that timely claims information can given, combined with that narrow but deeper view that their own medical records can give, as a really good foundation for making that transition rather rapidly.

*Mr. Price. Dr. Cutler? Cart before horse?

*Dr. Cutler. If you look at the hundreds of thousands of practices that have gone through NCQA certification, those high-level, patient-centered medical homes have built in many quality parameters. So I think some of the data is out there.

And if you also look at the results of practices that are patient-centered medical homes, we are seeing that hospital admissions are down huge percentages, readmissions are down, costs are down. So the

patient-centered medical home, I think, has built in some of the quality measures successfully that you are referring to. And the result is that costs are down. Patient satisfaction and professional satisfaction among those physicians is also quite high.

*Mr. Price. Thank you.

*Chairman Brady. All right, thank you. Mr. Pascrell?

*Mr. Pascrell. Mr. Chairman, thank you for this hearing. And each of the participants have been excellent, excellent.

Mr. Chairman, though, I wanted to clear up one thing that Dr. Price was getting into, if I may. From every account that I have seen, private contracting threatens the very health of America's senior citizens and people with disabilities. When out-of-pocket costs increase, patients will visit doctors less, obviously. These arrangements outside of Medicare would only deter beneficiaries from seeking preventative and other care until their illness worsens. Now, every report I have seen -- and I look at other reports, but I -- that is my conclusion. So we have heard some specific recommendations. Want to transform -- we want to transform the system as it exists right now.

As you know, Mr. Chairman, in 2009 the Democrats passed a permanent fix for Medicare physician payment, H.R. 3961. So I think our position is pretty clear. But I must commend you, I must commend Ms. Schwartz, and those people who have put some proposals on the table, because there is a lot of common factors when you look at all these recommendations. I hope that we can, with your help, get to the resolution. Because this cannot be hanging over our heads for the rest of the year or in years to come.

It is obvious that there is some kind of an agreement that the current formula is undermining the Medicare program. It is threatening physician participation and beneficiary access to care. So we can't afford these short-term patches.

Drs. Cutler and Courneya, many of you know in the reform bill we included a national health care work force commission, worked very hard on that, to get it into the bill. And associated grants to help states improve their efforts to promote an adequate health care work force, not only among doctors but also among nurses and assistants. We can't ignore the growing shortages of doctors, nurses, and allied health professionals. While payment changes can help, there is much more we can do.

I mentioned we took some very important steps under the Health Care Reform Act. Very seldom is it referred to -- of course we are always dealing with the sexy stuff on the top -- and realizing that there is a lot of good stuff in there, too. This is particularly true when it comes to primary care professionals, and I think you would agree with me.

So, both of you, can you talk about programs that advance primary care practice, if there is anything your organization is doing to address health work force issues?

*Dr. Cutler. Speaking for the American College of Physicians, you have touched on something we are very concerned about. And, sure, primary care has a shortage right now, and the students and the residents, as they come out of training, have huge debt. The debt drives their decision away from becoming a primary care doctor.

So, we are encouraged by any program that lessens that medical education debt, whether it is loan forgiveness, working in an under-served community somewhere in the country so that the debt can go down. And we would encourage more activity along those lines. Anything that can be done that would lessen debt, in my view, would increase the number of young doctors becoming primary care physicians. It is in their heart, they want to do it. But they are coming out of training with a mortgage and no house.

*Mr. Pascrell. Thank you. Dr. Courneya?

*Dr. Courneya. Well, I think even at least as important as that is that they need to step into practices where there is that joy that was alluded to earlier today.

I had the pleasure of talking before the National Health Policy Forum a couple of weeks ago on workforce issues for health care. And the reason that I was there was because we have been doing quite a bit work to transform that team-based model. And in the context of that change, what we have found is that physicians can actually see and manage a larger population of patients, they can do so well supported by an extended team of providers. And our satisfaction in practice within our own medical group from 2005, when the only thing that we had that was up in the high area was satisfaction with prior authorization process, ironically, has now gone from about the 25th to 35th percentile up to the 85th percentile as a consequence of changing the way physicians work in that practice.

We are now in a position in our own medical group where primary care docs are eager to come to us looking for work, because they recognize that joy is possible. And that is what is going to draw people into the profession.

*Mr. Pascrell. Thank you. In conclusion, Mr. Chairman --

*Chairman Brady. Thank you.

*Mr. Pascrell. Mr. Chairman, I just want to bring attention -- we don't have -- my time has run out -- on the specialty area, where it is a prolonged illness. And particularly something I worked on for a long time, and some of us at the panel, brain injury. And specifically in terms of what we are talking about today, we need to take a very, very special look at. And I know the NKF has been moving in some direction along those lines. This is a very serious problem in our country. Thank you.

*Chairman Brady. Thank you, Mr. Pascrell. Mr. Buchanan?

*Mr. Buchanan. Thank you, Mr. Chairman. This is a very critical hearing. And as we move forward on SGR, I can't think of anything more important. I think there is a general feeling -- I love this feeling, the idea, on a bipartisan basis, that we can really deal with this once and for all.

I am in a district in Florida, like many districts in Florida, 70, 80 percent of the revenues for many of our docs are Medicare-oriented. So it is important. That is the way they keep the doors open. In my district alone, 180,000 seniors are on Medicare. So it is a very high percentage. But I would say, again, it is not just my district, it is many districts that are in Florida.

So, I can tell you with our docs, the uncertainty that SGR -- this has created for them over the last five or six years since I have been here is enormous. It is not that we might not get it addressed, but they are trying to make capital investments over a period of 5 or 10 years, and the fact that it is constantly looming over there with a 20, 30 percent cut, is huge.

I would also just say that as someone that has been in business for 30 years, there is nothing -- and I say nothing -- more important than getting this right. Because this -- the doc here knows that pay-for-performance, however you want to measure it and look at it, that creates the behavior in the firm. I had 1,200 employees before I came here, and the one thing I wanted to get right from the top to the bottom is getting that pay plan right. And that is what we are talking about right here. Because what you measure is what -- the behavior you are going to get.

So, I guess I would ask the docs to start off -- just my first -- my own observation -- I think it is very applicable here -- is the fact that this idea -- we have got to make sure we take the time, the thoughtfulness,

as much idea as we can get from yourselves and others to get this right. And, Dr. Hoyt, do you agree with that?

*Dr. Hoyt. Let me give you an example. The way you can take data that is developed by registries and use it to effect behavior is as follows. If you graph it and put each provider, each physician on that graph, there is some on the right that are performing not as well as those on the left that are performing better. Those people on the right, when they see that and you make that data available to them, by the virtue of their commitment to their patients and improving as physicians, they want to move in the direction of improving. And so that is why data is such an important and powerful tool to get behavior aligned with, ultimately, quality.

If you then add to that their opportunity to come together and learn from each other, so that the ones that are performing less well can learn from the ones that are performing well, then you affect behavior change --

*Mr. Buchanan. Thank you. Dr. Courneya?

*Dr. Courneya. Yes. You know, it is really kind of joyful, remarkable acceleration that you see. If the incentives can be properly aligned so that quality improvement -- and the measures are properly selected so that not only is the incentive aligned, but the incentive and the objectives are aligned with the personal mission that physicians bring to practice, then you begin to marry that important financial element with what is, I think, a much more powerful motivator, and that is the desire to do well by your patients.

My mom lives in Florida. The issue of transparency and the availability of information for her about what care she can get is important to me. And any role that CMS can play in making that performance what we can expect across all markets is one that I am very excited --

*Mr. Buchanan. Doc, let me ask you, or just in general, W.C. Deming said that if you can't measure it you can't manage it. And I also want to be careful because, at the same time, I have always said you can't measure 48 things. What are the key things that need to be considered and measured going forward, you know, for docs across the country?

*Dr. Courneya. Well, you know, actually, there is one measure that I thought was particularly transformational for me in practice, and that was the comprehensive diabetes measure. The reason that was important is because there were five elements that we had to perform on. And it wasn't just measuring, it was actually getting our patients to goal for those five elements. We knew that we couldn't achieve that unless we really changed the way we approached care.

So, I think that there are certain high-impact measures like that that are important. Cardiovascular disease is another one. It is the place where the money is. It is also the place where the human suffering is. And so, selecting those in ways that create the kinds of force that requires substantial change is really important.

Those are the two that come to mind. But there are a number of others. I would say preventative service is a --

*Mr. Buchanan. Dr. Cutler, I have just got a few minutes. Any -- your thoughts on either of those questions or observations?

*Dr. Cutler. It is really tough, is the answer. Every patient I see is a little bit different. And so, sure, there are some very common diseases like diabetes, hypertension, hyperlipidemia. But getting down into the weeds on that and listing the specific ones is really difficult.

But I do want to go -- come back to a practice that is patient-centered that is a high-level functioning, patient-centered medical home, by very definition has many of the quality metrics built in to that certification. And those homes are doing quite well in terms of, as I said earlier, hospital readmissions, hospital admissions, cost of care. So I think the essence of the answer lies in team-based care and certified medical homes.

*Dr. Courneya. Right --

*Mr. Buchanan. Thank you, Mr. Chairman, and I yield back.

*Chairman Brady. Thank you. Representative Schwartz?

*Ms. Schwartz. Thank you. And thank you, Mr. Chairman, for holding this hearing and this series of hearings, but particularly for this panel. We don't always have a panel that is so much agreement. So really very pleased to see the consistency of both intention that we should repeal this SGR permanently, and replace it with a new payment system that does reward quality and outcomes, improved care, and cost containment. And many of you have talked to the fact that we can begin to measure it, and we can do this well, and particularly with the kind of work that has been done already in delivery system reforms, both in the private sector and through Medicare innovation center, Medicare and Medicaid innovation center. I thank you for participating in this and really getting it done out there in a real world, as we say.

But how we pay makes a difference, and can either encourage this transition and this transformation in the way we deliver care, improving health care for Medicare recipients, or not. Makes a big difference. I would contend many of you talked about -- and I want to thank Dr. Cutler, who is here from my district, actually, and practices in Norristown, Pennsylvania, lives in my district, and ACP has been very, very helpful, as many of you have, in helping me write that legislation to create a payment system for doctors under Medicare. I hope we get that done.

There is a lot of agreement and common ground on this. And many of you have really articulated what we have to do, which is to repeal SGR, provide some stability and updates for physicians, focus on primary care -- I haven't talked about that as much, that is going to be my question -- and really move over the next five years to move more physicians -- really, the majority of physicians in this country -- to a system with a variety of models for -- that could be -- really incentivize that kind of quality and value-based purchasing of care. So, I thank you for what you are doing and moving in this direction.

I did want to focus on just two things, if I may. You talked a good bit, many of you, about -- particularly Dr. Courneya and Dr. Cutler, thank you for talking a lot about team-based care models, particularly about the transitions of care and the -- what happens to patients when they leave your office or leave the hospital and -- when you thought you did all the right things and gave them their instructions, and, lo and behold, they didn't all understand them and do it all exactly the way you thought they might, and leaving out that time. It turns out to be pretty critical, in terms of cost and readmissions and care.

So, I wanted to ask two questions, if I may. And that is if you could talk a little bit more -- I will start with Dr. Cutler, but think Dr. Courneya might want to mention -- talk about this, as well -- the focus on primary care and how important that is to helping enable all specialists and all physicians and all primary care physicians to actually provide the right kind of care to patients, and the degree to which we have to or should be making sure that we focus on both increasing reimbursements and then also just making sure that the models that we move forward on actually include primary care. That is my first question.

And then, secondly, about the ability of the system to really move in this direction in the next four to five years, and whether we -- your point about -- I would ask you whether we should get started right now to make that happen.

So, both those questions. And, Dr. Cutler, if you would start.

*Dr. Cutler. Thank you, Representative Schwartz. Obviously, we have a huge shortage in this country on primary care physicians. And what is it that patients really want form their doctor? Well, they want the opportunity to talk to the doctor. They want the time. And the current system, which takes us back, really, to the opening comments from Chairman Brady, is that the current system is volume-driven. And it de-emphasizes time. So I think the solution that we have to aim for is one that rewards the ability of the doctor and the patient to sit and talk together, and to decide what is best for their care.

Team-based care, in my view, takes us right to the finish line on that. And it does it in a way -- and we are seeing it across the country -- that is really very cost-effective. Primary care services drive costs down.

*Ms. Schwartz. Right.

*Dr. Cutler. And, obviously, if you are treated for osteoporosis by a primary care doctor, your incidence of hip fractures has gone down. It is very expensive to take care of a hip fracture. It is considerably less expensive to treat osteoporosis. You can go through a whole series of diseases, and many cancers could be cured, discovered very early, and we won't need all of these expensive chemotherapeutic agents and radiation treatments and surgery.

So primary care is really the answer. It is a financial answer, it is an answer for the patients, because they appreciate it. And finally -- and this was mentioned earlier -- professional satisfaction, the satisfaction among the doctors and the members of the care team, is the highest of any model. It is considerably higher, and it gets away from all of the complaining that doctors do about not having time. So, I think the answer lies in patient-centered care and team-based care.

*Ms. Schwartz. Okay.

*Chairman Brady. Thank you. Mr. Smith?

*Mr. Smith. Thank you, Mr. Chairman, and certainly thank you to our panel here today. Just going over some of my notes here, and biography statements for our panel here, I see FFS, NSQIP, ACS, ASNC, NQF, CSAC. Of course we are talking about SGR in a place called D.C.

[Laughter.]

*Mr. Smith. But I only mention that because I think it is a reflection of some well-intending efforts of those associated with government to try to create a better situation. And yet, SGR, although well-intended, has not been impacting the situation as we would prefer. And it is very compelling when I hear that patients themselves -- for which there is no acronym description -- are seeing reduced access because of the obvious fiscal realities that exist. And that is without the next wave of health care reform efforts that I already sense are seeing some resistance.

So, with that said, I also know that we are seeing some consolidation in health care, physicians kind of leaving their independent practices to join larger practices, whether or not under hospital umbrella or not. And I am concerned that patients may not benefit from these changes.

And so, if you could perhaps elaborate when you take the consolidation issue, whether it is in rural areas or urban areas as well, what is the impact with SGR, whether you think it does not have any relationship whatsoever or patients should not be concerned or providers themselves should not be concerned. If any of you would like to, respond. Dr. Cutler?

*Dr. Cutler. Well, the ACP doesn't have policy on this. But just personally, I have been on both sides of the fence. I was self-employed, I owned my practice for most of my career. Just recently I have begun to work for a small hospital network.

I think the key really lies in the physicians, whether it is a two-doctor group or hundreds of doctors, the physicians being able to make the decisions that are best for their patients. So it -- in a network like mine, which has a great deal of physician input into the decisions that are made from a business standpoint, I feel quite comfortable working there. If the physicians are not in charge, I would worry about a system like that.

*Mr. Smith. Dr. Williams?

*Dr. Williams. Yes. Thank you, Representative Smith. As a imager, again, on the hospital side, university side, I have watched the influx of physicians that -- during this consolidation. And the concern is that, as Medicare has decreased payment to the fee schedule less than the hospital outpatient payment system, it drives people in to a system that ultimately costs Medicare more money. It does cost the patient more money to come away from their physician to a major facility, in terms of travel and time. But, more importantly, it takes away the on-site freedom of practice sort of environment that has allowed the imaging to flourish and to help people.

Now, obviously, some things had to be reigned in. There was a time when there were -- that nuclear cardiology probably sitting at this table only because of this -- it was the number one Medicare expenditure. That was about 2004, 2005, before the fees were cut dramatically. The volume has gone down, largely because of appropriate use criteria and getting people to certify in their specialty, and to make sure that labs were accredited. That was the MMA of 2010, that if you are not accredited, you are not allowed to do nuclear cardiology and other imaging.

And so, the quality measures really can impact in a positive way how much Medicare spends. Thank you.

*Mr. Smith. Dr. Hoyt?

*Dr. Hoyt. You know, I think, you know, in specialty care, particularly in surgery, we are seeing a trend toward employment as one form of this. And when you add to that, then, bundling of payments to entities or systems as a potential reimbursement model, you know, you create a -- on the one hand, some real advantages so that somebody that is part of a bigger system doesn't have the investment costs in electronic medical records, they may feel less burdened by liability in a more protected environment.

But I think the concerns about being able to perform at a quality level are really the same, so that we really need the same tools to be able to motivate people to perform quality care.

*Mr. Smith. Very briefly, Dr. Courneya?

*Dr. Courneya. Yes, it really depends on why they are coming together. We are going to see examples of groups that come together with the objective of serving patients well and competing in an environment where quality and good use of resources is the reward. They are going to do great. We are going to see examples of individual, single-physician practices who also do great in that environment.

We are also going to see examples of people coming together to exercise leverage that may not be as good. It really depends on their objectives, and whether they are led in a way that is in the interest of the patients.

*Mr. Smith. Very good. Thank you. I appreciate -- and certainly it is my objective that this panel doesn't come, or anyone else doesn't come, between you and your patients.

Thank you, Mr. Chairman.

*Chairman Brady. Thank you, Mr. Smith. As we wrap up, one, thank you very much for all five of our witnesses being here. Your experience and ideas are very helpful.

Dr. McDermott and I had very quick question, very briefly, and it goes to the point of if collaboration is important, timely feedback is important, a team-type of practice is important, I understand -- we understand how that works in the Twin Cities. How does that work for a rural doctor? How do you fit a rural doctor that may have another physician in town? May not be isolated hundreds of miles, but in that type -- how does this fit for them?

*Dr. Cutler. The American College of Physicians recognizes the difficulty that the doc or doctors in a small community have, certainly with support resources. And it is for that reason that we think we need five years to transition into these new models of care and payment.

Thankfully, the Internet exists. A lot can be done through electronic technology. But the fact is that many of these practices are one or two doctors. They are on a very tight operating margin, and they need time to transition into new models. So we think it can be done. We think perhaps the recommendation from the College of Surgeons dealing with affinity groups might help the small practices. If given the time, we can make it work.

*Chairman Brady. Very quickly, Dr. Hoyt?

*Dr. Hoyt. Yes. Well, just to add to that, I think we are seeing also some exploration of regionalization, which is probably good for certain types of patients. And vice versa, larger systems in urban areas supporting rural practices to provide them back-up, so that they really can feel comfortable practicing in isolation.

*Chairman Brady. So it can be done.

*Dr. Hoyt. Yes.

*Chairman Brady. Your answer.

*Dr. Hoyt. Yes.

*Chairman Brady. A reminder, any Member on the panel wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, I would ask the witnesses respond in a timely manner.

We are committed to finding a sound solution, permanent solution, reliable solution for the SGR this year, and we are committed to working together toward that.

With that, the meeting is adjourned.

[Whereupon, at 11:53 a.m., the subcommittee was adjourned.]

Member Submissions for the Record

Rep Issa Rep Farr

Public Submissions for the Record

Alliance for Quality Nursing Home Care

American Society of Transplant Surgeons

American Speech-Language-Hearing Association

California Hospital Association

CAPG

Community Hospital of the Monterey Peninsula

Greenway Medical Technologies

Mayo Clinic

Medical Society of New Jersey

Medicare Rights Center

Monterey County Medical Society

Palomar Health

Riverside County Medical Association

San Bernardino County Medical Society

San Diego County Medical Society

Santa Barbara County Medical Society

Sharp HealthCare

Sierra Sacramento Valley Medical Society

Sonoma County Medical Association

Sutter Maternity & Surgery Center of Santa Cruz