NEW MODELS FOR DELIVERING AND PAYING FOR MEDICARE SERVICES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

MAY 12, 2011

Serial No. 112–HL3

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 2011

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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CONTENTS

NEW MODELS FOR DELIVERING AND PAYING FOR MEDICARE SERVICES

THURSDAY, MAY 12, 2011

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 2:45 p.m., in Room 1100, Longworth House Office Building, Honorable Wally Herger [Chairman of the Subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Herger Announces Hearing on Reforming Medicare Physician Payments

Thursday, May 05, 2011

House Ways and Means Health Subcommittee Chairman Wally Herger (R–CA) today announced that the Subcommittee on Health will hold a hearing to explore new models for delivering and paying for services that physicians furnish to Medicare beneficiaries. In what will be the first in a series of hearings on this topic, the Subcommittee will focus on models that have the potential to improve quality and constrain the rate of cost growth. The Subcommittee will hear from witnesses who are participating in delivery reform models. **The hearing will take place on Thursday, May 12, 2011, in 1100 Longworth House Office Building, beginning at 2:00 P.M.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing. A list of witnesses will follow.

BACKGROUND:

The Sustainable Growth Rate (SGR) formula was implemented in 1998 as the mechanism that determines the rate by which Medicare fee-for-service payments to physicians are updated on an annual basis. The SGR limits the growth in Medicare physician service spending to the rate of growth in the overall economy. The formula is cumulative in that the tally of actual and target expenditures is maintained on an on-going basis since the formula's inception. If expenditures are lower than the target, physician payments are increased. If expenditures are higher than the target, payments are decreased. As the rate of growth in expenditures on physician services has consistently exceeded the rate of growth in the economy in recent years, the SGR system has called for a cut in physician payments in each of the past ten years. Congress has intervened to avert the cuts each year since 2003 through numerous pieces of legislation. As a result of this legislation and the cumulative nature of the SGR, the magnitude of the projected cuts to physician reimbursements and the cost to override future cuts have grown. The Centers for Medicare and Medicaid Services (CMS) projects that physicians will receive a 29.5% rate cut next year, absent Congressional action. The nonpartisan Congressional Budget Office (CBO) estimates that freezing payment rates at their 2011 levels for the next 10 years would increase Medicare spending by $298 billion.

The Medicare fee-for-service payment system provides an inherent financial incentive for physicians to increase the number of services they provide. The SGR formula has failed to constrain fee-for-service expenditure growth, primarily because of increased utilization but also because Congress has repeatedly passed legislation to override the cuts called for by the SGR. In addition, Medicare payments to physicians are currently made without taking into account the quality of the services provided. There is broad acknowledgement of the shortcomings of the current payment system and the growing importance of moving to payment models that incentivize patient-centered, high-quality, and outcomes-oriented care.

In announcing the hearing, Chairman Herger stated, **"There is widespread agreement that Congress must abandon the practice of short-term patches to avoid cuts to physician payment rates, which only make the problem larger and more expensive to fix. The SGR system creates tremendous uncertainty year after year forphysicians and Medicare beneficiaries alike. This hearing will enable the Subcommittee to hear details about other payment approaches that hold promise for driving high-quality, efficient care. The experience of those at the forefront of these innovative efforts will**

help the Subcommittee as it considers how to better reimburse physician services."

FOCUS OF THE HEARING:

The hearing will focus on innovative delivery and physician payment system reform efforts.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov,* select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Thursday, May 26, 2011.** Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/.*

Chairman HERGER. The Subcommittee will come to order. We are meeting today to hear from four individuals who have experience to share that will inform us as we consider how to reform Medicare payments to physicians. This is a priority for the Subcommittee as Medicare physician payment rates will be cut by nearly 30 percent on January 1 unless Congress acts.

The flaws of Medicare's sustainable growth rate are well known to members of this Subcommittee. Congress has repeatedly enacted legislation to avert scheduled rate cuts that have been called for

under the SGR every year since 2003. This has created deeper holes for the following years, and next year, with the scheduled 30 percent cut, is no different.

These cuts could be devastating for patients and physicians, especially in rural areas like my northern California district. Many physicians have warned they will have little choice but to stop participating in Medicare, leaving seniors without access to the medical care they need.

Republicans and Democrats alike have kicked the can down the road long enough. We cannot continue to patch over this problem with short-term fixes of a few months or a year at a time. The uncertainty of Medicare payment policies is taking a toll on physicians, and with each passing year the cost of a long-term solution grows larger. It is time that we work together to find a fiscally responsible solution to this problem.

In addition, we need the physician and provider community to be willing participants in this endeavor to reform the SGR. Medicare spending is on an unsustainable path, and we must find a better way.

This is the first of what will be a series of hearings the Subcommittee will hold on physician payment reform. It is my hope that by starting early, we will arrive at a payment system overhaul that can pass the House.

Today we will explore innovative delivery models that are taking place across the country. The testimony we will hear shares a common theme that coordinated care produces more efficient care with better outcomes at a lower cost, and that fee-for-service delivery systems encourage higher spending without regard to quality.

I believe that the future of Medicare depends on a transition away from the fragmented fee-for-service system to a system where the incentives are aligned with better patient care, not just more patient care. I am also open to hearing other ideas as we continue to explore alternatives to the SGR.

Chairman HERGER. Before I recognize Ranking Member Stark for the purposes of an opening statement, I ask unanimous consent that all Members' written statements be included in the record. Without objection, so ordered.

Chairman HERGER. I now recognize Ranking Member Stark for 5 minutes for the purpose of his opening statement.

Mr. STARK. Thank you, Mr. Chairman, and I want to thank your staff for working with us to put together this first hearing on the SGR reform. It is not a partisan issue, it is a problem that has been around for more than a decade, and neither party has been able to enact a permanent solution.

That said, it is not the Democrats that haven't tried, and last year we passed a permanent reform of the SGR system that would have gotten us out of this annual kick-the-can approach, but our legislation would have essentially reset the existing system and started over with a formula that divided physicians into two groups, primary care, including the preventive service and specialty care, and with different expenditure targets for each group. While the physicians would still be accountable for spending growth, access to primary-care services would have been promoted by getting an extra allowance for the primary care. Unfortunately, only one

Member on your side of the aisle, Dr. Burgess, was willing to join with us in that legislation, but it was endorsed by virtually the entire physician community.

Today's hearing is going to focus on a component of reforming the physician payment system, delivery system reform, and I think we will hear the witnesses say that we have no chance of reforming that until we change the way we pay for medical care, and that the existing fee-for-service system merely incentivizes the provision for additional care.

So our witnesses today provide great examples of experimentation going on across the country. I want to thank them for taking the trouble to be here.

I also want to tell them that as an incipient receiver of cataract surgery in the next week, I can't see you. I have your names down here, and you are kind of that nice blur, so if I misdirect a comment to you, please, please forgive me.

Again, thank you, and I look forward to hearing our witnesses. I want to thank them for coming today and being so patient because of the voting schedule that necessitated our stretching this out into the late afternoon.

Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

Chairman HERGER. Today we are joined by four witnesses. The first witness will share ideas on how Medicare can encourage physicians to participate in care models supported by different payment systems. The following three witnesses will describe their efforts to promote high-quality care at a lower cost under these types of payment systems.

Our witnesses are Stuart Guterman, who is vice president of payment and system reform at the Commonwealth Fund in Washington, DC; Dr. Lisa Dulsky Watkins, M.D., who is the associate director of the Vermont Blueprint for Health and an employee of Vermont Department of Health Access; Dana Gelb Safran, who is the senior vice president for performance measurements and improvement at Blue Cross Blue Shield of Massachusetts; and Dr. Keith Wilson, who is the chair of the governing board of the California Association of Physician Groups.

You will each have 5 minutes to present your oral testimony. Your entire written statement will be made part of the record.

Mr. Guterman, you are now recognized for 5 minutes.

STATEMENT OF STUART GUTERMAN, VICE PRESIDENT, PAYMENT AND SYSTEM REFORM, EXECUTIVE DIRECTOR, COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM, THE COMMONWEALTH FUND, WASHINGTON, DC

Mr. GUTERMAN. Thank you, Chairman Herger, Congressman Stark and Members of the Subcommittee for this invitation to testify on Medicare physician payment.

I am Stuart Guterman, vice president for payment and system reform at the Commonwealth Fund, which is a private foundation that aims to promote a high-performance health system that achieves better access, improved quality and greater efficiency, particularly for society's most vulnerable members, including those

with low incomes, the uninsured, young children and elderly adults.

The Congress faces a challenging dilemma in considering Medicare physician payment. On the one hand Medicare spending is rising at a rate that threatens the program's continued ability to fulfill its mission. On the other, the sustainable growth rate mechanism, which is intended to address that problem, produces annual reductions in physician fees that are equally difficult to accept. This dilemma arises from the underlying mismatch between the primary cause of rising spending, which is the volume and intensity of services provided, and the focus of the SGR, which is to set the fees that physicians receive for each service they provide.

Determining how much to pay physicians certainly is an important issue, but what is critical is determining how to pay physicians so that the Medicare program gets the best care possible for its beneficiaries.

We do get what we pay for in our health system, more volume and more intensity, with little reward for high performance either in terms of effectiveness or efficiency. We need to start paying for what we want; to reward providers for the kind of care they would like to be providing, but all too often are discouraged from or even penalized for under our current system.

In changing how we pay for health care, we must recognize the diverse array of organizational models that make up the health care delivery system and the differences in the environments in which those organizations operate.

Provider organizations vary widely in size, scope and degree of integration and in the extent to which they may be willing or able to assume broader clinical or financial accountability for their patients' care. One size will not fit all, which means that payment and health care delivery reform must provide an array of payment approaches that apply to providers in the context of their current organizational structure, while at the same time establishing rewards and requirements that both encourage high quality and value, and provide incentives for those organizations to evolve as necessary to meet the needs of their community.

The availability of more sophisticated and more substantial rewards for high performance for organizations that can deliver more effective and efficient care can be used to provide an incentive to move toward more coordination and accountability and away from the fragmented delivery system that patients currently face. The right incentives can encourage providers to work together either in formal organizations or in less formal relationships in ways that enable them to take broader responsibilities for the patients they treat and the resources they use, and to benefit from doing so.

As organizational arrangements evolve, payment methods can be adjusted to encourage and reward increasing levels of accountability with continuous development and improvement over time, but even over time different payment approaches and organizational models may be required in different areas and different circumstances to accomplish the goals of health reform.

An important vehicle for developing an array of new approaches to payment, organization and delivery is the new Center for Medicare and Medicaid Innovation in the Centers for Medicare and

Medicaid Services. The innovation center is mandated to pilot innovative payment and delivery system models that show significant promise for maintaining or improving the quality of care in Medicare, Medicaid and the Children's Health Insurance Program, while reducing program costs.

These pilots provide a mechanism for identifying, developing, implementing, testing and spreading innovative approaches to health care financing and delivery that can help improve health system performance. The underlying philosophy should be one of rapid development and spread of innovative payment and delivery models with the ability to move quickly, learn as one proceeds, and try multiple strategies rather than focusing on a single model; in other words, for CMS and other payers, as well as providers, to move beyond business as usual.

Medicare, by promoting an array of innovations in payment, organization and delivery, could lead the Nation to higher health system performance and yield great benefits for individuals, providers and society as a whole.

I am honored to be here with representatives of three innovative organizations and interested to learn more about what they are doing. Thanks.

Chairman HERGER. Thank you.

[The prepared statement of Mr. Guterman follows:]

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

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

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

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

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

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

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

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

THE SGR: ITS RATIONALE AND ITS FAILURE

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

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

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

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

Attempts to Control Spending by Adjusting for Volume and Intensity

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

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

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

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

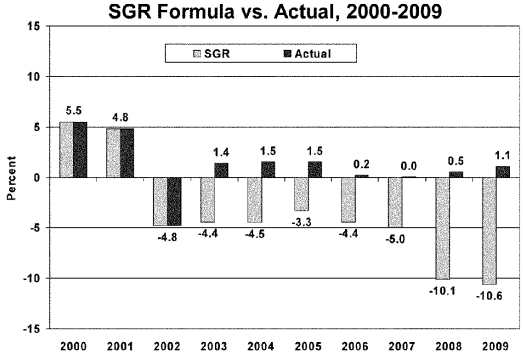
Policymakers saw the SGR approach as having the advantages of objectivity and stability in comparison with the VPS.[1] From a budgetary standpoint, the SGR method, like the VPS, is effective in limiting total payments to physicians over time. GDP growth provides an objective benchmark; moreover, changes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

Problems with the SGR Mechanism

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

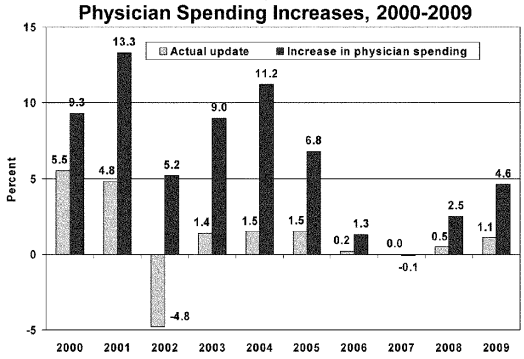
The pattern since then has been considerably different. In 2002, Medicare physician fees were reduced for the first time, by 4.8 percent; in succeeding years, the Congress has wrestled with a succession of negative updates produced by the SGR formula (Exhibit 1). Since 2002, reductions in physician fees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

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



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

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



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

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

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

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

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

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

THE NEED FOR CHANGE AND THE ROLE OF PAYMENT REFORM

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

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

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

Payment Innovation: A Key Component of Health Reform

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

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

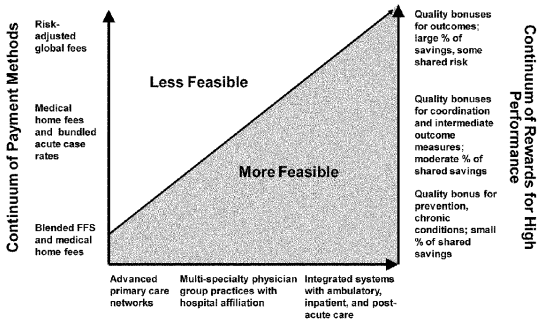
Changing the way health care is organized and delivered requires a change in the way it is paid for—moving from fee-for-service payment to alternative mechanisms that would align financial incentives with system goals, and enable and encourage providers to consider their patients' needs in a broader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

Payment, Organization, and Performance

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

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

The Relationship Between Payment, Organization, and Performance



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

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

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

SOME PROMISING ORGANIZATIONAL AND PAYMENT MODELS

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

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

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

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

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

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

Rewards for Provider Performance

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

Beneficiary Rewards and Responsibilities

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

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

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

Supporting Improved Provider Performance

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

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

Encouraging Provider Participation

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

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

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

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

PAYMENT INITIATIVES TO ALIGN INCENTIVES AND CONTROL COSTS

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

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

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

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

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

The Center for Medicare and Medicaid Innovation

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

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

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

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

- **Payment innovations proposed by states and private entities**—"Ground-up" as well as "top-down" approaches should be developed by encouraging and approving promising models developed by and with states and/or private sector entities. Medicare traditionally has played a lead role in developing and implementing new payment policies, including the diagnosis related group and resource based relative value scale payment systems. However, there are many initiatives currently being pursued by other public programs, state governments, and the private sector. CMS should pursue coordinated initiatives, including those developed and led by states or private sector entities, and actively encourage states to propose multi-payer payment reform initiatives.

- **Multi-payer approaches**—Medicare should join with other federal and state health programs, as well as private payers, in adopting these payment models for participating providers. New initiatives that involve Medicare, Medicaid, CHIP, state employee health plans, and private insurers can be expected to have a greater impact on provider behavior and should receive priority. This should provide more consistent incentives, reduce provider administrative burden, and more rapidly diffuse promising models throughout the health system.

- **"Innovation With Evidence Development"**—CMS has developed an approach to coverage determinations that it has termed "Coverage With Evidence Development," under which Medicare may cover a promising item or service under the condition that the patients using the technology participate in a registry or clinical trial. This approach provides beneficiaries access to promising treatments while continuing to monitor their effectiveness and safety. This same philosophy should apply to the development and implementation of new models of payment and health care delivery—a type of "Innovation With Evidence Development."

- **Transparency**—The process for selecting, developing, and implementing Medicare payment initiatives should be based on criteria that are well understood by potential participants. Making the process more transparent would help safeguard its integrity and allow for better and more timely decision-making. This would involve both establishing an explicit set of criteria for identifying and selecting new initiatives for development and allowing more open discussion of the policy changes of interest and their potential impacts.

- **Information and assistance**—Establishing appropriate incentives may not be enough to ensure success in achieving delivery system reform. Payers can assist providers by organizing or financing community-level shared resources such as health information exchanges to support clinical decision-making and facilitate coordinated care; 24-hour, seven-day coverage for after-hours care so patients can obtain the care they need when they need it; technical assistance with care redesign and quality improvement; and chronic care nurses to help patients with chronic conditions manage them. Collaboration among payers and providers in each community to provide these services can increase the probability of success while increasing system-wide efficiency and effectiveness.

- **Rapid data feedback**—Rapid data feedback and assessment will allow payment models to continue to evolve as experience is gained with them. Initiatives should be continuously monitored, and bellwether measures should be developed that allow preliminary evaluations to help indicate directions not only for the development of new pilots but also for changes in existing ones. Participating providers would also benefit by knowing where they are performing well relative to other providers, and where they might most appropriately focus their improvement efforts.

- **Sufficient authority**—Efforts must be made to simplify the approval process for testing payment innovations. Increasing transparency, as described above, and establishing clear lines of accountability would go a long way toward reducing the need for a lengthy and burdensome process as a protective mechanism against inappropriate proposals designed to advance the interests of specific institutions or geographic areas. Sufficient authority should be vested in the Secretary of HHS in consultation with the Administrator of CMS to make the decisions—including negative decisions—but holding her or him publicly accountable for those decisions.

- **Ability to "escape gravity"**—Both the Innovation Center and the providers, patients, and other payers who participate in the innovation process must focus on the need to be willing to try new approaches, even if they involve some risk. To be sure, CMS has a responsibility to protect both the fiscal and the policy integrity of the programs for which it is responsible and providers are justified in expecting fair and reasonable payment for their efforts, but Americans also have a right to expect a high

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

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

CONCLUSIONS

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

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

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

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

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

NOTES

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

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

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

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

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

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

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

[8] Atul Gawande, "Testing, Testing." *The New Yorker* December 14, 2009.

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

Chairman HERGER. Dr. Watkins, you are recognized for 5 minutes.

STATEMENT OF LISA DULSKY WATKINS, M.D., ASSOCIATE DIRECTOR, VERMONT BLUEPRINT FOR HEALTH, DEPARTMENT OF VERMONT HEALTH ACCESS, WILLISTON, VERMONT

Dr. WATKINS. Thank you very much. Chairman Herger, Congressman Stark, Members of the Subcommittee, thank you for this opportunity to address you today.

I don't think there is any question that fee for service promotes volume and rushed care, as Mr. Guterman has pointed out. And

the point of the Vermont Blueprint is to address that very issue with an emphasis on moving in a transition from episodic or acute care to planned and preventive care.

The Vermont Blueprint for Health is leading system delivery reform in our State and nationwide. We have been successful in some ways largely due to strong bipartisan support from our legislature and from our Governor over the last 8 years.

The 2003 launch of the blueprint, in response to the overwhelming, looming problems with the cost of chronic disease, as we look at the baby-boom generation aging and increasing obesity-related problems such as diabetes and heart disease, was a very specific chronic-care initiative. It has since transformed significantly into a true spectrum of prevention with health maintenance that is appropriate to age and gender, now moving into pediatrics and "birth to earth," if you will.

The overall goals are obviously to improve health care services both in terms of the outcomes that are able to be demonstrated clinically, as well as the experience with patient care; look at the health of the population as a whole; and control health care costs.

Our innovations in terms of payment reform have been twofold and very specific. We are continuing with fee for service because that is the nature of payment in our country today. But, in addition, we have two new streams of funding specifically for primary care, which has been the emphasis of our work thus far.

One, it revolves around true, enhanced payments on a per-patient, per-month basis attributed to those practices that are recognized as Patient-Centered Medical Homes through the NCQA recognition process, a grade, if you will, from 0 to 100. The higher the grade, the higher payment per patient per month. That goes directly to the practice. And this is not a function of lab tests or cutoffs that are punitive; this is truly a function of communication and access to the practice.

A second new stream of funding comes to the practice and the community through the hiring of individuals at a Community Health Team, a very novel approach to actually care coordination at the local level. These multidisciplinary, locally based care-coordination teams serve multiple practices and actually do the outreach and coordination that desperately needs to be done in primary care, but is not compensated for and, therefore, often falls between the cracks.

As I said, these are two new funding streams, and the innovation in Vermont has required that all insurers who do business in the State of Vermont, our major commercial payers, Vermont Medicaid and now Medicare, will be joining us to actually pay for these innovations. So it is additional funding to the primary care practices to benefit the patients and their families. The Center for Medicare Innovation has made that possible through the Multipayer Advanced Primary Care Practice Demonstration, allowing Medicare to join with private insurers and Vermont Medicaid in these innovations.

We do have trends that are very encouraging in terms of cost and decreased utilization. A lot of that detail obviously cannot be shared in 5 minutes, but we are actually seeing decreased utilization of emergency rooms and inpatient days, both of which are ex-

traordinarily expensive. And this is very encouraging as we look at our trends.

We have over 2 years of experience now in our first pilots. We are rolling out to the entire State because we have legislation that mandates that the insurers continue to allow us to do this work and actually support every primary care practice in the State of Vermont that chooses to be part of them.

Our evaluation infrastructure is extraordinarily robust. We are very excited to have probably more data than we will know what to do with, hopefully within the next year or so, both in terms of clinical data, experience of care, as well as a return-on-investment model that is allowing us to look at the financial impact and examine the efficacy of our program.

I don't have enough time to describe the anecdotes, but I think I can really very clearly state that in terms of the experience of this program, that both providers and patients are extremely happy with it. Patients will describe the sense of feeling someone cares about them, really wrapped around them, and getting services that fall far outside the normal traditional health care experience of going to the doctor's office. And the providers who have been involved in this process through these last couple of years have actually said in very clear terms and in public that the joy of the practice of medicine is back.

Thank you.

Chairman HERGER. Thank you.

[The prepared statement of Dr. Watkins follows:]

THIS TESTIMONY IS EMBARGOED UNTIL 2:00 PM MAY 12, 2011
VERMONT BLUEPRINT BACKGROUND AND HISTORY

Legislation

The Douglas Administration formally launched the Vermont Blueprint in 2003. The goal at the time was to address the increasing costs of caring for people with chronic illnesses, with an early emphasis on diabetes management in response to the overwhelming projected burden of morbidity and resource utilization. The transition to a more broadly defined Health Reform agent of change has occurred over time. Throughout the Blueprint's history, the Legislative and Executive branches have been critical in its support and development as follows:

- **2006** – The Blueprint officially became law when the Vermont Legislature passed Act 191, sweeping Health Care Reform that also created Catamount Health to provide coverage to uninsured Vermonters. The Act included language that officially endorsed the Blueprint and expanded its scope and scale.
- **2007** -- The Legislature further defined the infrastructure for administering the Blueprint with Act 71 and mandated "integrated" pilot projects to test the best methods for delivering chronic care to patients -- based on the Patient Centered Medical Home model and multi-disciplinary locally-based care coordination teams (Community Health Teams). The original pilot sites were chosen through competitive request for proposals processes in 2007 and 2008 from communities that had been actively involved in Blueprint quality improvement initiatives. Voluntary payment reform to support these innovations in health care delivery was introduced. This transition ultimately led to the Advanced Primary Care Practice model now being implemented statewide.
- **2008** -- Act 204 further defined the Integrated Pilots and officially required insurer participation in their financial support, which covered approximately 10 percent of the state population.
- **2009** – Launch of the Vermont Accountable Care Organization Pilot (ACO) -- A project led by the Vermont Health Care Reform Commission (HCRC) to investigate how ACOs might be incorporated into the state's comprehensive health reform program.
- **2010** – Act 128 updates the definition of the Blueprint for Health as a "program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management." It also requires the Commissioner of the Department of Vermont Health Access to expand the Blueprint for Health to at least two primary care practices in every hospital services area no later than July 1, 2011, and no later than October 1, 2013, to all primary care practices statewide that wish to participate.

See http://hcr.vermont.gov/legislation for more detail on specific legislation.

Blueprint Integrated Health Service Program and Advanced Primary Care Practice

The Advanced Primary Care Practice model (the basis for the original Blueprint Integrated Pilots and subsequent expansion to the Integrated Health Service program) is characterized by seamless coordination of care. It stresses the importance of preventive health – engaging people when they are well, as well as giving patients the tools to keep existing conditions from worsening. Patients are encouraged to become active partners in their own care, and practices become effective and efficient teams.

As one of the requirements of recognition as a Blueprint IHS APCP, practices must meet a set of criteria for Patient Centered Medical Homes, established by the National Committee for Quality Assurance (NCQA), a non-profit organization dedicated to improving health care quality. Per the 2007 Joint Statement from the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians and the American Osteopathic Association, a "Patient Centered Medical Home is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients and their personal physician and, when appropriate the patients' families." (See http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home).

The PCMH philosophy is that the delivery of health care is analogous to a "team sport". The following are some basic principles:

1. Patients identify and get access to their primary care team as their first contact for a new or ongoing health care concern. While the primary care provider directs the team, appropriate access is enhanced.

2. The practice routinely acts from a whole person and patient centered orientation. The scope of primary care is not just bio-medical care, but also the creation of a continuous healing relationship that address multiple dimensions of care (psycho-social) and social realities and concerns. Individual care plans are responsive to patient preferences and reflect up-to-date evidence-based guidelines.

3. Attention is paid to population health outcomes. The goal is to affect a whole population, and not just segments of it.

4. Care is coordinated and integrated, linking the practice-based activities with multiple external providers. This takes human resources, time, and the establishment of relationships – supported by technology for tracking, communication and decision making.

5. The PCMH practice demonstrates capacity for continuous learning and practice improvement. Emphasis is placed upon quality improvement both of internal practice

processes (electronic medical record implementation, scheduling for increased access, prescription filling, and laboratory test and imaging results) and evaluation and measurement of individual and group outcomes.

6. The practice is committed to achievement of the "Triple Aim": improving patient experience of care, improving health outcomes for the population, and "bending" the cost curve.

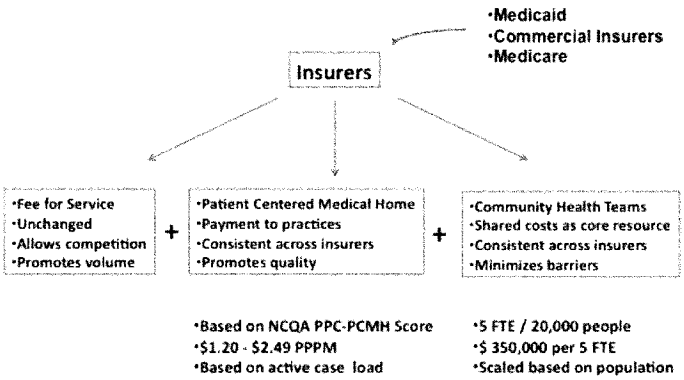
Using the NCQA Physician Practice Connection – Patient Centered Medical Home (PPC-PCMH) recognition rubric, practices are scored on their compliance with standards related to areas such as access and communication, patient tracking and registry functions and advanced electronic communications. These evolved practices create internal teams, maximizing the effectiveness of their staff and expanding the definition of their roles within the site and beyond.

See http://www.ncqa.org/tabid/631/Default.aspx for a full description of the NCQA PPC-PCMH standards.

Payment Reform

Figure 1. Payment Reform Schematic Diagram

Multi-insurer Payment Reforms



Vermont's Integrated Health System APCP model includes two components of payment reform, which are applied consistently to all participating public and commercial insurers. Currently, fee-for-service methodology remains intact, with the reforms below in addition.

1. *Enhanced Payments to Advanced Primary Care Practices*
   All insurers pay each recognized APCP an enhanced provider payment above the existing fee-for-service payments – calculated on a per patient per month (PPPM) basis – and based on the quality of the health care they provide as defined by the NCQA PPC-PCMH standards. In order to calculate payment, each insurer must count the number of their beneficiaries that are attributed to a practice, and multiply that by the PPPM amount.

2. *Community Health Team Payments*
   The Vermont Blueprint emphasizes that the excellent and challenging work of an APCP must be supported by more than just the NCQA PPC-PCMH-triggered payments. A dedicated Community Health Team (CHT) provides this essential

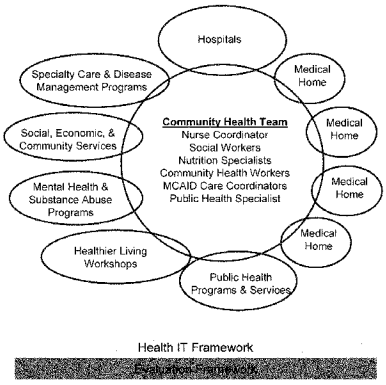
range of services. Insurers currently share the costs of CHTs equally. This support allows the services of a CHT to be offered free of charge to patients and practices, with no co-pay or prior authorization. Insurers provide a total of $350,000 per full CHT annually, which serves a general population of 20,000, with shares paid to a single existing administrative entity in each HSA. This combined funding covers the salaries of the core team, allowing for barrier-free access to the essential services provided. While this "core" CHT often works one-on-one with patients to meet a wide range of needs, the "functional" team may be much larger, including members of other local individuals and organizations who work in partnership with the CHT and the APCP.

Planning and refining these elements are achieved through consensus in the Blueprint Expansion Design and Evaluation Committee, and the details of implementation at the Blueprint Payment Implementation Work Group. Both groups are well represented by a wide variety of stakeholders and serve to advise the Blueprint Executive Director.

Community Health Teams

The Blueprint's cutting edge payment reforms allow for the innovative Community Health Teams (CHTs) to provide services free of charge to the APCP patients. The multidisciplinary CHT partners with primary care offices, the hospital, and existing health and social service organizations. (Please see Figure 2.) The goal is to provide Vermonters with the support they need for well-coordinated preventive health services, and coordinated linkages to available social and economic support services. The CHT is flexible in staffing, design, scheduling and site of operation, resulting in a cost-effective, core community resource which minimizes barriers and provides the individualized support that patients need in their efforts to live as fully and productively as possible. The CHTs function as extenders of the practices they support, and their services are available to all patients (no eligibility requirements, prior authorizations or co-pays).

Figure 2. Community Health Team Schematic Diagram

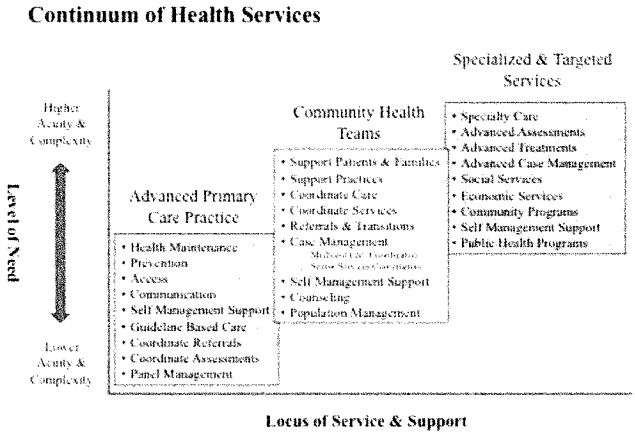


To ascertain the local Health Service Area's specific needs, the local IHS workgroup identifies current health services and existing gaps for patients and providers in participating primary care practices and the surrounding community. Based on the information obtained, the group will build the foundation of the CHT by working together to determine how existing services can be reorganized and what new services are required.

The overall design of the Blueprint Integrated Health Services model provides patients with seamless and well-coordinated health and human services. This includes transitioning patients from patterns of acute episodic care to preventive health services. Well structured follow up and coordination of services after hospital based care has been shown to improve health outcomes and reduce the rate of future hospital based care for a variety of patient groups and chronic health conditions (e.g. reduce emergency department visits, hospital inpatient admissions, re-admissions). CHT members, hospital staff, and other community service providers work closely together to implement transitional care strategies that keep patients engaged in preventive health practices and improved self-management. A goal of the Blueprint model is seamless coordination across the broad range of health and human services (medical and non-medical) that are essential to optimize patient experience, engagement, and to improve the long term health status of the population.

The Community Health Team serves as the central locus of coordination and support for patients. The spectrum of services from those appropriate for the general population to those targeted to subgroups with specific needs is illustrated in Figure 3, below.

Figure 3. Spectrum of Health and Health-Related Services



Expansion and Quality Improvement Program (EQuIP)

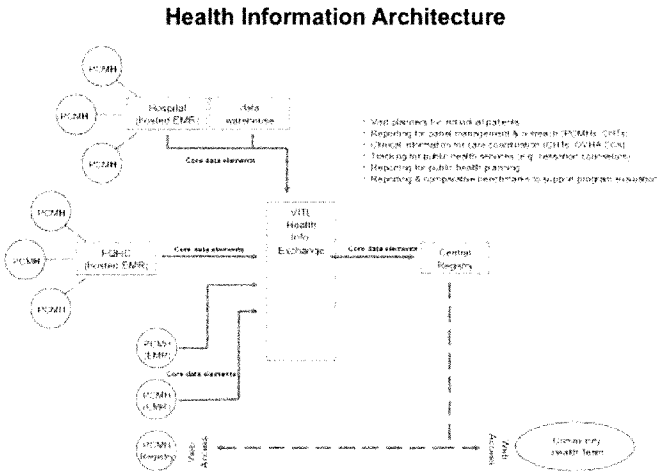
The scope and scale of primary care practice transformation requires extraordinary support. In addition to the enhanced financial components of the Blueprint's payment reforms, the individual primary care sites are working with highly skilled practice

facilitators through the statewide Expansion and Quality Improvement Program (EQuIP). These individuals, funded by the state, work with 9-15 primary care practices on process improvement, clinical projects and team building. While a great deal of emphais is currently on preparation for recognition as a patient centered medical home by NCQA, their work continues far beyond that in a continuous quality improvement cycle.

Health Information Architecture

The Blueprint works closely with the Vermont Information Technology Leaders (VITL) – the state-sponsored Health Information Exchange (HIE) – to develop infrastructure that supports the meaningful use of health information. The core of this infrastructure is the Blueprint's centralized registry and web-based clinical tracking system: DocSite-Covisint. The registry is used to produce visit planners that guide individual patient care, and to produce reports that support population management, quality improvement, program evaluation and comparative benchmarking.
Data from the IHS APCP sites are sent to DocSite from the point of care, either entered manually into the web-based portal or via interfaces with electronic medical records and direct feeds from labs and hospitals. It is a major goal to facilitate the entry of data at the point of care while minimizing any disruptions to the work flow of the practice. This is a major improvement process and effort at the practice level, facilitated by the EQuIP and internal practice teams. All aspects of the Blueprint's information architecture are designed to meet strict guidelines concerning data access and privacy protections.

Figure 3. Blueprint Health Information Technology Architecture



Evaluation Infrastructure

The Blueprint has established a multi-faceted assessment process to support evaluation and ongoing refinement of a complex transformation process. Where possible, evaluation and reporting build on Vermont's steadily growing health information infrastructure with centralized clinical and administrative data sources that are populated as part of the normal daily activities of health service providers. Web based flexible reporting is being instituted to make best use of these centralized data sources in a way that supports rapid cycle evaluation. In addition, supplemental research activities are required to more fully understand the impact of the program, particularly the human and societal impacts that may not be readily determined with structured clinical and administrative data captured as part of routine operations. The major components and current status of the Blueprint evaluation program are summarized below (Table 1).

Table 1. Evaluation infrastructure

Data Sources	Databases	Measures	Reporting	Status
Data feeds from EMRs and Hospitals through Vermont Information Technology Leaders (VITL) health information exchange network. Direct use of registry as health services tracking system by practices and other service providers	Web based central clinical registry. Developed and hosted by Covisint - DocSite.	▪ Clinical Processes ▪ Health Status ▪ Performance ▪ Comparative Effectiveness	▪ Web based flexible reporting by registry system ▪ Feeds to University of Vermont (UVM) Informatics Platform	▪ Active data transmission and reporting ▪ Expand interfaces and data transmission in collaboration with VITL as Blueprint expands statewide
Data feeds (demographic & paid claims data) from insurers. Common format allowing integration into single data base	Multi-payer claims database. Developed and hosted by Onpoint Health Data.	▪ Healthcare Patterns ▪ Resource Utilization ▪ Healthcare Expenditures ▪ Performance ▪ Comparative Effectiveness	▪ Analysis & standard reports generated by Onpoint Health Data ▪ Includes detailed evaluation of utilization & costs for patients treated in Blueprint model with comparison cohorts. ▪ Feeds to UVM Informatics Platform	▪ Complete data sets from all commercial insurers. ▪ Vermont Medicaid implementing data transmission ▪ Work beginning with CMS to get Medicare data sets
Data sets from hospital, practice, and insurer administrative data systems. Supplied by Information Technology staff at hospitals for hospital affiliated practices	Data sets maintained and analyzed by Jeffords Institute at Fletcher Allen Health Care	▪ Emergency Room Visits ▪ Hospital Admissions ▪ Utilization rates as affiliated practices transition to Blueprint model	▪ Analysis & standards reports generated by Jeffords Institute at Fletcher Allen Health Care. ▪ Includes trends over time in hospital based care for patients treated in Blueprint model	▪ Data and early trends available for hospital affiliated practices available from Blueprint pilot communities ▪ Medicaid preparing data set across communities
Structured chart reviews in primary care practices conducted by Vermont Child Health Improvement Program (VCHIP) based at the University of Vermont (UVM)	Chart review data set maintained and analyzed by VCHIP at UVM	▪ Clinical Processes ▪ Health Status ▪ Performance ▪ Comparative Effectiveness	▪ Analysis and standard reports generated by VCHIP / UVM ▪ Includes analysis of healthcare quality and health outcomes, trends over time	▪ ~ 4500 charts reviewed annually. ▪ ~ 3 years of data available thru CY 2009 ▪ Early trends available for pilot and comparison communities
Structured scoring of practices based on National Committee on Quality Assurance Physician Practice Connections-Patient Centered Medical Home (NCQA PPC-PCMH) standards conducted by VCHIP at UVM	NCQA PPC-PCMH scoring data set maintained and analyzed by VCHIP at UVM	▪ Clinical Processes ▪ PCMH Standards	▪ Analysis & standard reports generated by VCHIP at UVM ▪ Includes analysis of the relationship between NCQA PPC- PCMH standards, clinical quality, and health status measures from chart review	▪ Baseline NCQA PPC-PCMH Scoring available for practices in pilot communities. and in near term expansion communities ▪ Repeat scoring available in select practices

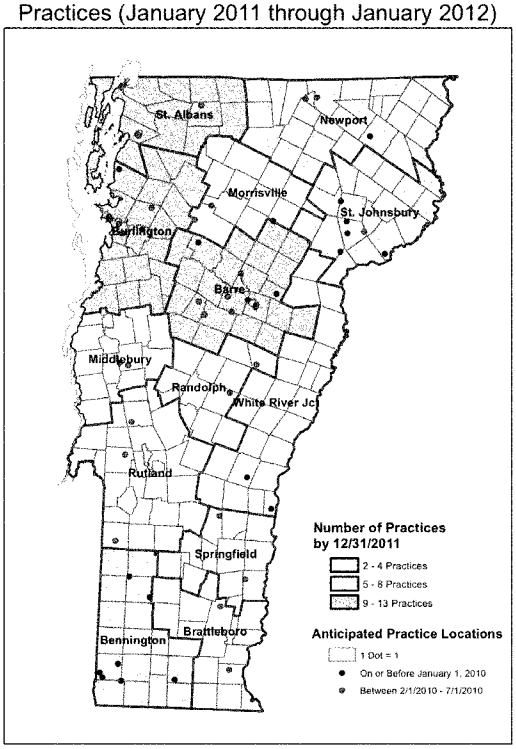
Data Sources	Databases	Measures	Reporting	Status
Structured qualitative assessments using focus groups and interviews addressing the experience of practice based providers, community health team members, and patients. Conducted by VCHIP/UVM.	Qualitative assessment data maintained and analyzed by VCHIP/ UVM	▪ Consistent trends and key findings based on the experience of practice based providers, community health team members, patients. ▪ Strengths, challenges, recommendations for improvement	▪ Analysis & standard report generated by VCHIP/UVM	▪ Early findings available for Blueprint pilot communities and one comparison community
Hospital Discharge data through Vermont Department of Banking, Insurance, Healthcare Administration (BISHCA). Behavioral Risk Factor survey data, and Youth Risk Factor survey data generated by Vermont Department of Health (VDH)	Public Health Registries maintained and analyzed by VDH Epidemiology & Statistics Section.	▪ Rates of hospital admissions, emergency care, procedures, associated charges, demographic risk factors, social risk factors, economic risk factors, behavioral risk factors, clinical risk factors	▪ Analysis & standard reports generated by the VDH Statistics Section ▪ Includes mapping and trends over time for multiple variables related to chronic conditions	▪ Report available that includes 10 year trends in Vermont ▪ Useful for planning health services strategies and tracking change over time at a population level
Data feeds from multi-payer claims database (Onpoint) and central clinical registry (Covisint DocSite) currently planned. Potential for other data sources (e.g. public health registries)	Integration of data and merged database maintained by Center for Translational Sciences at UVM	▪ Clinical process ▪ Health status ▪ Utilization ▪ Expenditures ▪ Predictive modeling	▪ Web based flexible reporting from novel statewide integrated informatics platform (e.g. merged clinical, utilization, and expenditure data) ▪ Data sets for advanced analytics	▪ Informatics platform under development at UVM ▪ Data sharing agreements being prepared for multi-payer claims data and central clinical registry data

Early trends are pointing towards decreases in utilization of expensive services such as emergency room visits and inpatient admissions in the initial pilot sites. Further collection and analysis of data will more clearly indicate the efficacy of the program. For more information, please see the *Vermont Blueprint for Health 2010 Annual Report to the Legislature* at the following link:
http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf

Please see the Financial Impact model in Appendix I for "Return on Investment" information.

Figure 4. Statewide Blueprint Expansion

Blueprint Expansion: Anticipated Advanced Primary Care Practices (January 2011 through January 2012)



Date: 1/14/2011

Blueprint expansion is mandated in legislation, and is currently on track to achieve the milestones articulated for July 1, 2011. The statewide network of project managers at the Health Service Area level is responsible for this complex process following the steps outlined in the *Blueprint for Health Implementation Manual.* (http://hcr.vermont.gov/sites/hcr/files/printforhealthimplementationmanual2010-11-17.pdf)

Endnote

For more information on the Blueprint, please see the *Vermont Blueprint for Health 2010 Annual Report to the Legislature* at the following link: http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf

For general information on Vermont's Health Care Reform efforts please see the following link: http://hcr.vermont.gov

Respectfully submitted,

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Chairman HERGER. Ms. Safran, you are recognized for 5 minutes.

STATEMENT OF DANA GELB SAFRAN, SC.D., SENIOR VICE PRESIDENT FOR PERFORMANCE MEASUREMENT AND IMPROVEMENT, BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, BOSTON, MASSACHUSETTS

Ms. SAFRAN. Thank you, Mr. Chairman, Congressman Stark, Members of the Committee. I am Dana Gelb Safran, senior vice president for performance measurement and improvement at Blue Cross Blue Shield of Massachusetts, and I thank you for the oppor-

tunity to speak today about the work that we are doing on payment reform.

As this committee considers the important issue of physician payment, and specifically the SGR, I am pleased to have this opportunity to share a model that has taken hold in Massachusetts.

This work and its early results suggest that it may indeed be necessary to think beyond physician payment to consider overall system payment in order to realize the goal of sustainable growth. A holistic view of payment may also be necessary to reduce the fragmentation of care that we all recognize as a key failing of our current system.

In 2007, Blue Cross of Massachusetts recognized that to address the unrelenting and unsustainable medical cost trends would require fundamental change in provider payment and incentives. With an annual medical spend of about $13 billion, we sought to develop a model that would do two things, significantly improve the quality, safety and outcomes of care, and significantly slow the rate of growth on that 13 billion. The alternative quality contract, or AQC, developed in 2007 and launched in 2009, was our effort to advance these twin goals.

Approximately 40 percent of our provider network has now contracted under the AQC model. There are five features of the model that differ from our traditional contracts. First, a provider organization that enters an AQC contract agrees to accept accountability for the full continuum of care for their patients from prenatal care to end-of-life care and everything in between. This doesn't mean that the provider organization itself must be capable of providing every aspect of care, but they must agree to be accountable for both the cost and quality of care provided to their patients, regardless of where it is provided.

Second, the AQC contract is a 5-year deal, which is considerably longer than our traditional contracts.

Third, payment is based on a global budget for a defined patient population. The AQC thereby moves way from fee-for-service incentives and establishes a model in which the provider assumes accountability for total medical spending on its patient population.

Importantly, each AQC provider's budget is set based on that organization's historical rate of spending for its patient population. In this way providers are assured that their starting budgets contain sufficient funds to care for their patients, but have a strong incentive to spend those dollars prudently.

A fourth distinguishing feature of the AQC is that the rate of inflation on total medical spending over the 5-year contract is negotiated up front and is designed to come down to rates approximating general inflation over the 5-year period.

A fifth and very important feature of the AQC is that it includes financial incentives tied to performance on a broad set of quality and outcome measures. In total, the model includes 64 nationally accepted, clinically important measures of hospital and ambulatory quality.

To our knowledge, the AQC is the first contract that requires providers to assume responsibility for the outcomes achieved through their care, not solely for the care delivered in the four

walls of their setting. The importance of this feature cannot be overstated.

Finally, let me highlight some early results of the AQC. With respect to medical spending, year 1 results show the AQC is on track to achieve its original goal of cutting spending growth rates in half over a 5-year contract period. Each and every AQC organization was successful in managing to their year 1 budget and achieving savings, despite the fact that AQC groups vary enormously with respect to size, organizational structure, geography and, importantly, their prior experience with accountability for medical spending.

With respect to quality, each and every AQC organization made significant improvements across a broad set of quality and outcome measures. By the end of year 1, quality of care in the AQC segment of our network was significantly higher than the non-AQC segment, and rates of improvement were several fold higher than prior improvement rates.

These early findings hold several important lessons, but perhaps foremost among them is that the model provides evidence that a payment system that creates provider accountability for both medical spending and health care quality and outcomes appears to be a powerful vehicle for realizing the goal of a high-performance health care system with a sustainable spending growth rate.

I thank you very much and look forward to your questions.

Chairman HERGER. Thank you.

[The prepared statement of Ms. Safran follows:]

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

Testimony of Dana Gelb Safran, Sc.D
Senior Vice President
Blue Cross Blue Shield of Massachusetts
Innovative Delivery and Physician Payment System Reform Efforts
May 12, 2011

Thank you, Mr. Chairman, Congressman Stark and Members of the Committee.
I am Dana Safran, Senior Vice President for Performance Measurement and Improvement at Blue Cross Blue Shield of Massachusetts ("BCBSMA") and I thank you for the opportunity to discuss our work towards realizing a vision of safe, effective, affordable, patient-centered health care.

Blue Cross Blue Shield of Massachusetts is one of 39 locally based, community operated Blue Cross and Blue Shield Plans that collectively provide health benefits to nearly 98 million Americans and contract with hospitals and physicians in every U.S. zip code. All Blue Plans share a commitment to transitioning from a payment system based on fee-for-service design -- which rewards volume and intensity of care -- to one that pays based on quality, safety, and value.

At BCBSMA, our highest priority is to make quality health care affordable for individuals, families and employers who have made us the health plan of choice in Massachusetts. Our promise and vision guide our efforts to create greater value for our members and employers. Founded in 1937 by a group of community-minded business leaders, BCBSMA is the leading private health plan in the Commonwealth---a not-for-profit company with a proud history of community and health care leadership.

As the Committee considers the important issue of physician payment, and specifically, the SGR, I am pleased to have this opportunity to share a model that has taken hold in Massachusetts. The payment reform efforts of BCBSMA that I will describe to you today, and early results of this work, suggest that it may indeed be necessary to think beyond physician payment to overall system payment in order to realize the goal of "sustainable growth." This holistic view of payment may also be necessary to reduce the fragmentation of care that we all recognize as a key failing of our current system. This fragmentation is, almost certainly, a by-product of payment models that contemplate physician payment and institutional payment separately.

In Massachusetts, as in the rest of the nation, the unrelenting rise of health care spending imposes an unsustainable burden on the economy and on individual consumers. In 2007, BCBSMA recognized that to fundamental changes in provider payment and incentives would be required to address medical cost trends. With an annual medical spend of approximately $13 Billion in claims, we sought to develop a model that would achieve two goals: significantly improve the quality, safety and outcomes of care; and significantly slow the rate of growth on that $13 Billion.

Developed in 2007 and launched in 2009, BCBSMA's Alternative Quality Contract (AQC), was our effort to advance these twin goals. Broadly stated, the AQC combines the financial incentives of a global budget as the basis for provider payment, very modest annual inflation rates over a 5-year contract period, and robust performance-based incentives on a broad set of quality and outcome measures. The AQC is providing evidence that improvements in both health care quality and spending are achievable through a payment model that establishes provider accountability for quality, outcomes and costs. To our knowledge, BCBSMA's AQC is the only payer-led initiative that has stimulated the formation of multiple accountable care organizations within a single market. Approximately 40% of our provider network has contracted under the AQC model. Continued significant growth, with additional contracts, is expected over the next many months.

AQC: History
In 2007, the company evaluated how to achieve the twin goals of significantly improving quality and outcomes while significantly slowing the rate of health care spending growth. The challenge before BCBSMA was to create a payment model that would align financial goals with clinical goals, linking payment to quality, outcomes and the careful use of health care resources.

A team of physicians, finance experts, and measurement scientists worked to develop a contract model that would give hospitals and physicians meaningful incentives to improve the quality and outcomes of care while also carefully stewarding overall health care spending. BCBSMA tested the concept with key hospital and physician leaders, local and national policy experts, employers, and other health care purchasers throughout the development process, and used that feedback and input to finalize the model.

What resulted is the *Alternative Quality Contract*, an innovative global payment model that uses a budget based methodology, which combines a fixed population-based budget (adjusted annually for health status and inflation) with substantial incentive payments for performance on a broad set of clinically important, nationally accepted measures of quality, outcomes, and patient care experiences.

AQC: The Cornerstones
The Alternative Quality Contract includes several key components that distinguish it from our traditional contracts and that are designed to enable the provider organizations to succeed at significantly improving quality and outcomes while moderating costs and spending growth.

- **Integration Across Continuum of Care**

A provider organization that enters an AQC contract agrees to accept accountability for the full continuum of care provided to their patients – from pre-natal care to end-of-life care, and everything in-between. This does not mean that the provider organization itself must be capable of providing every aspect of care, but they must agree to be accountable for both the cost and

quality of care provided to their patients, regardless of where it is provided. The only stipulation related to organizational structure in the AQC is that the provider organization must include sufficient primary care physicians to account for at least 5,000 our HMO or POS enrollees.

The very essence of the AQC is the important role of the primary care physician (PCP) as the center of a patient's care. The decision to forego a prescriptive approach to AQC organizational structure was made as we recognized that it was premature to know which structure or organizational features were truly required to be successful under a model requiring accountability for cost and quality. As it has unfolded, the range of organizational structures among AQC groups is extremely varied – including, at one end of the continuum, an AQC organization that includes only primary care physicians and at the other end of the continuum, a large multispecialty physician group with a history and roots as a staff-model HMO (that is, as much like Kaiser as anything we have in Massachusetts). In between are several physician organizations of varying size and scope, some including a broad range of specialist physicians, others not; some including a hospital as part of their contract and others not; almost all including a very large number of practices that are small or solo physicians tied together through an infrastructure and leadership that work to enable their success under the AQC model.

Regardless of the organizational structure and scope, each and every organization is accountable for the full continuum of care and for the total cost and quality of care received by their patient population. They do this through relationships that expand well beyond the confines of the providers that are party to their AQC contract. Importantly, as I will detail later, every one of these organizations is achieving substantial success – both on quality and on managing overall medical spending. This proves an important lesson in terms of the value of a payment reform model serving as the impetus for delivery system reform, but the importance of allowing those delivery system reforms to take shape in response to the new payment incentives.

- **Sustained Partnership (Five-Year Agreement)**

The AQC arrangement is a five-year agreement that encourages providers to invest in long-term, lasting improvement initiatives. It also establishes a new kind of partnership between the health plan and the organization that moves away from the sometimes adversarial relationship, which is focused on ongoing contract negotiations, and toward a more collegial partnership, which is focused on and committed to each other's success. These 5-year contracts are significantly longer that BCBSMA traditional contracts, which are typically 3-years for a hospital and 1- 3 years for physicians. The 5-year arrangement was viewed as important because we recognized that success under this model would require provider organizations to make significant changes in care processes, staffing and infrastructure, and we did not want either the provider or Blue Cross to be concerned by a next contract negotiation looming 6 or 12 months out.

- **Global Budget Financial Structure with Performance Incentives and Savings Opportunities**

BCBSMA establishes a global budget for AQC provider organizations to cover all services and costs. The contract model is designed to include inpatient, outpatient, pharmacy, behavioral health, and other costs and services associated with each of their BCBSMA patients. The initial global budget is based on historical health care cost expenditure levels. In this way, providers are assured that their starting budgets contain sufficient funds to care for their patient population -- but importantly, the provider now has important incentives to consider how best to use those funds in

service of the best quality, highest value care for each and every patient. If the AQC organization achieves savings on its budget, the organization retains all or some of those savings. If the organization outspends its budget, the organization is responsible for all or some of that deficit. There are numerous protections to guard against excessive or unfair financial risk to providers, but the AQC model creates a very real set of incentives for provider organizations to be careful steward of health care dollars. Budgets are adjusted throughout the 5-year contract to reflect changes in the health status of the provider's BCBSMA population. Since the AQC's global budget and annual inflation rates are set at the outset of the agreement for a five year period, the model brings both predictability and stability to annual health care cost increases, a significant benefit to the purchasers of health care, including consumers, employers and government.

- **Performance Measures**

Central to the AQC model is it's a set of significant financial incentives tied to performance on a broad portfolio of quality and outcome measures. As described elsewhere,[1] the model includes 64 nationally accepted, clinically important measures of hospital and ambulatory quality that, collectively, support the vision of safe, affordable, effective, patient-centered care. The accountability for performance on this broad set of quality and outcome measures, and the significant financial incentives associated with this, serve as an extremely important backstop against any impulse toward "underuse" or stinting that might otherwise be a concern under a global budget model.

BCBSMA evaluates AQC groups' performance on the quality measures in terms of performance targets ("gates") ranging from 1 to 5. For each measure, Gate 1 is set at a score that represents the beginning of performance considered to be good enough to merit some financial reward. Gate 5 is an empirically-derived score for each measure that represents the best that can be reliably achieved in a patient population. By presenting a range of targets that represent "good to great" performance, the AQC model incentivizes both performance excellence and continuous performance improvement. And through use of absolute performance targets that are fixed over the course of the contract and identical for every provider that enters the contract in that year, the model enables organizations to plan their resources in a way that will allow for continuous improvement toward Gate 5 performance over the course of the contract.

One of the most important aspects of the measure set is that it includes significant accountability for health outcomes – not just for health care processes. To our knowledge, the AQC is the first contract that required providers to assume responsibility for the outcomes achieved through their care – not solely for the care delivered in the four walls of the care setting. The importance of this feature cannot be overstated.

- **Data Support**

In order to succeed under the AQC model, BCBSMA understands that physicians need both clinical and financial data to help them identify opportunities for both efficiency and quality. Thus, with the launch of the AQC in 2009, BCBSMA established an internal team dedicated to supporting AQC groups' ability to implement timely medical management, and to continuously improve quality and efficiency. The AQC Support program is extended to all AQC organizations and includes a

[1] M. E. Chernew, R. E. Mechanic, B. E. Landon and D.G. Safran., "Private-Payer Innovation in Massachusetts: The 'Alternative Quality Contract," Health Affairs, Jan. 2011 30(1):51–61.

series of regular data and performance reports, ongoing consultative support from a team of clinicians and quality improvement advisors, and regular organized sessions where the groups meet together to address performance improvement issues and share best practices. Some information is provided to AQC groups daily – including information on patients who are in-hospital so as to allow the AQC to coordinate closely with the hospital and plan for the care that will be required when the patient is discharged. Performance information is provided monthly or quarterly through a series of reports allow groups to monitor their performance on the quality bonus measures, to monitor spending relative to their budget, and to evaluate opportunities for savings.

One unique set of reports that BCBSMA provides to assist AQC organizations with managing their use of overall resources is information on clinically-specific, unexplained practice pattern variations. The approach is rooted in the seminal work and compelling observations of Jack Wennberg and the Dartmouth Atlas – but importantly, moves the observations of practice pattern variation off of maps and into a framework that is clinically actionable for practicing physicians. The set of practice pattern variation analyses (PPVA) reports that BCBSMA provides includes: (1) condition-specific variations in treatment provided in a given medical or surgical specialty; and (2) potentially avoidable use of hospital resources (e.g., 30-day readmissions, non-urgent emergency department use, admissions for ambulatory sensitive conditions).

The condition-specific practice pattern variation analyses demonstrate how physicians within a given specialty (e.g., cardiology), differ from their peers in their use of particular treatments, tests or procedures for patients with the same underlying clinical status. The AQC groups receive analyses related to conditions such as: treatment of knee, back and hip pain; use of brand-name medications rather than generics, cardiac catheterization and coronary artery bypass graft (CABG) procedures; advanced imaging; non-urgent emergency room care; and treatment of gastroesophageal reflux disease (GERD).

BCBSMA's PPVA approach draws from a methodology developed by Dr. Howard Beckman (Rochester, NY) and successfully implemented through his work with Focused Medical Analytics' (FMA).[2] Dr. Beckman's work has demonstrated that, by comparing physicians' use of services to their local peers, and by addressing case mix concerns by narrowly defining the patient population of interest, individual physicians become quickly and meaningfully engaged in understanding and addressing differences in their tendency to use various treatments, tests and procedures compared with their peers. In beginning to use this approach in our network and the AQC groups in particular, BCBSMA's aim is to provoke important discussion among clinicians and leaders within each specialty, and ultimately, to stimulate the development of best practices and standards of care from within the profession. Such a process is preferable to one of externally imposed standards that might never be fully accepted by clinicians or patients.

AQC: The Results

First-year results show the AQC is on track achieve its original goals of improving patient care and moderating health care costs. In year-1 of the contract, all AQC groups met their budgets, and achieved a surplus. On the quality side, the AQC groups' first year improvements in the quality of

[2] RA Greene, HB Beckman, T Mahoney, "Beyond The Efficiency Index: Finding A Better Way To Reduce Overuse And Increase Efficiency In Physician Care," *Health Affairs*, 27, no. 4 (2008): w250-w25.9

patient care were greater than any one-year change seen previously in our provider network – well exceeding both the rates of improvement on quality measures that AQC groups were achieving prior to the contract, and exceeding rates of improvement among non-AQC physicians.

As previously mentioned, it is important to note that despite the fact that the AQC groups vary with respect to geography, size, management structure and experience with taking on risk for patient care, each and every AQC organization was successful in managing the global budget and significantly improving quality and clinical outcomes. The range of organizational models in the AQC includes multi-specialty integrated groups, independent practice associations, and several physician-hospital organizations, in which a physician group contracts with a particular hospital. Although all AQC physicians are part of some organizational structure that contracts on their behalf, about twelve percent of participating physicians are in one- or two-physician practices and one-third are in practices with fewer than five physicians. For these more distributed practices, qualitative feedback indicates that the role of the organizational leadership has been critical to their success. In fact, some of the most significant quality improvements come from the more loosely-affiliated, smaller provider organizations in the AQC.

Improving Quality and Outcomes

The first year quality results demonstrate that the AQC is changing the delivery of care across the system and improving patient care overall. As stated earlier, BCBSMA's set of AQC performance measures include both ambulatory and hospital quality indicators.

Ambulatory Performance: Clinical Process Measures. On the ambulatory care side, within the BCBSMA network, physicians that are part of an AQC group performed much better than those outside of an AQC arrangement on important measures of preventive care, like cancer screenings and well-baby care, as well as measures of chronic disease care. With respect to preventive care, the rate of improvement in AQC groups' performance on certain process of care measures was *three times* that of non-AQC physicians — and more than twice the AQC groups' own improvement rates prior to the contract.

Process measures assess the appropriate use of tests or procedures in accordance with clinical guidelines. For chronic diseases such as diabetes and cardiovascular disease, among the most costly and prevalent chronic care conditions, the AQC groups' rate of improvement on screening and monitoring measures far exceeded those of physicians not in an AQC contract. In year one of the contract, AQC organizations made gains on these measures at a rate *more than four-times* what they had been accomplishing before the contract. Importantly, AQC physicians serving a large segment of socio-economically disadvantaged patients were equally successful as those serving more advantaged groups with respect to achieving high levels of performance in both preventive and chronic care quality.

Ambulatory Performance: Clinical Outcome Measures. AQC groups also achieved extremely high performance on ambulatory outcome measures — that is, effectively managing a patient's chronic conditions to ensure that he or she is stable. In fact, for several of the clinical outcome measures, performance among AQC groups reached or approached the highest levels of quality believed to be attainable for a patient population. Outcome measures are clinical results, such as control of blood pressure, blood sugar, or cholesterol, which indicate that a patient's chronic condition like diabetes or cardiovascular disease is well-managed. Achieving high performance on these

measures requires physicians to engage with patients in a way that extends well beyond the bounds of the office visit. This is because success on these measures requires patients to both understand and be diligent about managing their condition on a day-to-day basis – including ongoing attention to dietary restrictions, medication use, and physical activity. Year one results on these clinical outcome measures demonstrate that the AQC physicians are indeed rising to the challenge of accountability for these results that occur *after* the patient leaves the office visit.

Hospital Performance: On the hospital side, the AQC groups made significant improvements on hospital quality in year-one, including improvements on a broad set of clinical quality and patient experience measures. Hospitals contracted as part of an AQC arrangement ended year-1 with significantly better results on inpatient clinical outcomes, including fewer infections and complications, and made significantly greater gains in patient care experience measures than non-AQC hospitals. All hospitals in our network participate in a program called Hospital Performance Incentive Program (HPIP), which offers hospitals financial rewards for performance on a set of measures nearly identical to those used in the AQC.

Moderating Health Care Spending

Year-1 results find the AQC on track to achieve its original goal of reducing annual health care cost trends by one-half over the five years of the AQC contracts while continuously improving quality. All AQC groups met their year-1 budgets, and achieved surpluses that enabled them to invest in important infrastructure and staffing improvements, such as care managers and electronic data sharing between physicians and the hospital. Infrastructure investments will help provider organizations deliver care more effectively and efficiently.

For the most part, the early savings relative to budgets were achieved through AQC providers addressing the price rather than the quantity of services received by their patients. That is, using information provided through the BCBSMA support program, AQC providers were able to identify less costly care settings for elements of care such as lab tests, imaging and routine procedures. By managing referrals for these types of commodity services to lower cost, convenient settings, AQC providers achieved significant savings without impinging on or disrupting existing patient care relationships. In other cases, AQC providers made concerted efforts to establish new relationships with lower cost, high quality hospitals and to begin moving business accordingly. The *Boston Globe* reported on a number of these newly forged relationships, wherein AQC providers began moving business from one Boston-based academic medical center to another – based both on the cost and quality of care at the AMCs.

To a more limited extent in year-1, AQC organizations began the more complex and challenging work of identifying and reducing clinically wasteful care. For example, one AQC group reduced non-urgent use of the emergency room by 22 percent in year-1, which translated into $300,000 in avoided ER costs. Two of the more mature AQC organizations, were able to significantly reduce hospital readmissions, saving $1.8 million in avoided hospital costs. Efforts to address overall utilization, identifying and reducing clinically wasteful care, are continuing and maturing over the course of the 5-year contracts.

AQC: The Future

The AQC first year results offer promise that provider organizations – given the right incentives, information, data and leadership – can quickly accomplish significant improvements in patient care and outcomes while at the same time reducing the growth in health care costs. Going forward, BCBSMA will continue to develop, expand and refine the AQC model, as well as:

- Work with AQC providers who would like to be part of Medicare and/or Medicaid payment reform demonstrations under a similar global budget model with quality incentives
- Align member incentives through new product and benefit design
- Pilot the expansion of AQC into PPO using either an attribution-based method or a "physician of choice" model (or both) as the means of identifying members' primary physician

In 2011, BCBSMA made some revisions to the original AQC model, taking into account key lessons learned from our experiences with the initial cohort of AQC groups. The two main revisions are as follows:

(1) In 2011 and 2012 contracts, annual inflation targets over the 5 year contract period will be tied to regional network average trends, rather than set in absolute (fixed percentage) terms. This change will obviate the need for some of the protections for environmental and/or market effects that have been necessary to include with the original model's fixed percentage trend targets. With targets tied to the regional network trend, these environmental factors will already be accounted for and thus, will not require ongoing adjustments over the course of the contract that added unintended complexity to the original model.

(2) Beginning with 2011 and 2012 contracts, the AQC model establishes a link between performance on quality and the AQC provider's share of surplus or deficit. Higher quality scores translate into a higher share of surplus retained by an AQC provider who achieves savings relative to their budget; and translate into a lower share of deficit borne by an AQC provider who overspends their budget. In this way, regardless of whether an AQC organization is running a surplus or deficit relative to their budget, they have a strong incentive to strive for the highest possible performance on the quality measures.

As the model evolves and expands, the AQC will lead to long-term sustainability of the health care delivery system and improved patient care and health. BCBSMA is committed to working with clinician and hospital partners to make the AQC model work for all types of health-care delivery systems.

For federal and state policymakers, the findings from the first year of the AQC hold several important lessons. Among these is evidence that a payment model that creates provider accountability for both medical spending and health care quality and outcomes appears to be a

powerful vehicle for realizing the goal of a high performance health care system with a sustainable rate of spending growth. Additionally, the demonstrated success of provider organizations that varied widely in size, scope, and composition – some with a hospital, others without; most comprised of many small and solo practices united through a common leadership – is encouraging and should inform delivery system reform efforts nationally. Multi-year contracts based on a global budget, with annual inflation rates that are set at the outset of the agreement can bring important and welcome predictability to health care costs for employers, the public and others purchasing care. Finally, payment models that liberate providers from many of the constraints of fee-for-service payment, and importantly, from a mindset that one only does for patients those things for which there is a billing code, are almost certainly necessary and fundamental to making real the vision of safe, affordable, effective, patient-centered care.

On behalf of Andrew Dreyfus, President & CEO of Blue Cross Blue Shield of Massachusetts and all of my colleagues, we look forward to working with the you as you address the important issues of delivery system reform. Thank you again for the opportunity to testify. I look forward to any questions you may have.

Chairman HERGER. Dr. Wilson, you are recognized for 5 minutes.

STATEMENT OF KEITH WILSON, M.D., CHAIR, GOVERNING BOARD AND EXECUTIVE COMMITTEE, CALIFORNIA ASSOCIATION OF PHYSICIAN GROUPS, DIAMOND BAR, CALIFORNIA

Dr. WILSON. Thank you, Chairman Herger, Ranking Member Stark and members of the Health Subcommittee for inviting me to testify on potential new models of health care delivery and physician payment models for Medicare beneficiaries.

I am here representing the California Association of Physician Groups, also known as CAPG, and its over 150-member multispecialty and IPA groups. Together we care for over 15 million Californians, or one-half of the insured population of California.

I am also here as a practicing physician and regional medical director of HealthCare Partners, a large multispecialty medical group, and IPA serving much of greater Los Angeles Orange County area.

I would like to speak to the virtues of capitation in contrast to the unsustainable nature of fee-for-service medicine. I would also like to highlight the value of capitation leading to a system of coordinated, integrated care that is not usually replicated in the fee-for-service model.

In California we have over two decades of experience in making prepaid medicine work, and I would like to share with you some of the lessons learned.

Capitation is great at creating an environment in which the at-risk provider groups are forced to focus on the total cost of health care and consequently figure out creative ways to impact the cost. This is usually best done by keeping patients as healthy as possible and out of the hospital.

We have designed systems of care that treat the patient based on their individual need and disease burden so that we may improve and stabilize their condition. We do this through a patient-centric model, allocating resources in a targeted manner.

My written testimony highlights a few of these creative interventions California groups have deployed, such as risk stratification and disease-specific care management programs.

We have learned to protect the public from groups taking excessive risk and subsequent failure through the implementation of regulatory oversight by the Department of Managed Health Care. California groups are required to report quarterly on solvency metrics, such as tangible net equity, timely payments and cash-to-claim ratios, among others.

We have also learned to avoid denial of care through public reporting of quality metrics and patient satisfaction scores deployed by the Integrated Healthcare Association.

Health plans incentivize physician group performance through pay-for-performance quality metrics developed by multiple stakeholders.

Capitation, if I might describe it a bit, consists of a fixed payment paid directly to the medical group, usually in the form of a PMPM, or per-member per-month payment. The physician group, or IPA, is then accountable for providing care for patients assigned to them within that budget. This payment methodology allows a predictable revenue stream that enables groups to plan for capital improvements and investment in infrastructure, like health information technologies. Indeed, some of the most sophisticated and advanced IT infrastructure exists in California groups as a direct by-product of capitation.

CAPG has developed a Standards of Excellence program that allows groups to compare their internal processes and capabilities on a voluntary basis. This program also provides a roadmap to up-

and-coming groups, identifying the tools and capabilities they will need to provide patient-centered care.

We think the California model can be a model for the rest of the country as we seek an alternative to fee-for-service medicine and to promote the spread of ACOs. We see the ACO model, however, as being handicapped, as they will need similar infrastructure to California groups, but there is no source of revenue such as capitation to benefit from.

We call for the deployment of capitation as the law allows for groups that are ready to take risk. We also suggest a means of front-loading revenue to groups and potential ACOs be sought and found so that they can develop the systems of care necessary to be responsible for a population of patients.

In closing, I would like to emphasize the superior performance of capitated model in delivering better quality, superior outcomes with great cost savings. One example of this is the comparative bid days between capitated Medicare in California yielding bed days of 982 per 1,000 versus traditional fee-for-service Medicare yielding bed days of 1,664 per 1,000. This relative value to overall system in terms of dollars and cents is astronomical.

I would like to thank you for the opportunity to speak to the committee today. I hope this information has been useful, and I would be happy to answer questions as I can.

Chairman HERGER. Thank you.

[The statement of Dr. Wilson follows:]

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

Statement of Keith Wilson, M.D., Chair, Governing Board and Executive Committee, California Association of Physician Groups
Testimony before the Subcommittee on Health of the House Ways and Means Committee
May 12, 2011

Thank you Chairman Herger, Ranking Member Stark, and Members of the Health Subcommittee for inviting me to testify regarding potential new models for healthcare delivery and paying for the services physicians furnish to Medicare beneficiaries.

I am pleased to testify today on behalf of the California Association of Physician Groups (CAPG). CAPG represents over 150 California multi-specialty medical groups and independent practice associations (IPAs). Our members serve over 15 million Californians, approximately one half of the state's insured population. Our patient base is larger than the total population of most other states. CAPG members provide comprehensive health care through coordinated, accountable, physician group practices. We strongly believe that patient-centered, coordinated, accountable care offers the highest quality, the most efficient delivery mechanism and the greatest value for patients. California physicians, including CAPG members, have operated under this accountable, budget-responsible model for over 25 years.

I also address you today in my capacity as Regional Medical Director for HealthCare Partners and as a physician. I have firsthand experience with many of the payment and quality issues that I will speak to in my remarks today and look forward to sharing these firsthand insights with the Committee. By way of background, HealthCare Partners medical group is composed of more than 50 medical offices and employs more than 700 primary and specialty

care physicians. Our service area includes Los Angeles, Pasadena, the San Gabriel Valley, South Bay, Long Beach, the San Fernando and Santa Clarita Valleys, and Orange County. HealthCare Partners provides health care services to commercial enrollees and fee-for-service patients and is one of the largest providers of pre-paid health care for seniors in California. In addition, the HealthCare Partners Independent Practice Association (IPA) model enables physicians in the community to affiliate with HealthCare Partners. These regional IPAs consist of more than 500 primary care physicians supported by 1400 specialists. The IPA service area surrounds the medial group, providing care to the populations of the San Fernando Valley, Pasadena and the San Gabriel Valley, Central Los Angeles and the South Bay.

We know that the current Medicare fee-for-service (FFS) payment system is unsustainable. Medicare spending is growing at a rapid rate and is consuming an ever greater portion of our federal spending—and the existing Medicare FFS payment methodology does nothing to restrain this growth. It is also a barrier to improvements in quality. Rather than encouraging providers to achieve the highest quality, efficient care for patients, the FFS methodology incentivizes providers for greater volume and intensity of services provided. In order to address the spiraling growth of health care costs, we must look at the underlying payment system and identify ways that it can be fundamentally changed to provide the necessary incentives to modify provider behaviors and move away from utilization-based payments.

In California, we have vast experience with payment models that provide viable alternatives to this failed FFS system. As I will describe today, the California model has used

capitated[1] payments for decades, combined with robust quality reporting and public accountability provisions, and a backstop provided by state regulation of risk-bearing entities. We believe that our capitated payment system can serve as a model for the rest of the country, especially as health care providers around the nation consider delivery system reforms, like accountable care organizations, whether they be Medicare, Medicaid or commercial payer-driven. We also believe that the lessons we have learned can pave the way for a delivery system in a post-SGR world that is more efficient, provides better quality care, and begins to bend the cost curve.

The California Medical Group/IPA Model – Containing Costs

I will begin with a description of the payment model our medical groups operate under, which is predominant in California. Our medical groups and IPAs are paid under a capitated model. In this model, provider groups are paid a fixed amount for each enrolled patient for services over a span of time, most commonly per member, per month, regardless of the amount of care the patient consumes. Nearly a third of California's population, including employer-based plans, Medicare, and MediCal, are covered under capitated arrangements. The scope of services covered by the capitated payment may vary for each given arrangement.

In California, medical groups and IPAs assume financial risk for patient care through capitation, and also have been delegated administrative and care management duties that would otherwise be performed by insurers. Under this "delegated model" the medical groups and IPAs

[1] We use the term capitation throughout but recognize that in the current health policy dialogue, this term can be used to embrace a variety of other concepts, such as bundled payments, partial capitation, condition-specific capitation, virtual partial capitation, and others.

assume certain responsibilities, like utilization management and chronic disease management to a group of physicians, typically a multi-specialty group practice or an IPA.

It is important to point out that these capitated payments I have just mentioned are made directly to the medical groups. Some of these groups then provide downstream payments to primary care or specialty care groups. These downstream payments may take the form of subcapitation, salary, or even some FFS payments in the event the group wants to incentivize higher utilization for a certain type of service, like preventive services. For example, a group might pay a FFS payment for childhood immunizations. The capitated payment made directly to the group permits this type of flexibility – the ability to encourage the provision of the types of care and patient outcomes that lead to healthier populations at a lower cost.

The delegated model and capitated payments directly to groups enable physicians to take responsibility for certain activities, such as engaging physicians in care management activities, promoting prevention, and coordinating care. The monthly, upfront payment of a budget for care for each patient in our population has enabled us to make strides in terms of improving outcomes for patients through initiatives that better manage patient conditions and have the effect of reducing costs in the system. Specifically, our member groups have been able to use the flexibility within their payment models to establish programs of care that have the effects of reducing unnecessary hospital admissions, reducing unnecessary emergency department visits, and caring for patients with chronic illnesses. I will now describe some of the CAPG members' initiatives in greater detail to give the committee a sense of the types of interventions we are talking about and the potential to improve care for patients.

Customized Care – Aligning Quality, Patient Experience, and Affordability

HealthCare Partners developed a program whereby they could maximize resource use by grouping patients into different levels based on the patients' health care needs:

- Level 1 – primary care physicians motivate, educate, and engage patients to get involved in their care and self-management with their primary care physician and care team;
- Level 2 – complex care management/disease management provides a long-term enhanced care oversight, multidisciplinary team approach for high activity patients, including those with diabetes, chronic obstructive pulmonary disease, congestive heart failure, chronic kidney disease, depression, or dementia
- Level 3 – comprehensive care and post discharge clinics provide intensive one-on-one physician care and case management for the highest risk patients;
- Level 4 – home care program provides in-home medical and palliative care management, physicians, nurse practitioners, care management, and social workers;
- Hospice/Palliative Care

Among patients enrolled in the program, HealthCare Partners was able to achieve significant results in terms of reducing admissions, reducing days of ER use and reducing urgent care use as shown in Table 1 below.

Table 1: HealthCare Partners Program Results

	Admits/1,000	Days/1,000	ER/1,000	UC/1,000
Pre-Program	1,339	5,460	959	534
In Program	1,144	4,261	141	130

HealthCare Partners has also created special programs, such as a comprehensive care clinic, an ESRD program, and a behavioral health program to assist with the complex needs of certain populations. Each of these interventions have resulted in improved outcomes for patients and cost savings in terms of reducing admissions, reducing lengths of stay, reducing ER use and reducing urgent care use.

Reducing Avoidable Emergency Care

Monarch HealthCare in Irvine California, is an integrated physician association covering all of Orange County with 2,500 physicians, 20 hospital affiliations and approximately 200,000 patients (commercial, senior and MediCal). Monarch recognized that inappropriate ED use often leads to poor care continuity and can contribute to poor patient outcomes. To address the problem of avoidable emergency care use, Monarch created a cross-departmental team, consisting of physicians, nurses, data specialists and provider relations representatives. Monarch then used data to analyze which patients were accessing the ED inappropriately and why. Monarch's team analyzed barriers to care and other reasons why patients were inappropriately accessing the ED, and was able to identify patients accessing the ED frequently and reached out to them directly. Monarch was able to reduce inappropriate ED use by 12.9% in the commercial population and 15.5% in the senior population. Monarch created a standardized reporting format for physicians to use as a platform for engaging patients that frequently access the ED. In addition, Monarch assessed its urgent care sites and created a brochure for patients and physicians listing the urgent care locations and the scope of service provided at each hospital.

Caring for Patients with Chronic Illnesses

Sharp-Rees-Stealy Medical Group is an integrated medical group in San Diego and part of the Sharp Healthcare System. Sharp-Rees-Stealy created a heart failure disease management program designed to reduce readmissions associated with heart failure. The group employed discharge planners and hospitalists, and implemented a communication system around discharges, including post discharge instructions. The group also measured outcomes. In the last two years, readmissions to the hospital within 30 days for all causes dropped by 33% resulting in a savings of approximately $2.2 million.

Financial Solvency

It is also important to note that the state has successfully grappled with the financial solvency of provider organizations that enter risk-bearing contracts with health plans. Then State-Senator Jackie Speier sponsored legislation, SB 260, establishing reporting and oversight that is vested in the California Department of Managed Health Care, the state's HMO regulator. Risk Bearing Organizations report their key financial metrics on a quarterly and annual basis to the Department. Five key metrics are used to determine solvency (IBNR, cash-to-claims, claims payment timeliness, etc.). If a risk bearing organization is deficient on one or more of the metrics, corrective action plans are implemented to prevent the entity from closing due to insolvency. Prior to the implementation of this program over 120 such entities had closed their doors. Since implementation, closures have been avoided completely, or other controlled forms of restructuring such as mergers, or "de-delegation" of financial risk have been employed with the result that the market has been greatly stabilized. We believe that this regulatory scheme in the state provides a key backstop, protecting both consumers and healthcare providers as they take on risk.

The California Medical Group/IPA Model – Improving Quality

A critical aspect of the success of our payment models is ensuring the highest quality care to patients. In California, we have combined innovative payment modeling with a robust quality measurement infrastructure, both at the state and organizational level.

First, the Integrated Healthcare Association is a statewide multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care in the state. The IHA evaluates physician groups based on four categories: clinical quality, coordinated diabetes care, information technology-enabled systems, and patient experience. The IHA's pay for performance programs reward physician practices and other providers with incentives based on their performance on these measures. (Notably, 45 CAPG member organizations, representing approximately seven million patients in the state, were awarded the highest overall quality rating in 2009 from the IHAs statewide pay-for-performance program.)

Pay-for-performance programs, like IHA's, compliment the capitated payment model by providing necessary protections against potential incentives to stint on care. By requiring groups to provide high quality care, and incentivizing quality through the use of financial and other bonus payments, IHA's pay-for-performance program plays a critical role in ensuring that our patients receive the most efficient, highest quality care. One criticism of the capitated payment model is that it incentivizes providers to withhold care in order to maximize their payment. Quality performance programs, particularly those with financial incentives tied to performance benchmarks, can outweigh such incentives in a capitated model.

Furthermore, CAPG has instituted a Standards of Excellence Program for its member groups and IPAs. In 2006, the CAPG Board designed the SOE to annually assess and publicly report the key features and capabilities of coordinated, accountable healthcare organizations to

bring quality and affordability to individual patients and populations. The SOE evaluates groups on four domains:

- Care management – inpatient and outpatient systems to support our physicians and patients to achieve reliable, safe, continuous, and affordable care;
- Health IT – the essential tools to offer timely decision support, consistency in preventive and chronic care, and feedback to doctors for improvement;
- Accountability and transparency – measuring and reporting our work in public, compliance with fiscal responsibility regulations in the state;
- Patient-centered care – features to accommodate individualized patient needs and preferences, embracing our responsible role in a culturally diverse community.

CAPG members are scored on a star basis and the results are publicly available on the CAPG website. Each domain consists of multiple questions with a maximum potential point score. Groups that surpass a certain, pre-determined threshold earn a star for that domain. In addition, groups receive feedback on areas where they can improve.

In 2011, 25 organizations, caring for a population of nearly 10 million Californians, achieved Four Stars, or Elite capability. Five organizations qualified for Three Stars, or Exemplary performance.

This year, SOE added a fifth domain, Administrative and Fiscal Capability, recognizing a national interest in the management of multispecialty networks with multiple revenue streams

with complex payment methodologies. In 2011 this fifth domain was measured, but the results were not reported.

Measuring Patient Satisfaction – Achieving Patient-Centered Care

In addition to these specific quality initiatives, CAPG member groups, like HealthCare Partners, are focused on providing patient-centered care. We achieve this result through the efforts of the individual groups, CAPG's Standards of Excellence, and the statewide IHA pay-for-performance initiative.

CAPG's Standards of Excellence program contains certain elements that promote patient-centered care, such as ensuring patient access to health information and secure communications with their healthcare provider, looking at the group's capabilities to provide evening and weekend care, language interpretation services, documentation of patient complaints, surveying and monitoring timeliness of appointments, educating patients about their role in their care, and identifying choices, risks and benefits for alternative courses of treatment.

In addition, the IHA uses a Patient Assessment Survey, which is derived from the national standard Clinician Group Patient Experience Survey, endorsed by the National Quality Forum. The IHA survey tool questions address the following areas (1) doctor-patient communication; (2) coordination of care; (3) specialty care; (4) timeliness of care and service; and (5) overall care experience. This focus on patient experience of care provides important feedback to our medical groups in terms of providing patient-centered care.

A Model for the Rest of the Nation

I believe that our successes are achieved in part through the flexibility that is afforded to our groups through the captitated payment model. This payment model is bolstered by strong quality initiatives and by physician leaders who constantly strive to improve the patient experience and care outcomes. I believe that a model based on the lessons learned in California can be successfully implemented throughout the country. However, I hope that the Committee will consider key factors that are necessary to protect and foster the growth of our model.

The existing legal and regulatory framework provides some opportunity for physician groups like ours to further experiment with capitated payment models, such as partial capitation. We believe the opportunity presented is two-fold. First, it will allow us to continue to build upon the successes of our model – to develop additional interventions and care plans for vulnerable populations and further improve the delivery of care to our patient populations. Second, these programs, like accountable care organizations (ACOs), provide an opportunity for California's medical groups and IPA's to spread the lessons we have learned to other areas of the country.

However, to gain these benefits, programs like Medicare's ACO program, must be properly structured. This means that the financial incentives have to be appropriate, the quality metrics must not be overly burdensome and should align with metrics providers are already collecting and reporting, and that the program requirements must be reasonable. Finally, models, like ACOs, must provide the cash flow necessary for providers to start new delivery models. One of our biggest concerns about the proposed ACO regulation, for example, is that although the agency acknowledges substantial start-up costs associated with developing the model, no funding is made available to potential ACOs to build the model. Combined with a FFS payment system and shared savings payments that may lag as much as 18 months to two years from the time services are rendered, it may be incredibly difficult for providers to come up with the

funding to create an ACO. We believe that this weakness in the proposed rule could be addressed in one of two ways. One method is providing start-up funding for ACOs. The other is establishing partially capitated or fully capitated ACOs. Capitated payments could assist in providing the necessary financing on a month-to-month basis that would permit ACOs to acquire the personnel and infrastructure necessary to deliver high quality, coordinated care, without increasing costs to the Medicare program. The existing law permits the creation of capitated ACOs and we believe that such a model would have greater potential to implement the types of care coordination programs that CAPG members have been able to implement, resulting in even greater savings to Medicare through reductions in unnecessary hospitalizations and improving care coordination and prevention for individuals with chronic illnesses. In addition, we look forward to providing comments on the agency's proposed rule and we anticipate that some of the issues we have mentioned may be addressed in the agency's final rule.

In addition, we believe that attention must be paid to the Medicare Advantage (MA) program. In California, Medicare patients who were enrolled in a plan using a capitated payment methodology had hospital utilization rates of 982.2 hospital days per 1,000 as compared to Medicare FFS patients with 1,664 hospital days per 1,000. This lower utilization rate in the capitated model has enormous potential for cost savings. Given the potential for savings and seniors' well-documented satisfaction with this program, we encourage the Committee to consider ways in which this program can be provide value to seniors in the future.

Conclusion

Thank you for the opportunity to speak to the Committee today. I hope that this information has been valuable and I would be happy to provide any additional information for the Committee as you consider alternatives to the sustainable growth rate formula.

Chairman HERGER. I want to thank each of our witnesses for describing their involvement and efforts that use payment models that encourage coordinated, efficient care. One goal of today's hearing is to understand the impact of Medicare paying physicians on a fee-for-service basis, including its contribution to the SGR problem.

With that in mind, I would like to ask the three witnesses involved with different payment models to briefly state their view of the fee-for-service payment method.

Dr. Watkins, if you could respond first, followed by Ms. Safran and then Dr. Wilson.

Dr. WATKINS. I believe the fee-for-service model has been severely detrimental, especially to primary care. I believe that is true nationwide and not just in Vermont. The sense that primary care providers have of being on a hamster wheel, of having to see patient after patient and being rewarded for seeing more patients in a day, as opposed to the quality of the services they provide, is a never-ending negative cycle.

Chairman HERGER. Ms. Safran.

Ms. SAFRAN. I believe you summed it up well in your opening remarks, actually, that fee-for-service payment system has delivered to us really what it was designed to, which is a system that incentivizes more services.

But now we realize that more services don't necessarily provide to us better quality or better outcomes for the patient population, and that, in fact, we will need a different system of payment if, in fact, what we are looking for out of our health care system is not simply a larger quantity of care, but better quality and outcomes of care. And also we will have to move away from a fee-for-service system if we look to resolve the fragmentation that we have today, because paying each for their own individual piece adds up to pieces not tied together as a whole.

Thank you.

Chairman HERGER. Thank you. Dr. Wilson.

Dr. WILSON. Yes, sir. As a practicing provider, I have worked under both fee and payment methodologies, fee-for-service as well as capitation, and I can say pretty unequivocally that I much enjoy the practice of medicine in a capitated environment than I do in a fee-for-service environment.

And as I have shared, you know, physician locker rooms with docs who practice fee-for-service medicine, the motivation behind those doctors' behavior is vastly different than the doctors who practice under a capitated or a salary model. And I think patients oftentimes are harmed by fee-for-service models that are overly zealous, and they don't lead to coordination and integration of care.

So in summary, I would just say that capitation and/or other means of payment, even if it is just a salary model, lead to a purer form of medicine being practiced than fee-for-service, and I think patients benefit more in that model.

Chairman HERGER. Ms. Safran, your health plans go by the Alternative Quality Contract Program of increased quality and a slower rate of growth as the one we share. I have a few questions related to your success in achieving these goals. How much has provider-spending come in under budget?

Ms. SAFRAN. Well, in year 1 of the first 5-year contracts, every AQC provider organization came in under budget, and that ranged from 1 to 2 percent under their budget in what they were able to achieve in just the first year of savings.

Chairman HERGER. Are you surprised that the AQC provider groups have fared so well on 64 quality measures of outpatient and inpatient care?

Ms. SAFRAN. I was very surprised. I have spent my career as someone developing and implementing quality measures and have never seen anything like the magnitude of improvement on a very broad set of quality measures that we saw in year 1 of this con-

tract. So it was really clear that not just the incentives that are in front of them that make a difference, though I will not say that they don't, they are a very important piece, but also important is the fact that they are receiving, on an ongoing basis, information over the course of the year about how they are doing on those measures so that they are able to manage to success. And every one of those organizations has put in place leadership that is very much dedicated to working with the front-line physicians on that broad set of quality and outcome measures.

Chairman HERGER. How have the AQC participants been able to reduce costs through important improvements, such as decreased hospital infections, so quickly?

Ms. SAFRAN. Well, in year 1 of the contract, the improvements on spending really came through—more through the work on thinking carefully about where those providers were referring patients for things like standard laboratory tests and imaging and other forms of care in which there are no relationships in place, where, roughly speaking, it is a commodity service. And the provider now was quite aware of the fees that we pay for those services in different areas, and it became important to them to refer their patients to lower-cost settings for services where it was a commodity like a lab test or imaging.

The harder work of reducing readmissions, changing overall utilization of care, reducing non-urgent ED use, is work that some of the more mature AQC organizations did make progress in, and significant progress, in year 1. But those types of more difficult changes are things that we know we are going to see greater progress on in years 2 through 5 over the contract.

Chairman HERGER. Thank you.

Ranking Member Stark is recognized for 5 minutes.

Mr. STARK. Thank you, Mr. Chairman, and I would like to again thank the witnesses for their very informative testimony.

Dr. Wilson, you have huge numbers in your groups. Now, are the Kaiser physician groups part of your group?

Dr. WILSON. Yes, they are.

Mr. STARK. They are, I gather, I have been led to believe, the largest professional partnership and the largest professional corporation in the country; is that not correct?

Dr. WILSON. To my understanding, they are the largest professional physician group in the country.

Mr. STARK. I know that in my district, or in the county that I represent, there are 1.2 million people, and half of them belong to Kaiser. They always say if you are run over by somebody, you have a 50 percent if you take them to the Kaiser emergency room that you are going to the right place.

Do you think that the Kaiser model, the staff model, could be used in other areas? Kaiser has worked here in the Washington area with not any great success, because they have been unable to hire physicians, they have had to contract with groups, and they have had to rent hospital rooms the same as any other managed-care plan.

But if we could establish some type of staff model outline, do you think that we could transmit that success to other parts of the country?

Dr. WILSON. The answer would be yes. I think, you know, there are obvious challenges in importing a new model of care to a delivery system, and, you know, often there is a requirement of critical mass before you can actually start to impact the culture of that environment.

Kaiser, you are right, is the largest physician delivery system in the State of California. The company that I work for, HealthCare Partners, is the second largest physician organization in the State of California, with practices in Florida and Nevada.

I know Kaiser has exported its model to other parts of the country successfully. Washington seems to be one of the exceptions in which it didn't quite succeed, and, I guess, Maryland as well.

But I do think the model is transplantable. I think physicians coming out of training now are more likely to seek a Kaiser type of practice than they are to hang their own shingles. I think, you know, that the types of doctors graduating training have changed. They are different than the doctors that graduated with me.

But so in short, yes, I do think that model can be explored.

I do think there are other models in California, I think, that are potentially more easily exported than Kaiser, because Kaiser is a bricks-and-mortar kind of organization, and so it requires significant up-front cost. And so, you know, the ability to just sort of plant that in an environment in which, you know, the economics haven't been established is a little bit more challenging.

But, you know, a large number of California physician groups, or IPAs, Independent Practice Associations, which don't have the overhead of a Kaiser model, but do bring the infrastructure, the coordination of care, the integration, the IT capabilities and the other things that capitation, as I spoke of, lends itself to, but it is probably more easily transplantable.

Mr. STARK. Thank you.

Ms. Safran, do you suppose that the recent Massachusetts universal care law, or whatever it is, adds to the performance that you noticed in the insurance plans, or adds to the participation, I guess I should say?

Ms. SAFRAN. Well, without question, universal insurance has drawn our attention now in Massachusetts to the cost of health care and importantly to the rate of increase in that cost.

And so without a doubt the providers in the Massachusetts market are aware that attention is on cost, that payment reform is happening. They are very active conversations, not just because of our model, but in the State as a whole. So absolutely, I think that uptake of providers into our AQC model happened much more quickly because of the attention to costs that came upon us as we had universal insurance.

Mr. STARK. And in the great State of Vermont, is there something we can learn there that can be exported? You are the only single-payer State; is that right? Or the only single-payer plan, I guess.

Dr. WATKINS. We have legislation that was passed in this most recent session and will be signed into law by Governor Shumlin. That legislation could best be described as a first step towards an integrated payment system for the State of Vermont.

Chairman HERGER. Excuse me. The gentleman's time has expired. Thank you very much.

I recognize the gentleman from Washington Mr. Reichert for 5 minutes.

Mr. REICHERT. Thank you, Mr. Chairman. I will add my thanks to all of you for being so patient and waiting in our waiting room while we have been so busy voting.

I have just jotted down some common themes here. I know that all of us—I think the good thing, as Mr. Stark has stated, we are all here, this is a bipartisan effort, recognizing that the patients are the focus of this effort, trying to provide high-quality health care, cost-effective and accessible, as we use those three descriptors.

But the witnesses today have been pretty consistent in mentioning coordinated care, coordinated team, community care, overall system payment, holistic system, holistic approach, a full continuum of care, patient-centric model, coordinated, integrated. I think that is what everyone is hoping for and wishing for, and it looks like some of you on the panel today have at least begun to accomplish some of those goals in making the patient the center.

I am really interested, of course, in the seniors in this discussion. And as we look forward to reforming the current formula, I think it is important that we ensure that our seniors continue to have access to quality and effective care and affordable care. So I think it is key—and this question is for Ms. Safran—it is key to communicate and educate our seniors. So under your AQC plan, is there an education component, you know, one where you would educate, especially seniors, or anyone under the plan for that matter, about their care provider now is an AQC plan member and, therefore, would deliver service in a different way?

Ms. SAFRAN. The answer to your question is that we gave an enormous amount of thought to how and whether to do education for our members about the AQC, and in the end the plan has not done any kind of proactive outreach and education to our members about the AQC. And the reason for that is that the AQC has a contract with our physician network and, in some cases, with hospitals party to those contracts.

Our members have bought products from us that still stand, that are unchanged by those contracts, and that in our experience, when we have a communication with our members, it won't surprise you to know members get confused and worried when they hear from their health plans. And so we really hold ourselves to a standard that we will communicate with our members when there is something that they need to do, when there is something that they need to pay attention to.

And as we struggled with what exactly would we tell them about the AQC, it wasn't clear, in fact, that there is anything different that they need to do. And, in fact, when we had the impressive year 1 results, we thought again about communicating with them and saying—you know, congratulating them on how fortunate they are to be in practices like this. But in the end we have left it to the physicians to communicate if they want, but really there is nothing the plan needs to advise the members about.

Mr. REICHERT. There is nothing in part of the contract that would require the doctors to communicate any difference. And wouldn't it be important for the patients to know that they are now in this holistic sort of preventive care arena, or they just, as they go through it, kind of realize that in communicating with their provider?

Ms. SAFRAN. Well, I think they do realize it, and they realize it in a very positive way. That is to say, in order to be successful on the quality and outcome measures, these practices are interacting with their patients in a way that the patients, when they communicate with us, tell us that it feels like concierge care, but they never paid a concierge fee, because the practice is suddenly doing outreach to them between visits to let them know about care that they need, to find out how their management of their chronic condition is going and what barriers they are facing. So that is what the members and the patients are experiencing.

Mr. REICHERT. I appreciate that.

I notice that my time is getting short, and my next question is going to be a little bit longer, Mr. Chairman, and I will submit that question to Dr. Wilson in writing.

[The information follows: Dr. Wilson]

Dr. Wilson's Response to Follow-up Question from Ways and Means Committee

Question: Dr. Wilson, you mention that assessing physician groups on a robust set of quality measures and collecting information on patient satisfaction effectively counters any financial incentive under a so-called capitated model to provide patients less than optimal care. Could you provide some details on what is measured and how it prevents under-treatment of patients? Can you inform the Committee some of the results of your patient satisfaction surveys?

Response: The Integrated Healthcare Association (IHA) is a statewide multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care in the state. The IHA evaluates physician groups based on four categories: clinical quality, coordinated diabetes care, information technology-enabled systems, and patient experience. The IHA's pay for performance programs reward physician practices and other providers with incentives based on their performance on these measures.

Pay-for-performance programs, like IHA's, compliment the capitated payment model by providing necessary protections against potential incentives to stint on care. By requiring groups to provide high quality care, and incentivizing quality through the use of financial and other bonus payments, IHA's pay-for-performance program plays a critical role in ensuring that our patients receive the most efficient, highest quality care. One criticism of the capitated payment model is that it incentivizes providers to withhold care in order to maximize their payment. Quality performance programs, particularly those with financial incentives tied to performance benchmarks, can outweigh such incentives in a capitated model. Examples of how the P4P reporting has improved performance are attached.

The Measures

In its pay-for-performance program, IHA includes 68 measures in five domains. The measures are developed through a consensus process that includes input from physician groups. The domains are:

- Clinical quality – includes preventive, chronic and acute care and incorporates both process and outcomes measures.
- Coordinated diabetes care – promotes efforts to redesign processes and create a systematic approach to diabetes care. Measures are diabetes related and include process and outcome clinical measures; population management activities such as registries, actionable reports, and individual physician-level measurement, and care management processes.
- Patient experience – measures patient ratings of care received from physicians and other providers in a physician group.
- IT-enabled systemness – evaluates support and infrastructure that physician groups use for systemic processes of care. Includes population management, point-of-care activities, care management processes, and individual physician-level measurement and incentives.

Incentives

As I discussed in my testimony before the Committee, California physician groups receive most of their compensation for HMO enrollees in the form of professional services capitation. In addition to the capitated payment, IHA makes available incentive payments related to the pay-for-performance program. Individual physician groups receive incentive payments based on their performance. In 2010, total incentive payments equaled about $49 million, or about one percent of compensation to physician organizations.

Public reporting and public recognition also serve as incentives to improve performance. California groups exist in highly competitive environments. Each group is trying to outperform the other to attract and retain market share. The transparent nature of the IHA P4P process allows for the patients opinion and the group versus group performance to be displayed in the public domain. For example, under IHA's program, an annual public report card is published online, showing performance scores for physician groups by measure and by composite score for each county. IHA publicly recognizes top performers and most improved physician organizations during the annual stakeholders meeting and through a press release.

Top performers are identified by calculating composite scores in each measurement domain, which are then weighted according to the recommended P4P payment weights. An overall composite score for each group is calculated and the top 20% of groups with the highest overall composites are designated as top overall performers.

Physician groups in each of eight geographic regions that demonstrate the highest relative quality improvement over the previous year are designated as winners for most improved. An improvement score is calculated for each physician group based on the percent of relative improvement the group achieved in their overall performance composite score from the previous year to the current measurement year.

Patient Satisfaction

In addition we conduct patient satisfaction surveys and display them openly within the group to promote provider performance and we incentivize the outcome. This process effectively precludes providers from withholding treatment because the ultimate judge of his or her performance is the patient themselves.

Mr. REICHERT. Thank you. I yield back.

Chairman HERGER. The gentleman yields back.

The gentleman from Wisconsin Mr. Kind is recognized for 5 minutes.

Mr. KIND. Thank you, Mr. Chairman. Thank you for holding this very important hearing, and I want to thank our witnesses for your testimony here today.

Listen, we have just gone through a very gut-wrenching health care reform debate ourselves here in Washington, and incorporated a lot of aspects of what is happening around the Nation. I assume, Ms. Safran, the Massachusetts model, too, is something that was under consideration.

And I think the ultimate verdict on health care reform is going to be not only changing the way health care is delivered, but how we pay for it. I mean, it is replete with studies here that show that close to one out of every three health care dollars is spent on tests and procedures and things that don't work. They don't improve patient care. And oftentimes, because of the overtreatment patients are receiving, they are being left worse off rather than better off. That is close to $700 billion a year in a 2.3-, $2.4 trillion system that we are not getting a good bang for the buck for.

And I have been encouraged hearing the testimony here today, and perhaps there is an opportunity for some bipartisan cooperation to move forward on a lot of the reforms that you are all testifying about, a more integrated, coordinated, patient-focused care system.

Now, for the sake of full disclosure, I come from a country, western Wisconsin, that has the Mayo system in it, Gundersen, Marshfield, Dean, that are doing this already and producing tremendous results. And it sounds like that is a model that we should be encouraging. And, in fact, it is something we incented in the Affordable Care Act, those types of models of care that are more coordinated and patient-focused, which is really at the heart of the Affordable Care Act, including payment reform.

And I am convinced that fee for service, as I am hearing from all of you today, is an unsustainable model of payment for our health care providers. It is not fair to them; it is not fair to the patient. We are not getting a good bang for the buck, and how do we get to a value- or quality-based reimbursement system, that is going to be crucial.

And, Ms. Safran, you were talking about the quality measurements that Massachusetts was just establishing, I think 64 criteria so—that you are using right now. My question to you is who is establishing those quality measurements, and what type of buy-in have you gotten from the practicing physicians and the care providers in Massachusetts for that type of criteria?

Ms. SAFRAN. So, that was my job, to establish which measures. And we really drew from nationally accepted measures wherever we possibly could, so that means NQF endorsed almost every single one of those 64 measures. We then put the measures through some additional paces to be sure that we think they are ready for the high-stakes use involved, meaning attaching dollars to payment on, you know, a score. And it was important to us that that measure set include inventory and hospital measures, and that in both of those settings that the measures include clinical process, clinical outcome and patient care experience measures. So that is how we have—and they have been completely accepted because of the rigor that we paid attention to in the measures that we chose.

Mr. KIND. Because some of the concern, I think, many of us had or shared in regards to what Massachusetts was moving forward on, so you are doing coverage before cost. And now it seems like you are trying to play catch up with the cost issue right now. And we are trying to get out ahead of that ourselves with the Affordable Care Act to not fall into a similar type of box as we move forward.

I know it is very unfair to ask it, you know, because volumes and books can be written on each topic, but if I can get just a quick response from you on a couple of key issues, I think it is important as we move forward.

The role of comparative effectiveness research. Important or not, Mr. Guterman?

Mr. GUTERMAN. I think comparative effectiveness research is key, because if we are going to spend the vast amount of resources that we spend on health care, and if we are going to address the issue of the massive amount of waste in the health care system, we need to know how to spend that money more wisely so that we can

get a better return on it for our patients. And comparative effectiveness research is intended to provide information to help decisionmakers, the physician and the patient, make the decision for the appropriate care.

Mr. KIND. Dr. Watkins.

Dr. WATKINS. I completely agree with my colleague that it is absolutely essential. We have the opportunity, because of our involvement in the Multipayer Advanced Primary Care Practice Demo through CMS Center for Innovation, to actually work closely with our colleagues in other States and have a multi-State collaborative that is actually beyond those States involved.

Mr. KIND. Ms. Safran.

Ms. SAFRAN. No question that we need a better evidence base to guide us. Less than 3 percent of medical decisions are made every day—every minute of every day are based on solid evidence. Comparative effectiveness is absolutely one important way to do that. I think there are others, but we absolutely need a better evidence base.

Mr. KIND. Dr. Wilson.

Dr. WILSON. I would agree with all that has been said before me. Yes, comparative effectiveness would be good, and I agree also that too little medicine is done through evidence-based medicine.

Mr. KIND. Now, another big role that we had here, unfortunately, under the Affordable Care Act was talking about reimbursing providers in regards to counseling for advanced directives. Good idea, Mr. Guterman.

Mr. GUTERMAN. When decisions get made about medical care, having that decision be made between the patient and the physician is always a good idea. And the more information people have in making those decisions, the better it is.

Mr. KIND. May I get a written response from the rest of the witnesses because I see my time has expired? Thank you, Mr. Chairman, for your indulgence.

Chairman HERGER. Thank you.

The gentleman from Pennsylvania Mr. Gerlach is recognized for 5 minutes.

Mr. GERLACH. Thank you, Mr. Chairman.

Thank you for coming today and being part of the panel.

Let me ask, Ms. Safran, in Massachusetts, a State that has undergone tort reform relative to medical liability and medical malpractice cases, and are there protections, medical malpractice protections, for physicians in Massachusetts, like, say, Texas and California, where there are caps on noneconomic losses in medical malpractice cases?

Ms. SAFRAN. I apologize. That is a question that is out of my area of expertise. I would be glad to get the answer, though. I don't believe there has been significant tort reform in Massachusetts that has been discussed.

Mr. GERLACH. Yes, I don't think so either, but I don't know exactly if that is the case. But that really is the premise for my question, because I am thinking in the AQC model that you have, what has been the impact of an AQC contract with a group of physicians relative to how they otherwise may be practicing defensive medicine if their tort liability may still be just as high as it might be,

say, in New York, Pennsylvania, other States where there are no tort reforms to protect them against the medical liability cases? What have you seen as the difference between a physician practicing in Massachusetts who is not in an AQC arrangement versus one that is relative to the types of defensive medicine costs that they produce?

Ms. SAFRAN. Well, the answer is that it is early right now to know, to notice or see really any differences in the patterns of use. And so I think if we were to look at the data—and we have a formal external evaluation by Harvard Medical School that is looking at the data to see how things are changing—they would find that for the most part, the savings in year 1 were based on choosing lower-cost settings where that could be done, not by doing the hard work of changing use.

However, there is a lot that these practices are doing to start to try to understand the vast practice pattern variation that exists even within a group of physicians who practice together, caring for the same condition, how differently they care for that. And we are helping to fuel that with data that we provide on a very regular basis to highlight these differences and what we hope is promote physicians discussing with each other what best practice would look like, and to form that consensus and reduce that variation.

Mr. GERLACH. Assuming the American Medical Association is accurate in its estimate that in any given year there is approximately 100- to $150 billion in defensive medicine costs that are incurred around our Nation each year, and you could probably extrapolate out from that overall figure how much of that is out of Massachusetts, is this Harvard study that is being undertaken, is it going to compare and contrast the national experience relative to defensive medicine costs with what is happening in Massachusetts both within an AQC setting and a non-AQC setting?

Ms. SAFRAN. Yes. I don't know that they will bring in national data specifically, but they absolutely have information and will be studying over a long period of time to see how practice patterns change in the AQC compared with how things change or don't change outside of the AQC.

Mr. GERLACH. I would like to yield the balance of my time to Dr. Price, if I may.

Chairman HERGER. The gentleman yields to Dr. Price.

Mr. PRICE. I thank the gentleman for his time, and I appreciate his question because I think it is an interesting line. I just want to say that all of us agree that the status quo is unacceptable. It is just where we go from here.

I was curious about the response of the panel to the question about comparative effectiveness research and the overwhelming support for it. And I assume that would be the same for the Independent Payment Advisory Board. Mr. Guterman, you are wholly in favor of the Independent Payment Advisory Board?

Mr. GUTERMAN. The notion of having a mechanism to translate the best policy ideas into focusing on Medicare programs to try to slow down cost growth is an interesting one. I think there are——

Mr. PRICE. You support the IPAB?

Mr. GUTERMAN. Do I support the IPAB?

Mr. PRICE. Yes.

Mr. GUTERMAN. I would like to see, frankly, the IPAB have broader powers because I suspect that a lot of the issues that they will have to deal with in terms of Medicare cost growth are driven by the same factors that——

Mr. PRICE. Dr. Watkins, do you support the IPAB?

Dr. WATKINS. I don't feel qualified to answer your question.

Mr. PRICE. As a physician running a large entity, you don't feel qualified to answer whether or not the IPAB you support or not?

Dr. WATKINS. I am sorry.

Mr. PRICE. Ms. Safran, do you support the IPAB?

Ms. SAFRAN. I apologize. I don't have enough information.

Mr. PRICE. Dr. Wilson, might you have an opinion on the Independent Payment Advisory Board?

Dr. WILSON. Unfortunately I am not adequately familiar with the expectations of that Board to render an intelligent response.

Mr. PRICE. I thank you.

Chairman HERGER. The gentleman's time has expired.

The gentleman from New Jersey Mr. Pascrell is recognized for 5 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman. Thanks for having the hearing, and thanks to the panelists. Excellent.

We are sitting here talking about changing the way we pay providers, and I have listened to my friend from Wisconsin over the last 3 years talking about containing costs enough times to not only believe him, but listening to the specifics of where he is coming from, and I think that is very, very important, containing costs.

We might start, I think, maybe the four of you could agree with me on this, by having patients look at their bills, if we are talking about containing costs. Nobody knows what—particularly if they are covered—what do I have to worry about what is in the bill? My insurance covers, the Lord covers me, whoever covers them. And you don't look at the specifics of what is in that bill. And I think that that is a very dangerous practice that we have gotten into.

The first words out of the patient is usually, don't worry about it, I am covered. And what we should be concerned about of what that means in the minutiae of the bill, how much things cost.

And so we are moving away. I think both sides agree that we need to move away from paying physicians for a specific service. Fee for service, I think, is a dog that is not hunting anymore, and we need to look for other models, and that is one of the many of the questions that have gone in that direction today.

I have said many times health care reform is entitlement reform. I think it has already started. It will help us to transform this health system. One-third of the entire new Health Care Act is devoted to Medicare and Medicaid and how we can contain those costs. Some of the ideas being discussed were included in the Health Care Reform Act.

I am interested if these ideas are what you support, what is contained in the Health Care Act? One proposal I think we do have some bipartisan agreement on is the issue of the IPAB, the Independent Payment Advisory Board. At least I have gathered that from your written testimony.

I think this committee already has the knowledge, the experience and the jurisdiction to determine appropriate payments to pro-

viders as opposed to an independent body, and we may debate that. We may debate that. But I think that this group has done a pretty good job. If we can agree on this, I think we can find other areas of agreement in terms of provider payments.

We are here to specifically focus on physician payments, and I hope we don't have to have another patch. I think the chairman shares my view. We have had enough patches over the last several years, and we need a permanent solution. It reduces the anxiety in terms of the doctor, and we need to reduce the anxiety in the patient. Of course, there is a lot of questions out there as to what is a guaranteed benefit, what is not a guaranteed benefit. We want to reduce anxiety in all parties.

On our side we passed a permanent fix for Medicare physician payment in H.R. 3961. We did that in 2009. The other side of the building, of the Capitol, they are still trying to clean out the offices, I think. I don't know what they are doing over there.

So I have a couple of questions. On physician shortages, workforce, we spent a lot of time on that when we put this legislation together. Many of you know in the health care reform bill that we did change and try to provide incentives to respond to the shortage of physicians, of primary physicians, and also nurses. A National Health Care Workforce Commission was established and associated grants to help States improve their efforts to promote an adequate health care workforce. We can't ignore the growing shortages. Here we are changing, reforming health care. Will we have enough folks to deliver the service? That is not a good idea.

My question is for the witnesses. In Massachusetts, Vermont and California, can you tell me how your models affect workforce shortages, and do they create more stability in the system for physicians? Who would like to take the first crack at that? Doctor.

Dr. WILSON. I will take it.

In California, yes, we are very concerned about physician shortage, especially in the primary care ranks. We anticipate, if you look at the numbers, 45,000 physician shortage in the next decade by 2020.

We think our model—and there has been probably as much experience, if not more, in using midlevels as teams of care and using physicians to coordinate that care. And so that is one of the ways we anticipate mitigating this problem.

I still have anxiety because I think that looming physician shortage is going to be a challenge for the Nation and not just for California.

Chairman HERGER. The gentleman's time is expired. Perhaps the witnesses could respond in writing to the question, please.

Chairman HERGER. The gentleman from Georgia Dr. Price is recognized on his own time, 5 minutes.

Mr. PRICE. Thank you, Mr. Chairman.

Let me just first say that I am astounded at the lack of responsiveness to my question about the Independent Payment Advisory Board by three of the witnesses. This is a major, major undertaking by this Federal Government to impose upon physicians what they may or may not do for their payments, and to have three supposed experts, individuals who lead large physician groups and health care groups, not be able to opine for this country about their

stance on the Independent Payment Advisory Board is amazing. It is astounding to me, absolutely astounding.

So let me go to the other extreme. Do you believe that fee-for-service medicine ought to outlawed? Stu.

Mr. GUTERMAN. No. We ought to look for different ways of paying. There are different ways, in fact, of modifying fee-for-service medicine so it serves the purpose better than unfettered fee-for-service medicine that typifies most of the health care system.

Mr. PRICE. And you believe one can have a coordinated care system in a fee-for-service model?

Mr. GUTERMAN. I think it is more difficult unless you get ahold of some of the incentives that fee-for-service medicine provides.

Mr. PRICE. Dr. Watkins, do you believe that fee-for-service medicine ought to be outlawed?

Dr. WATKINS. I do not.

Mr. PRICE. That is encouraging.

Dr. WATKINS. I believe that in our program we have actually already demonstrated that with fee for service unchanged, we have improved the quality of care delivered, the perception of care on the part of the patients, and the perception on the working conditions, if you will——

Mr. PRICE. That is within the fee-for-service model right now.

Dr. WATKINS. That is true.

Mr. PRICE. Thank you.

Do you believe, Mr. Safran, fee for service ought to be outlawed?

Ms. SAFRAN. I believe that we have to move our system away from fee-for-service medicine for all the reasons that we have talked about this afternoon. Whether we have to do that through the use of law, or whether through a demonstration that we have a way to do it that works better and provides better quality and outcomes, I couldn't say. I would hope that we can reform the system and move to another model of payment without necessarily legislating away the fee for service.

Mr. PRICE. I think we need to move to another model as well, but what I hear you talking about is coordinated care and whether or not one can have a payment model for physicians that appropriately compensates them for the wonderful work that they do, and whether or not that needs to be in the kind of model that you describe, I think, is really open to question.

Do you believe that one patient ought to be able to visit a single physician and contract for that service individually between those two individuals? Should that be legal?

Ms. SAFRAN. I want to understand better how that would look and, for example, is that a physician——

Mr. PRICE. I walk into a doctor's office. I say, I am feeling a little ill, I would like to have you evaluate me, will you do that for—what is the charge—50 bucks, okay? Is that all right? Should that be legal?

Ms. SAFRAN. That should be legal.

Mr. PRICE. Thank you very much.

Dr. Wilson, do you believe that fee-for-service medicine ought to be outlawed?

Dr. WILSON. No, I do not. If I were just to refer to our California model, we use fee-for-service medicine as well as capitated

and sub-capitated medicine, and I think the sort of the overlying important issue here is how is care coordinated, and how is it managed.

Mr. PRICE. Exactly. And that may be completely different than the cost of it or how it is paid for, correct?

Dr. WATKINS. Correct.

Mr. PRICE. Mr. Chairman, I was struck yesterday by an article from the Associated Press entitled "Obama Plan for Health Care Quality Dealt a Setback," which highlights accountable-care organizations, and in it the article states that at the Mayo Clinic, the administrator of the Mayo Clinic wrote that 90 percent of their members, physician members, would not participate because the rules as written were so onerous, it would be nearly impossible for them to succeed. And the American Medical Group Association went on to say that their members, including the Cleveland Clinic, Intermountain Utah, Geisinger Health Systems in Pennsylvania, et cetera, would find that significant change to be much more difficult to provide care. And I ask unanimous consent that that be included in the record.

Chairman HERGER. Without objection.

[The information follows: The Honorable Mr. Price]

Obama plan for health care quality dealt a setback

Wed, May 11, 2011

President Barack Obama's main idea for getting quality health care at less cost was in jeopardy Wednesday after key medical providers called his administration's initial blueprint so complex it's unworkable.

Just over a month ago, the administration released long-awaited draft regulations for "accountable care organizations," networks of doctors and hospitals that would collaborate to keep Medicare patients healthier and share in the savings with taxpayers. Obama's health care overhaul law envisioned quickly setting up hundreds of such networks around the county to lead a bottom-up reform of America's bloated health care system.

But in an unusual rebuke, an umbrella group representing premier organizations such as the Mayo Clinic wrote the administration Wednesday saying that more than 90 percent of its members would not participate, because the rules as written are so onerous it would be nearly impossible for them to succeed.

"It's not just a simple tweak, it's a significant change that needs to be made," said Donald Fisher, president of the American Medical Group Association, which represents nearly 400 large medical groups around the country providing care for roughly 1 in 3 Americans. Its members, including the Cleveland Clinic, Intermountain Healthcare in Utah, and Geisinger Health System in Pennsylvania, had been seen as the vanguard for accountable care.

The medical groups say they are worried they will be left holding the bag for losses, that the government has designed things so there is no easy way to tell which patients are part of the program, and that there's no reliable way to adjust for patients who are sicker and require closer follow-up and more expensive treatments.

The deadline for public comments on the proposed regulations is still weeks away, but Fisher said "we needed to get their attention early on, so (the administration) could be thinking about how major changes are needed to make these regulations viable."

Medicare spokesman Brian Cook said the agency is doing extensive outreach to explain and take feedback on the regulations and hat "we will carefully consider this input."

"We are confident that providers' decisions on whether to participate in the program will be made on the basis of the final rule, which will reflect the feedback we receive," added Cook.

Many in the health care industry were silent partners backing Obama's overhaul law, but disappointment over the accountable care rules has put a chill into the relationship. During the congressional debate, Obama extolled Mayo and Geisinger, holding them up as a model of what he wanted to achieve for the nation. Industry criticism of his administration's proposal has been building up for weeks in online forums.

"This has all the hallmarks of a party that nobody comes to, unless there is a serious

rethinking," said former Medicare administrator Gail Wilensky, who ran the agency under President George H.W. Bush.

Wilensky said the idea of coordinating care isn't the problem, but "it sounds like (the administration) really overshot the mark."

The regulations are "overly prescriptive, operationally burdensome, and the incentives are too difficult to achieve to make this voluntary program attractive," the medical group association said in its letter. One of the major problems seems to be that medical groups have little experience in managing insurance risk, and the administration blueprint rapidly exposes them to potential financial losses.

Without major changes, "we fear that very few providers will enroll ... and that (Medicare) and the provider community will miss the best opportunity to inject value and accountability into the delivery system."

Private insurers are also experimenting with versions of the accountable care idea, but successful adoption by Medicare is seen as the key to spreading it across the country. The Obama administration had estimated as much as $960 million in savings from the first three years of the program, and bigger amounts thereafter.

Fisher, the medical association head, said he does not think the administration will easily back off its approach, because on paper it saves the government money.

Mr. PRICE. I would just caution this panel and this committee and this Congress that the SGR system was this Congress' solution to how to pay physicians a few short years ago, and it has run amok, clearly. It doesn't work. What we ought to take from that, I believe, is that solutions imposed from Washington often times result in terrible consequences for patients, which is where we are right now with this system.

And I yield back.

Chairman HERGER. The gentleman's time has expired.

The gentleman from Oregon Mr. Blumenauer is recognized for 5 minutes.

Mr. BLUMENAUER. Thank you, Mr. Chairman, and I really do appreciate your bringing before us people who are on the front lines of trying to squeeze more value out of the system and give us different approaches in how that can be accomplished.

Half of us on the committee come from regions of the country that are low cost, high value. If they practice medicine the way they do in Congressman Kind's district; my district in Portland, Oregon; Seattle; and some parts of the bay area, we wouldn't have a Medicare funding crisis. We would have better outcomes. People would live longer. They would get sick less often. They would get well faster. And you have described ways—and I do, Ms. Safran, at some point like to get information about your notion that only 3 percent of the medical decisions were based on objective evidence. I want to get that right.

I do agree with my friend from Georgia, the mess we have got is imposed by Congress. And one of the reasons why some of us supported the IPAB and, in fact, wanted it stronger is because Congress has proven itself incapable of being able to make some of the really difficult decisions with this fix and that fix, and the SGR is a perfect example, which I didn't vote for, was wishing away outcomes.

We are on a path now where much of what you have talked about we attempted to incorporate in the reform legislation. It would have been better, but we had a complete collapse in the Sen-

ate, and we couldn't legislate it, but we have got embedded some pilot projects and whatnot. The approach is in some instances repeal it and start over. Part of it is to trim back the bill. For example, there is some bipartisan interest in reining in what powers we have given to the IPAB because people are afraid it might work.

Another alternative is to actually accelerate the reforms that were envisioned, demonstration projects. Things that you are doing now appear to me to have been part of what at least some of us wanted to see, hope will happen, and, in fact, can occur under the framework, but it was made more complicated because we didn't have a particularly functional legislative arena.

But it is the law of the land now. There are elements in place. I would like to know from each of you the extent to which elements that are there in the reform legislation now can incorporate your experience, build upon it, and perhaps be strengthened by it.

Maybe we can talk to the three practitioners here who are representing the systems.

Dr. Watkins.

Dr. WATKINS.I would be glad to speak to that. The Community Health Teams, our multidisciplinary, locally based care coordination teams are actually clearly outlined in the ACA in Section 3502. And we are very clear that that level of coordination is essential to providing quality care regardless of what the structure is, where the payment is being made, whether that is fee-for-service, if it is single payer. It doesn't matter on some level. The need to do quality improvement and to push that side of the equation is going to be uniform regardless.

Mr. BLUMENAUER. Ms. Safran.

Ms. SAFRAN. I think that the proposed regs have within them a working excellent framework that, in fact, bears a lot of resemblance to what I have described to you about the AQC. But fortunately, there is this comment period that hopefully can provide feedback to CMS and create the changes that will enable those who currently perceive that the risk/reward threshold is such that they would be concerned to participate to change that sum, because we have seen in our model that it is possible to do that, as we have talked about, and have very quick uptake in even a two-sided model such as the one that we have. So I am optimistic that we can get it right.

Mr. BLUMENAUER. Thank you.

Dr. Wilson.

Dr. WILSON. I think the ACL model holds a ton of promise and opportunity, and I think it would be a great benefit to this country if it could be rolled out and adopted.

I have some concerns, as I mentioned in my testimony, about with the funding of it, and I think many of the groups that have spoken in that letter share those concerns. I think those groups also agree with the intent of the ACL model and the benefit it would bring to the American people. And so I think if some things can be fixed, it still has an opportunity to succeed.

Mr. BLUMENAUER. Thank you very much, Mr. Chairman.

Chairman HERGER. Thank you.

The gentleman's time has expired.

The gentleman from Washington Mr. McDermott is recognized for 5 minutes.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Thank you for having this hearing and having these witnesses.

I was reading the material here, and I am a physician, and I am a general practitioner, and I would like to join, okay? So look at me as a somebody walking into the door in Vermont and Massachusetts and California.

I saw in the California stuff Monarch Health in Irvine covers all of Orange County, 2,500 physicians, 200,000 patients, and that is about 80 patients per doc if you just sort of divide it by 2,500.

Two questions. Do I have to bring patients in to your system to join it, or can I walk in the door and you will assign me a panel? That is the first question.

And the second question is how am I going to be paid for my patients? Because I have this general practice of kids and people between 18 and 50 or 65, and then I have got some seniors. Will I be capitated on all of them about the same way, or what Medicare pays and what the commercials pay? Or how does this work is what I want to hear from being a physician. Because Dr. Price has raised all the questions. People understand fee-for-service: Patient comes in, you do something, you put out your hand, they give you money, that is it. How does yours work? Please, the three of you, tell me what would happen to me.

Dr. WATKINS. We are dealing exclusively at this point with primary care.

Mr. MCDERMOTT. Yes.

Dr. WATKINS. So for our practices, when the practice goes through the process of being recognized nationally for its quality through the NCQA recognition process, once they get that recognition, a fixed dollar amount per patient per month——

Mr. MCDERMOTT. How much?

Dr. WATKINS. It varies. Somewhere between $1.29 to $2.39, I believe, per patient per month, for every patient attributed to that practice covered by one of the three major commercial insurers in Vermont, Vermont Medicaid and soon to be Medicare.

Mr. MCDERMOTT. So it doesn't make any difference whether they are commercial or Medicaid or Medicare, I still get the same $1.29 or $1.39.

Dr. WATKINS. That is exactly right, and it is a function of what kind of score they got on that rubric.

Mr. MCDERMOTT. Do I have to bring my own patients, or will you set me up in a practice somewhere and say, go to that practice, they have got a bunch of extra patients?

Dr. WATKINS. Yeah, I wish we had a whole bunch of doctors coming into the State that we could have that problem. We are actually dealing with currently existing practices, and they get enrolled through a process, a queue, if you will, that we are rolling out through the State.

The fee-for-service schedule still exists, so the patients who are seen in that practice are being—generating income for the practice because of having their normal visits. But in addition, if those patients are attributed to the practice by the insurers, then they generate that income for the practice. So that is additional money.

On top of that, a Community Health Team is established in that area, also paid for by the insurers as a shared resource. They each split it approximately 25 percent of the cost.

Mr. MCDERMOTT. This social worker and a visiting nurse——

Dr. WATKINS. Exactly. It is multidisciplinary team that is locally based in contrast to the remote disease management programs that the insurers also still have. But they really do one-on-one counseling and interventions, outreach, panel management——

Mr. MCDERMOTT. Let me stop you because I want to hear what happens in Massachusetts.

Ms. SAFRAN. The answer is that your day-to-day existence as a physician under an AQC model and how you would see patients, who you would know who to see, and how you would get paid for that would be largely the same. What would be—that is to say there is still—as in Vermont, there is still a fee-for-service payment schedule, we still have a fee schedule with you, you still bill for that service. However, you are now part of an organization that has assumed accountability for the total cost of care for your population. So even while you are going about your day-to-day business of taking care of patients in much the same way, you are having a new level of information and support from your practice, however that is defined, about how you are doing, about how you are doing on your quality measures, about which of your patients need things that they haven't gotten yet, about which of your patient have blood pressures that are out of control and you need to adjust their medicines, about how your overall level of use of lab tests and high-cost imaging compares with other PCPs who practice in the same hallways that you do.

Mr. MCDERMOTT. How do I get paid?

Ms. SAFRAN. You get paid by us, by Blue Cross. You get paid for the claims that you submit.

Mr. MCDERMOTT. Exactly the way they are talking about in Vermont; that is, a certain amount each month for every patient I got enrolled.

Ms. SAFRAN. Yes—no. Just paid for your claims. For the visits that you have generated, you are still getting paid for that; however, there is now accountability in your practice for whether you are at the end of the day spending too much, and the practice as a whole will have its own way of dealing with the individual clinicians. It is not proscribed by Blue Cross for how they address that.

Primary care physicians under the AQC have gotten enormous increases in revenue because of the quality dollars that we have put on the table that these organizations feed right back to primary care, because that is who is generating those quality dollars.

Chairman HERGER. The gentleman's time is expired.

The gentleman from Louisiana Dr. Boustany——

Mr. MCDERMOTT. Mr. Chairman, can I ask the gentleman from California to submit in writing—I would appreciate knowing how you do it in California.

Chairman HERGER. Yes. And all of our members, if we have questions, should be—I would like to request to be able to submit our witnesses in writing, and that within a reasonable amount of time they be responded to.

Chairman HERGER. With that, again, the gentleman from Louisiana Dr. Boustany is recognized for 5 minutes.

Mr. BOUSTANY. Thank you, Mr. Chairman.

I am a cardiac surgeon, and my father was a physician, so I know a little bit about physician behavior. And I was involved very much in attempts to put different groups together back in the 1990s, and also initiated a number of quality initiatives at the hospitals where I practiced that allowed us to achieve top 100 status for heart surgery.

I am kind of concerned that these ACO regulations as we have seen them appear to be a little bit overly proscriptive and burdensome. And, Mr. Guterman, I would be curious to know your opinion. I know it is a first impression based on what has just come out, but could you give me your opinion on that?

Mr. GUTERMAN. We have heard some feedback, as Mr. Price cited, that some folks are feeling that way. And we have called for CMS to work with the provider community to be able to come up with a set of rules that is viewed as reasonable from both sides.

Unfortunately, we can pay however we want, but we still—in order to really achieve improvement in the health care system, we need to have both sides kind of build up enough thrust to escape the gravity of business as usual, and that applies both to the government and to the providers of health care.

Mr. BOUSTANY. Thank you.

Do you think gainsharing might be a useful way to incentivize more integration and coordination of care?

Mr. GUTERMAN. Before I was with Commonwealth Fund, I was at the Centers for Medicaid and Medicare Services, and we did develop a gainsharing demonstration. We think it can be promising. As with any innovation in payment approach, it needs to be monitored so that the right incentives get transmitted, but it certainly could be a promising way as a tool to achieve the kind of efficiencies and effectiveness that you want to achieve.

Mr. BOUSTANY. I have had conversations with CMS, and it is felt there that no further statutory authority is needed to proceed with a gainsharing demonstration or model. But I have concerns that if we were to do so, physicians in hospitals that might be willing to do this would want statutory protection, because based on some of my previous experiences with this, oftentimes lawyers will say, well, we think you can do this, but it hasn't been to court yet; we think it will pass muster.

Do you think if we are going to move forward, we need further statutory protections to allow this sort of model to go forward?

Mr. GUTERMAN. I don't think I have the expertise to answer that question definitively, but I do remember when I was at CMS, we ran into difficulties in the court in getting the first attempts at gainsharing demonstrations to be put into place.

Mr. BOUSTANY. Thank you, sir.

And one other question for the panel, I know you have had success with your models, capitation and so forth. It seems to me a lot of what has been focused on here has been the primary care piece to this. And you have to bring in the specialties, and then you have got specialties like cardiac surgery and liver transplantation.

Do you have surgeons, all those surgeons, in your plan, and are they on some salary? How does that work?

Dr. Wilson.

Dr. WILSON. Sure. Cardiac surgeons, neurosurgeons, surgeons that typically require a larger population base to fill out their practice typically don't sign on as employee docs in practices of any reasonable size. And so typically those relationships exist in one of several contracted methodologies.

For some of our network, and I am now going to refer to my network specifically, we have sub-capitated contracts with our thoracic surgeons. They take on responsibility for a population of patients and provide that care and have their own quality metrics, and then they are responsible to us, and we hold them accountable for the care that they provide and the responsiveness they have to their patients.

We also conduct patient satisfaction surveys and look at their performances. And in other parts of the network, we may have case rates that define the cost of an episode of care based on whatever intervention is needed, and even still in some other parts of our network, we may have just a strictly fee-for-service arrangement. And all of the above.

Mr. BOUSTANY. Is it the same thing in Vermont with the specialties, the surgical specialties, the procedure-based specialties?

Dr. WATKINS. We are a very small State, as I am sure you are aware. Our total population is just over 600,000. There are only a few people that actually practice medicine at that level. There is one academic medical center in the State and one in neighboring New Hampshire. The Blueprint for Health has, as I said—and we are in our early days still focused exclusively on primary care, but we do have ongoing discussions around a much broader view of what payment reform means, obviously having to loop in specialists. So that is in the future.

Mr. BOUSTANY. Thank you.

I see my time has expired, Mr. Chairman.

I think we probably need to look at how specialties are reimbursed. That is one of the big drivers of cost, and it is going to be different than what would apply to primary care. At least that is what my instinct tells me on this. So thank you.

Chairman HERGER. And thank you. I believe that is something that the committee should be looking into as well.

With that, I want to thank each of our witnesses for your testimony today. Your experiences with delivery models that have shown to improve care and reduce spending would be of great benefit as the subcommittee seeks to reform Medicare physician payments.

Our work in this area has perhaps never been more important. As the Medicare Board of Trustees will report tomorrow, the current rate of growth in Medicare spending is unsustainable. The program will soon go bankrupt if changes are not made.

There has been a vigorous debate over the future of Medicare in recent weeks. I, along with many of my colleagues on the Republican side, believe we ultimately need to bring competition and market forces into the Medicare program in order to reduce costs,

which is in sharp contrast to the approach the President has proposed.

Regardless of the outcome of the debate over Medicare's long-term future, we will continue to focus our efforts to finding the best way to fix the SGR.

As a reminder, any Member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, I ask that our witnesses respond in a timely manner.

[Whereupon, at 4:10 p.m., the subcommittee was adjourned.]

[Submissions for the Record follow:]

AARP

May 12, 2011

The Honorable Dave Camp
Chairman
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Wally Herger
Chair, Health Subcommittee
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Pete Stark
Ranking Member, Health Subcommittee
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Representatives Camp, Levin, Herger, and Stark:

I am writing to you on behalf of AARP's millions of members and the millions of older Americans and their families who depend upon the Medicare program. We applaud the House Ways and Means Committee for holding a hearing on addressing the flawed Sustainable Growth Rate (SGR) system.

As you know, the SGR formula by which Medicare updates its physicians' fees is widely viewed as broken. Yet for more than a decade, Congress has failed to change the system, and the problem continues to grow worse. It has become increasingly more expensive to fix, and the anticipated cuts to doctors continue to grow larger. Unless Congress acts by the end of this year, doctors will see a nearly 30 percent cut in their payments from Medicare. Facing this constant uncertainty and dramatic cuts to their payments, more and more physicians are choosing to no longer take Medicare patients, which impacts beneficiaries' access to care.

Protecting seniors' access to their Medicare doctors is one of AARP's top priorities. We have surveyed our members, and whether they are Democrats, Republicans or Independents, they believe Congress should find a bipartisan, fiscally responsible solution that will keep doctors in the Medicare program. They are concerned that they will lose access to their doctors and future retirees won't be able to get the care they need.

Medicare Physician Payments: Direct Financial Consequences for Beneficiaries

Medicare beneficiaries are directly impacted by the problems associated with the SGR system. Since 1997, Medicare Part B premiums are statutorily set at 25% of Part B program costs. As more is spent on Part B services (such as physician reimbursement), beneficiaries pay more in Part B premiums as well as higher cost-sharing for individual services.

However, for the second year in a row, premiums for most Medicare beneficiaries were not increased for 2011 because current law contains a "hold harmless" provision that protects Medicare beneficiaries who receive Social Security benefits from reductions in their monthly checks when the increase in Part B premiums exceeds that of the Social Security cost-of-living-adjustment (COLA). Because Social Security recipients have received no COLA and their benefit checks have remained the same, the majority of people on Medicare have not experienced a premium increase. However, approximately 25 percent of Medicare beneficiaries – including those assessed a higher income-related premium and those new to the Medicare program – have paid even higher Part B premiums over the past two years to meet the statutory 25% level.

Increased costs to beneficiaries are not limited to premiums. Cost-sharing obligations – which usually reflect 20 percent of Medicare's payment – also jump each time provider reimbursement rates increase. For each increase of $10 billion in physician payments, beneficiary coinsurance amounts increase roughly $2 billion. In addition, the increased Part B spending also leads directly to a higher Part B deductible. Since 2005, the annual deductible has increased along with per capita Part B expenditures.

The Medicare program must be kept affordable. When it was created in 1965, more than half of older Americans were uninsured and they were the population most likely to be living in poverty. Today, the average older person already spends about one third of his/her income on health care. If Part B premiums and cost-sharing continue to escalate, many more beneficiaries will find it increasingly difficult to pay for the care they need.

Private Contracting and/or Balance Billing

Some Members of Congress and provider organizations have recently suggested relaxing "private contracting" and/or "balance billing" rules as a potential solution to the physician payment problem. Under current rules, a physician may enter into a private contracting arrangement with a beneficiary and, in such an arrangement, the beneficiary agrees to pay 100 percent of the physician's charges for services (under this arrangement, physician charges are typically higher than the Medicare-approved charge for the same service). Some physicians who have private contracting arrangements also charge an additional monthly or annual fee for their services (e.g., concierge medicine). Although such arrangements are possible, Medicare does not cover services provided by physicians who have entered into a private contracting arrangement with Medicare beneficiaries. Physicians who engage in these practices

are barred from participating in Medicare for two years; and those who enter into private contracts must do so for all of their Medicare patients (e.g., they are forbidden from picking and choosing patients and/or services they may bill Medicare).

Under current law, Medicare allows for "balance billing" by non-participating providers; however, the program places a limit on how much non-participating physicians may "balance bill" beneficiaries -- no more than 15 percent of Medicare's allowed charges. So, for example, nonparticipating physicians are permitted to charge $115 for services for which Medicare would reimburse only $100.

The recently introduced Medicare Patient Empowerment Act (H.R. 1700) would relax the Medicare private contracting rules to allow Medicare beneficiaries to contract with their physician outside of Medicare at rates established between the patient and provider. AARP strongly opposes relaxing the current Medicare rules related to balance billing and/or private contracting because they would do nothing more than shift costs onto Medicare beneficiaries. Private contracting and balance billing increase health care costs by raising prices. Seventy-five percent of all health care costs in our country are spent on the treatment of chronic diseases, many of which could be easily prevented with early interventions. Research has shown that when out-of-pocket costs increase, consumers will visit doctors less. These arrangements would only deter beneficiaries from seeking preventive and other care until their illness worsens. Discouraging preventive care will increase the need for more costly treatment and intervention of these chronic diseases, shifting costs to other parts of the Medicare program.

Finally, not only do private contracting and balance billing shift costs onto beneficiaries, but neither do anything to improve the quality of care delivered. In fact, under both approaches, physicians will continue to be rewarded by the quantity of care provided, rather than on the quality of that care. As Congress grapples with how to address the SGR problem, it should focus on rewarding quality providers, not the quantity of services provided.

AARP Encourages Delivery System Reforms

Repeated short-term band-aid approaches for the broken physician payment system is not helpful. Rather, we urge Congress to enact legislation that emphasizes value over volume and improves the quality of care for Medicare beneficiaries.

As you know, the recently enacted Affordable Care Act (ACA) included many delivery system reforms—such as Accountable Care Organizations (ACOs), patient-centered medical homes, value-based purchasing, quality-based payments, and patient safety initiatives. We have been working closely with providers, physicians, and health plans to help ensure that these delivery system reforms can be implemented so that current and future beneficiaries can realize a Medicare program that is both higher quality and more efficient.

For example, AARP believes that ACOs hold the promise of culture change for health care by improving quality, creating better care coordination and service delivery, greater efficiency, and in the long run, lowering costs. We believe that ACOs that meet rigorous performance criteria should share savings with Medicare and be rewarded for higher quality and greater efficiency. Essential protections are needed, however, to ensure that beneficiaries who receive care from clinicians participating in ACOs know their rights and responsibilities and are made aware of the financial incentives inherent in an ACO. We believe that the opportunity for patients to develop trusting relationships with their providers is key to effective patient engagement, which is essential to the success of ACOs.

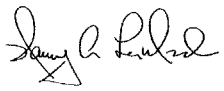
Recently CMS released its proposed rules regarding ACOs and AARP plans to submit formal comments. In general, we are pleased that the proposed rules emphasize a patient-centered approach and contain a strong focus on the three aims of better care, affordable care, and better health for individuals and communities.

It is important to keep in mind, however, that these types of major delivery system reforms take time, planning, and commitment from Congress, the Administration, and providers to achieve a new way of delivering care with new incentives based on achieving quality -- not quantity -- of care. In addition, we believe our nation's leaders must help educate seniors about both planned and proposed changes to the Medicare system. Asking seniors simply to continue to pay more and more to see their doctor can't be the answer.

Conclusion

Over 47 million older and disabled Americans depend on Medicare today. Giving seniors the peace of mind that they can keep seeing their doctors isn't a Republican or Democratic issue. Older Americans agree it's time to work together to find a solution that will keep doctors in Medicare. AARP is committed to working with both sides of the aisle to ensure Congress reaches a financially responsible solution that will ensure seniors have access to the doctors they trust and depend on through the Medicare program.

Sincerely,



Nancy LeaMond
Executive Vice President
State and National Group

American Chiropractic Association

May 25, 2011

House of Representatives
Ways and Means Health Subcommittee Committee

The American Chiropractic Association (ACA) is a professional society composed of doctors of chiropractic (DC) whose goal is to promote the highest standards of ethics and essential patient care, contributing to the health and well being of millions of patients. On behalf of the ACA, thank you for recognizing the importance of the Medicare reimbursement issue and for holding a hearing to gather stakeholder input on the Sustainable Growth Rate (SGR) formula. We appreciate the opportunity to comment on the SGR formula and the effort to explore new ways to operate the Medicare reimbursement system.

As was noted by Subcommittee Chairman Wally Herger, "the SGR system creates tremendous uncertainty year after year for physicians and Medicare beneficiaries alike." For doctors of chiropractic who are already hamstrung by restrictive, anti-competitive Medicare coverage policies, facing annual periods of uncertainty regarding Medicare reimbursement rates pushes many to consider whether their practice can be financially viable if they continue to serve Medicare beneficiaries. Having to choose whether it is financially possible to continue treating America's seniors is not an acceptable position for any doctor to be put in, yet this has been the reality for the past several years.

The ACA believes the SGR formula in its current state should be eliminated. The targets used in the formula, such as the Gross Domestic Product (GDP), have no relationship to physician services. As the costs of operating healthcare clinics are continuing to increase each year, we believe that the Medicare reimbursement formula should reflect these increases. The inaccurate SGR formula must be replaced and a long term solution is needed to appropriately compensate healthcare providers.

Although there is much agreement that the current Medicare reimbursement system is flawed, there is much less agreement regarding how best to fund a revision to the SGR formula for the long term. It is doubtful that we will solve this problem before the end of 2011. However, America's physicians deserve some semblance of Medicare reimbursement stability in the near future. As such, we recommend that a period of Medicare payment stability be put into place beginning in 2012 and last through 2017. During this five year period of stability, Congress can gather more information from stakeholders to develop a new Medicare reimbursement system. Along with the period of payment stability, we believe that physicians should receive small increases in reimbursement with each passing year. These increases would be reflective of the increasing costs of patient treatment.

When exploring new payment models and how to best fund the SGR fix, we believe Congress should continue to consider quality measurement and the impacts of increased care coordination. The

focus on patient satisfaction that is at work in the value based purchasing program for hospitals should also be considered when developing a new approach to Medicare reimbursement. If CMS is truly looking towards moving to a reimbursement system that focuses on quality, the voice of the patient is instrumental in communicating healthcare service value. Additionally, it is critical that Congress consider how new payment models will impact the solo-practice healthcare provider. New payment models should not be adopted if they cause a regulatory burden so onerous that they are unable to be implemented by the solo-practice healthcare provider or providers who work with limited staff support.

Thank you for providing the opportunity for the ACA to comment on this very important issue. We look forward to reviewing future Congressional plans to address the Medicare fee schedule.

Rick McMichael, DC
ACA President

The previous statement is attributed to Rick McMichael, DC of the American Chiropractic Association.

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Title of Hearing: Reforming Medicare Physician Payments

American College of Cardiology

Statement for the Record

Presented to the

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
HEALTH SUBCOMMITTEE

Hearing on Innovative Delivery and Physician Payment System Reform Efforts

May 12 2011

The American College of Cardiology (ACC) is pleased to submit a statement for the record for the Ways and Means Health Subcommittee hearing, "Innovative Delivery and Physician Payment System Reform Efforts." The ACC commends the subcommittee for its work to address the problems with the current system of Medicare physician reimbursement.

The ACC is a professional medical society and teaching institution made up of 39,000 cardiovascular professionals from around the world – including 90 percent of practicing cardiologists in the United States and a growing number of registered nurses, clinical nurse specialists, nurse practitioners, physician assistants and clinical pharmacists.

The College is committed to working with Congress, the physician community, the Center for Medicare and Medicaid Services (CMS), and the Administration to strengthen the Medicare program and to ensure that Medicare patients can benefit from the life-saving and life-enhancing care that cardiovascular specialists provide.

The Flawed Medicare Physician Reimbursement Formula

The ACC appreciates Congress' past efforts to ensure that cuts due to the SGR formula were not enacted. The ACC recognizes the challenges involved in stopping the 29.5 percent Medicare physician payment cut scheduled for January 1, 2012 and replacing the flawed sustainable growth rate (SGR) formula.

The College, along with many other physician organizations, urges Congress to act this year to avert scheduled reimbursement cuts; repeal the SGR; provide stable payments for a period of several years to allow testing of different payment models; and then allow for a transition to new payment models.

The current reimbursement formula is severely flawed. It does not accurately reflect the cost of providing care to Medicare beneficiaries. It does not account for changes and improvements in technology, shifts in the site of service, and the changing demographics of the Medicare population.

Since the formula was established, Congress has repeatedly stepped in and stopped pending cuts but did not address the underlying problems with the formula. Each time Congress has passed a short-term intervention it has only created practice instability, deepened the payment cuts in future years, and increased the cost of permanently resolving the problem.

Medicare physician payment rates that keep pace with the rising cost of practicing medicine are essential to physicians' efforts to improve the quality of care provided to Medicare beneficiaries. Medicare beneficiaries deserve access to the highest quality care, and America's doctors deserve a reliable and fair payment system.

Re-Aligning Incentives to Reward Quality Instead of Volume

The ACC has invested significant resources in its quality infrastructure, including the largest national cardiovascular data registry, clinical guidelines, appropriate use criteria,

and other quality initiatives. The ACC is committed to providing its members with tools to help ensure that the highest quality of care is provided to patients with cardiovascular disease, leading to better outcomes and more responsible use of limited health care resources. Based on the College's experience, deficiencies in quality and efficiency are not generally the result of uneducated or recalcitrant physicians, but rather the result of misaligned incentives and inadequate systems.

The ACC strongly supports moving the current Medicare physician payment system away from a volume-based system and toward a value-driven system that aligns financial incentives with performance of evidence-based medicine and with improving care delivery systems. A new payment system must more accurately reflect the cost of providing health care services to Medicare beneficiaries.

The College supports the testing of new payment models of delivering and reimbursing for care through the CMS Innovation Center, private payers, and other initiatives. The experience gained by testing models will be essential to reforming the system, incentivizing quality and better outcomes, and bending the cost curve.

The ACC believes there is no "one-size-fits-all" replacement for the payment system. Models are needed that work for a variety of settings, including small, independent practices and rural area. These models need to address the infrastructure challenges private practice and rural areas need to be successful. New payment models tested need to focus on high cost, high impact conditions as a priority.

Conclusion

In conclusion, the ACC is committed to working with you to design payment models that will ultimately achieve the intended results of improving the health of all Americans. The ACC believes it is important to engage the physician community in the critical task of reforming the flawed Medicare physician payment formula. ACC's CEO John C. (Jack) Lewin, M.D., and Senior VP for Advocacy James (Jim) Fasules, M.D., F.A.C.C., offer the ACC as a resource to you and your colleagues as you work to enact reform this year.

American College of Rheumatology

AMERICAN COLLEGE OF RHEUMATOLOGY
EDUCATION • TREATMENT • RESEARCH

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Written Testimony of the American College of Rheumatology

On Reforming Medicare Physician Payments

Submitted by: Tim Laing, MD

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Written Testimony of the
American College of Rheumatology

On Reforming Medicare Physician Payments

Submitted by: Tim Laing, MD

The American College of Rheumatology is pleased to have the opportunity to provide the House Ways & Means Committee written testimony on our recommendations for reforming the Medicare physician payment system. I commend Chairman Herger and Ranking Member Stark for your interest in reforming the current payment system and look forward to working with you to develop a sustainable solution to Medicare.

The ACR represents over 5,500 rheumatologists - physicians who treat arthritis, rheumatic and musculoskeletal conditions, many of which are complex, chronic, painful, disabling and sometimes fatal diseases. These rheumatic conditions include rheumatoid arthritis, psoriatic arthritis, lupus, and ankylosing spondylitis. Rheumatologists are uniquely trained to perform intense evaluation and management services to ensure proper diagnosis, determine the best treatment option and provide expert care. Rheumatology services require lengthy discussions and review of a patient's history. It is necessary to recognize that unlike many internal medicine subspecialists, rheumatologists do not perform invasive procedures regularly and rarely visit the hospital. Given the types of diseases we treat, and the adults and children who rely on our specialized care, rheumatologists do not fit into common payment model which should be acknowledged in physician payment reform.

Permanently Repeal the Flawed SGR Formula

It is generally recognized that the sustainable growth rate is flawed and must be repealed. For the past ten years, physicians have been subjected to ongoing concerns regarding their Medicare reimbursement. In

2010 alone, Medicare physicians dealt with five short term patches and four retroactive "fixes". Although eventually patched, the repeated retroactive "fixes" forced rheumatologists to endure revenue interruption, causing financial instability in the office and disruption in patient care. The SGR causes economic turmoil in the health care system and is tremendously detrimental to Medicare patients' access to care given its instability. The ACR supports the premise that the SGR should be discarded for other payment mechanisms.

Create 5-Years of Payment Stability

As Congress determines next steps in reforming the physician payment system, it must develop a period of stability for both physicians and Medicare beneficiaries. While considering alternative payment methods, Congress should establish a five year stability period that includes incremental increases in physician payments. This will provide physicians and beneficiaries necessary confidence in the Medicare system and allow sufficient time to test, adjust and implement new payment models.

Balance the Payment System

A successful health care system must include a balance of physicians - both primary care physicians and specialists. Currently, the physician payment system is imbalanced, weighing reimbursements for physicians who perform procedures higher than cognitive specialists, such as rheumatologists, neurologists, endocrinologists, hematologists and infectious disease specialists, who perform primarily evaluation and management services. The current system devalues spending time with patients. This creates considerable pay inequity among physicians resulting in workforce issues and in turn, impedes patient access to appropriate, specialized care. By ensuring appropriate balanced reimbursement for cognitive specialists, medical students can chose careers based on talent and interest rather than income potential. Without a balanced and adequate workforce, the delay in proper diagnosis and treatment results in needless patient suffering and increased health care costs.

Evaluation and Management Services

Congress recognized the physician payment imbalance - and the undervaluing of evaluation and management services – and took a positive step by including the 10% primary care bonus in the *Affordable Care Act*. However, the bonus only helps a single group of physicians who perform significant E/M services. Cognitive specialists who predominately perform E/M services should also be included and receive a bonus payment.

With the additional training rheumatologists and other cognitive specialists receive, they have been lumped together with surgical and procedural specialties even though their patient care aligns more with primary care. Recognizing the differences in these specialties is important when reforming the physician payment system.

Physician pay inequities exacerbate the imbalance of the physician workforce. Rheumatologists have completed 2-3 years of additional training after their internal medicine residency.This additional training prepares specialists to handle complex diseases and determine best treatment options. Workforce and training surveys forecast shortages in various specialties, such as rheumatology, endocrinology and neurology over the next 20 years. This is particularly concerning with the aging baby boomer generation.

Prior to 2010, physician specialists were reimbursed for a consultation service. A consultation occurs when one physician requests the expertise of another physician to appropriately diagnosis a patient. The elimination of consultation codes in 2010, combined with inadequate payment for high level E&M consultative services, demonstrates CMS' failure to recognize the advanced training and expertise in cognitive specialty care. Adequately reimbursing cognitive specialists for their advanced training,

expertise and ability is essential to ensure high valued care is accessible to patients with complex, chronic conditions.

Multiple Models

Numerous payment models have been proposed to improve the system. However, there is not one payment model that works for all physicians.

ACOs

Regulations were released in March of this year to provide guidance in developing accountable care organizations. The ACO strives to reduce costs while providing quality health care. With a focus on reducing costs, rheumatologists are concerned that ACOs may avoid including rheumatologists and rheumatology patients due to the high cost associated with treating chronic, debilitating conditions that often require expensive biologic medication treatments. Alternatively, requesting or requiring rheumatologists to join ACOs could reduce the availability throughout the US, forcing patients to travel long distance to receive high quality health care from a qualified rheumatologist. Rheumatologists are committed to reducing health costs while providing high quality care, yet we remain concerned about the ability of rural and underserved community providers continuing care for their patients.

The Patient Centered Medical Home

The patient centered medical home concept has been thoroughly discussed. Rheumatologists agree that patients should be the center of care and that physicians should be responsible for coordinating patient care. However, rheumatologists are specially trained to diagnose and treat patients with arthritis, rheumatic and musculoskeletal conditions. Rheumatologists would rather not be responsible for a patient's routine preventive examinations or immunizations. There has been discussion of a 'neighbor' concept to the medical home, but reimbursement models have not been released. The PCMH is limited in

utility beyond the primary care physician. The model will likely fail unless an appropriate reimbursement model is provided for specialists' consultative services.

Payment Bundling

Bundled payments for specific diseases or conditions have also been widely discussed. The ACR remains concerned about implementation of this system. Patients with multiple chronic conditions, like RA or lupus, are treated by a variety of specialists. For example, upon diagnosis of RA or during a flare the patient may frequently see a rheumatologist. However when the disease is well-controlled that patient may go months without seeing their rheumatologist. This complicates how the diagnostic bundled code must be split among the physicians in a fair and equitable manner. In addition, the bundled payment model is not conducive to itinerant Americans who often change physicians. Conceptually a bundled payment system seems viable, but realistically, a bundled payment system may only work for a small number of beneficiaries.

Multi-Target System

The multi-target system, establishing separate targets for various services, is a concept worth reconsidering. This could potentially create a more level field if designed with appropriate safeguards in place. However, as with any new model, it is untested, but should not be abandoned without further discussion.

Immediate Steps

- Immediately eliminate the flawed SGR.
- Establish a five year stability period to allow the Center for Medicare and Medicaid Innovation to assess alternative payment models.

- Consider payment options that account for the diverse set of physician specialties and practice-types.
- Recognize that cognitive specialists play an essential role in diagnosing and managing chronic conditions.
- Balance the currently skewed reimbursement system to ensure a stable physician workforce across all physician groups.

Payment reform is a complicated mission and it is challenging to satisfy all physician sectors. We commend the Ways & Means Subcommittee on Health's interest in developing a more stable, fair and appropriate system that will ensure patients have access to necessary care.

The American College of Rheumatology appreciates the opportunity to provide written testimony and looks forward to working with the subcommittee to repeal the SGR and transition to a system that incorporates new payment models designed to improve care coordination, quality, and control cost.

American Geriatrics Society

WRITTEN STATEMENT FROM THE

AMERICAN GERIATRICS SOCIETY

FOR THE SUBCOMMITTEE ON HEALTH OF THE WAYS AND MEANS COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

HEARING ON REFORMING MEDICARE PHYSICIAN PAYMENTS

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May 20, 2011

The Honorable Wally Herger
Chairman, Ways and Means Health Subcommittee
United States House of Representatives
Washington, D.C. 20515

The Honorable Fortney Pete Stark
Ranking Member, Ways and Means Health Subcommittee
United States House of Representatives
Washington, D.C. 20515

RE: American Geriatrics Society Recommendations on SGR Reform

Dear Sirs:

On behalf of the 6,000 multidisciplinary geriatrics health professionals that comprise the American Geriatrics Society (AGS), we thank you for the opportunity to submit our comments and recommendations regarding a new payment framework that will replace the unworkable Sustainable Growth Rate (SGR) system.

AGS members are the geriatricians and other health professionals specializing in the care of the elderly, including advanced practice nurses and physician assistants, who are responsible for furnishing and directing care for our nation's growing number of elderly patients with multiple and complex conditions. The population of Americans aged 65 and older is expected to nearly double, to more than 70 million, by 2030. Of added significance is the phenomenal growth of the population of adults aged 85 and over. This segment is growing at four times the rate of the rest of the population and encounters greater overall disability, as well as need for medical and other support services. In fact, frail elders and those with multiple chronic conditions account for the highest percent of Medicare expenditures.

We believe it is imperative that a new payment system recognizes that these frail elderly with multiple conditions are the patients who will benefit the most from transformation of Medicare into a patient-centered system focused on primary geriatric care, chronic care management and coordination of care across settings.

A new payment framework should incorporate the following principles:

- Define "sustainable growth" in terms of total health care expenditures.
- Support and properly value primary care services, geriatrics expertise and care coordination.
- Replace volume-based payment structure with a value-based payment model that rewards quality and takes into account differences in the complexity of patients' health care needs.

- Use payment mechanisms to promote optimal use of clinicians and support staff, promote the efficacy of care transitions between settings and reduce preventable hospital readmissions.

- Establish stable and predictable updates that accurately reflect increases in provider expenses.

Background

The current Medicare program with its "siloed" payment systems, has contributed to fragmented care delivery, resulting in health care that is provider-centric, not patient-centric.

The SGR formula relies upon national spending patterns across many different provider types. It creates a budget with accountability enforced by updates, yet completely fails to create or foster organizational capacity to manage expenditures. The current system has incentivized increasing the volume of care rather than improving outcomes. If anything, the SGR rewards excessive utilization as providers seek to take what they can before cuts are imposed. But the imposition of penalties is indiscriminate with respect to current efficiency.

It also significantly under-pays primary care physicians, especially geriatricians, because it does not take into account the needs of older adults with multiple illnesses or the cost of providing coordinated patient-centric care. In June 2008, the Medicare Payment Advisory Commission (MedPAC) noted that nonprocedural "evaluation and management (E&M) services - the hallmark of primary care - are undervalued, potentially creating an imbalance relative to procedurally-based services." This disproportionately affects geriatrics health care professionals -- physicians, advanced practice nurses, and physician assistants alike -- because the vast majority of their patients are Medicare beneficiaries. According to the report, 65% of geriatricians' payments are derived from nonprocedural primary care services, and this percentage was the highest among all primary care specialties.

Also, MedPAC recently assessed the current physician payment system and the current SGR formula for updating payments annually (which penalizes all physicians when aggregate spending exceeds a spending target in a given year) and determined that the current system does not differentiate by provider. While the SGR formula was designed to constrain growth, MedPAC described it as "strictly budgetary" with no tools for improving quality or efficiency, such as care coordination. Certainly, some growth is necessary and to be expected; but Congress should consider approaches to change the current system in order to constrain the growth of health care costs to a level that is fundamentally sound from an economic standpoint. Such an approach (or potentially multiple approaches) should consider total costs of health care (*e.g.*, including lost productivity for caregivers) and not just the costs associated with health care delivery.

A new payment system needs to fully recognize the importance of geriatrics in the care of the sickest Medicare patients - the patients who cost the system the most money. The kind of high-quality care provided by geriatricians and the interdisciplinary geriatrics care team requires that Medicare changes how it pays for services. We need innovative models for financing care that pays for value, not volume. These innovative models should create systems that incent and provide coordinated, patient-centered care -- the kind of care which is most likely to result in savings or, at minimum, reduced growth. This means properly compensating geriatricians and other geriatrics health professionals for the type of care provided and for the value added by improving functional outcomes and reducing the number of hospitalizations and unnecessary tests and procedures that are performed on patients. It also means increasing Medicare's investment in the development of performance standards, metrics and

measurement methodologies as well as establishing additional incentives to use electronic health records and data collection tools.

Also, without a focus on the importance of geriatric care, younger physicians will continue to pursue training in more financially rewarding interventional medical specialties rather than in geriatric medicine. This could further exacerbate the fragmentation of care and increase health care costs that could be avoided, or at least mitigated, through the type of care provided by health professionals with skills and training to meet the needs of older, frail adults. Our nation already faces a shortage of geriatrics health professionals across disciplines. For example, in 2010, there were 7,029 certified geriatricians -- one geriatrician for every 2,699 Americans 75 or older. Due to the projected increase in the number of older Americans, this ratio is expected to drop to one geriatrician for every 5,549 older Americans in 2030 unless the payment system is reformed to correct long-standing payment inequities for primary care services delivered by geriatrics providers and other primary care professionals.

Recommendations for Payment Reform

We recommend a process involving steps that will achieve comprehensive payment reform that reduces costs, pays providers fairly, and rewards value and quality care delivered to Medicare beneficiaries. While the SGR must be repealed and permanently replaced with a new payment model, such fundamental reform may not be feasible before the end of 2011.

The first objective should be to stabilize current payment for the short-term so as to ensure continued physician participation in Medicare. In the long term, we believe that the system should provide options (in the most expeditious manner) for providers to voluntarily choose to be paid under other newly created payment systems. This will support migration away from the physician-fee-schedule by clinicians. The transition could be done in a way that reduces total spending while actually increasing reimbursement to physicians who provide high quality cost effective care in these other payment systems.

Short-Term: Concrete Steps to Phase Out the SGR

If Congress must adopt an interim approach, it should be one that begins the transition by modifying the current physician payment formula as a prelude to replacing it with a permanent solution. In the short-term, improvements in primary care payments are needed (1) to stabilize the current payment environment under the SGR; and (2) to attract and retain primary care clinicians.

As a first step toward value based purchasing, and to concurrently identify how money is being spent on physician services, we propose considering replacing the single update for all physicians with separate updates for different types of services and or specialties. Congress could consider establishing five separate updates for: (1) evaluation and management (*i.e.*, office visit) services furnished by primary care and geriatrics physicians; (2) evaluation and management services furnished by other specialties; (3) diagnostic/imaging services; (4) minor surgical services; and (5) major surgical services, each with a different conversion factor based on utilization, growth and other factors.

Based on past analysis, it is likely that primary care/geriatrics services would receive higher annual updates than diagnostic or imaging services. Such a system would create incentives for primary care and geriatrics providers in the short term, and the existence of five "pools of money" would facilitate the migration of physicians away from the current payment system. This would allow Congress to

accurately score the cost of that migration because it could allow an accurate reduction of the money in each pool as physicians begin to provide services under other payment systems while also identifying the savings provided by that migration. We believe it is likely that this approach will reduce the "cost" of eliminating the SGR system because the dollars being moved would be vastly more cost-effective in the other systems and those savings could be recognized.

During this time period, the primary care provider bonus for primary care clinicians should remain in place, or be extended for a number of years past its current 2015 expiration date. An extension would help create a more stable environment and provide an incentive for new physicians, advanced practice nurses and physician assistants to enter and stay in primary care, including geriatrics. Moreover, creation of a specific pool and update for primary care evaluation and management services will allow the continuation of the 10% primary care bonus beyond 2015 in a targeted, cost effective way because it will be easy to define both the services and providers who are eligible for the bonus.

We understand that creating a system with separate updates and conversion factors is a complex undertaking. In developing a new or revised system to begin transitioning away from the current SGR system, it is important that the old formula is not replaced with a similar flawed formula. Significant and meaningful discussion will have to take place regarding spending targets and growth rate formulas to ensure that the goals of promoting primary care, inclusive of geriatrics, are achieved. Again, these are complex issues that will require a great deal of serious thought and discussion.

Long-Term

At the same time that Congress establishes short-term revisions to the SGR system, it should further facilitate the phase-out of the physician-fee-schedule by enacting new payment systems into which physicians and other providers could opt in a budget neutral way with respect to the current fee schedule (*i.e.*, as physicians migrate to other payment systems, money is moved from the physician-fee-schedule into the new systems).

These new payment systems could include bundled payment (*e.g.*, for all items and services furnished over defined episodes of care); partial, risk adjusted capitation; and shared savings options. All options would incent care coordination and the provision of high quality, evidence-based medical care. This would mean higher payments for providers, including physicians and hospitals, that furnish the most effective and efficient care. Under the direction of Congress, the Centers for Medicare & Medicaid Services (CMS) has tested and even begun implementing some of these concepts, such as bundling, gainsharing, medical homes, and beginning in January of 2012, accountable care organizations (ACOs). The new Center for Medicare and Medicaid Innovation will soon begin testing a variety of new and innovative health care delivery and payment models that promote care coordination and cost efficiency, which, if successful, could swiftly be expanded to the broader Medicare program. Additionally, Congress could enact new programs or direct CMS to test other promising models.

The challenge will be to define sustainable growth in a way that is economically feasible and promotes high quality care. Importantly, while physician services make up a relatively small portion of total health care costs, physicians (and other professionals) direct or influence a greater portion of costs by admitting patients to the hospital, writing prescriptions, ordering services, *etc.* In the long-term, physician payment should recognize this and provide incentives for managing high quality, cost-effective, well-coordinated patient care.

The biggest question is not what needs to be done, but how best to get there. As an organization that represents health care professionals who specialize in the care of the oldest and most frail members of society, we understand the complex issues that face Congress as it works to reform SGR. We are ready to work closely with Congress on specific approaches that can be implemented now and in the future to improve health care payment and delivery, and to make the growth of health care spending sustainable over the long-term.

We look forward to working with you. Please do not hesitate to contact Alanna Goldstein, Assistant Director of Public Affairs and Advocacy, at agoldstein@americangeriatrics.org or 212-308-1414, should you have any additional questions.

Best Regards,

Barbara Resnick

Barbara Resnick, PhD, CRNP
President

Jennie Chin Hansen

Jennie Chin Hansen, RN, MS, FAAN
Chief Executive Officer

CC:

The Honorable Dave Camp
Chairman, Committee on Ways and Means, U.S. House of Representatives

The Honorable Sander Levin
Ranking Member, Committee on Ways and Means, U.S. House of Representatives

American Occupational Therapy Association

AOTA® The American Occupational Therapy Association, Inc.

Occupational Therapy: Living Life To Its Fullest®

May 26, 2011

The Honorable Wally Herger, Chairman
Congress of the United States House of Representatives
Committee on Ways and Means, Health Subcommittee
2155 Rayburn House Office Building
Washington DC 20515-6115

The Honorable Fortney Pete Stark, Ranking Member
Congress of the United States House of Representatives
Committee on Ways and Means, Health Subcommittee
2155 Rayburn House Office Building
Washington DC 20515-6115

Dear Chairman Upton and Ranking Member Waxman:

On behalf of the American Occupational Therapy Association, the national professional association representing more than 140,000 occupational therapy practitioners and occupational therapy students nationwide, we want to thank you for the opportunity to provide comments on reforming payment under the Medicare physician fee schedule. AOTA would like to express its thanks to the Committee for its bipartisan approach towards addressing this critical issue in the 112th Congress.

Occupational therapists provide critical health care services to beneficiaries under Medicare Part B to assist individuals regain and develop skills critical to full participation in everyday life activities, helping beneficiaries remain in their homes and communities at their maximum functional level. Outpatient occupational therapy services are reimbursed under Medicare Physician Fee Schedule (MPFS) making occupational therapy practitioners extremely concerned with the adverse effect the pending 29% reduction, based on the current sustainable growth rate formula, will have on beneficiary access to essential health care services including occupational therapy.

Occupational therapy practitioners are significantly impacted by the Medicare Physician Fee Schedule and its payment policies. AOTA considers a strong Medicare Part B program essential to the provision of high quality, cost-effective, and accessible care to our nation's seniors and people with disabilities in need of care. The Medicare program's payment policies help shape policies utilized by private insurers, Medicaid, workers compensation, and others payers making Medicare policy critical to the entire health care system.

AOTA believes it is necessary to find a long term solution to the flawed sustainable growth rate in order to achieve a more stable and efficient program that will deliver optimal outcomes for Medicare beneficiaries for generations to come.

The goal of these reforms needs to be focused on providing continuity, consistency, and accuracy in the payment system to adequately cover the full panoply of essential services including occupational therapy, that are critical to patient care, while avoiding arbitrary and unfair policies

like the Medicare Part B outpatient therapy caps and the Multiple Procedure Payment Reduction Policy (MPPR) issued by CMS in the 2011 MPFS rule.

Moving away from the current, antiquated system and avoiding arbitrary policies like the therapy caps and the MPPR will be essential to establishing a more rational and adequate payment system that ensures beneficiary access to the care they need when they need it.

AOTA recognizes the need to not only avoid the 29% reduction in payments under the MPFS but also to find a long term solution that will help control costs while providing beneficiaries with access to the necessary skilled services and AOTA recommends the committee consider:

- Replacement of the Sustainable Growth Rate with an annual index of health care inflation. AOTA believes that off-setting the cost of repealing the SGR should be done through reforms to payment policies under the Medicare program that ensure high quality health care is delivered by professionals licensed and qualified to provide those services thereby reducing fraud and abuse.

- Expansion of quality reporting, value based purchasing, and use of electronic medical records under Medicare Part B as part of this reform. AOTA recommends the Committee consider policy changes needed to ensure that all providers that are eligible in the statute to participate in quality reporting can do so. Improving quality of care while also decreasing costs will require participation by all providers in the adoption of health information technology. Expansion of the health information technology incentive program to include other qualified health providers including occupational therapy practitioners would help improve quality and the efficacy of the initiative. As it exists, the initiative's capacity is limited in its ability to provide a truly integrated information management system across providers and settings in order to maintain accurate records of the full scope of beneficiaries' health and rehabilitation needs.

AOTA would also urge the Committee, while looking at reforms to the Medicare physician fee schedule, to also address problematic policies that result in arbitrary and unfair reimbursement rates for providers such as the Medicare Part B outpatient therapy caps and the MPPR policy as applied to occupational therapy and physical therapy without appropriate distinction between disciplines. Congress should act to correct these problems permanently.

Thank you for your attention to these pressing health and payment policy issues under Part B of the Medicare program. AOTA is available to assist the Committee with its work and looks forward to continued opportunities to share our thoughts and priorities with the Committee.

American Physical Therapy Association, Private Practice Section

PRIVATE PRACTICE SECTION, APTA

APTA
American Physical Therapy Association

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May 16, 2011

The Honorable Wally Herger
The Honorable Pete Stark
Subcommittee on Health
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Herger and Ranking Member Stark:

On behalf of the Private Practice Section (PPS) of the American Physical Therapy Association (APTA), and its over 4000 members who function as small businesses, we are pleased to offer this statement to the Health Subcommittee of the House Committee on Ways and Means germane to the May 12 hearing on the topic of the Medicare payment system.

PPS members provide a valuable service to communities across the nation and they do so in a convenient, cost-effective manner. But as is typical for small businesses, narrow margins are jeopardized when a significant sector of its market cuts reimbursement without regard to the value of the service provided. Moreover, when such an action is unpredictable and is taken by an influential payer such as Medicare, the effect is to negatively influence the business environment and create an untenable situation for the providers. More importantly, the Medicare beneficiaries are left in a vulnerable position, unable to depend on the access to convenient, cost-effective, high-quality care to which they have become accustomed.

Physical therapists in private practice provide critical health care services to beneficiaries under Medicare Part B to enable individuals to return to their highest functional potential. Yet, PTs in private practice will be among the professional clinicians who will see Medicare reimbursement rates cut by 29 percent on January 1, 2012, unless Congress takes some important and necessary action.

As the Committee on Ways and Means considers legislative options for reforming Medicare payment policies, PPS is pleased to offer guidance and suggestions in the following categories:

- Effects on the PT providers as small businesses
- Effects on the patient
- Effects on the Medicare system

SGR Repeal
A 29 percent cut in Medicare reimbursement, if allowed to take effect next year, would have a crippling impact on private practice physical therapists and their small businesses. Since many private insurers benchmark their payment rates to Medicare, the impact of such a significant cut would be felt far beyond the Medicare community. The recent history of extending a minimal rate increase for a few months or even a year is an unwise and detrimental way to run an insurance program for 47 million beneficiaries. It is time for Congress to repeal the flawed and dysfunctional formula known as the sustainable growth rate (SGR) which has created an unpredictable and untenable business environment for Medicare Part B providers.

In doing so, PPS would urge Congress to consider placing more emphasis on the value of the service provided including the resultant effect of the care on the patient.

Electronic Health Records
Congruent with this notion is the need for Congress to expand the incentives for providers to establish electronic health records. Nonphysician providers such as independent physical therapists were not included in the federal programs that encourage and reward the adoption of health information technology. Yet, our members provide an important and valuable service that should be coordinated and communicated electronically. What sense does it make to encourage an information superhighway, but only allowing a certain select type of car to drive on it? The sooner Congress and the administration can set the standards for an interoperable electronic health records the sooner waste and redundancy can be wrung out of the system.

Private Contracting
Section 4507 of the BBA of 1997 included a provision allowing physicians and other selected providers of Part B services to opt-out of the Medicare program, meaning they can collect out-of-pocket payments from Medicare beneficiaries if certain requirements for opting-out are met But this provision was only authorized for physicians, osteopaths, and selected non-physician providers (clinical psychologists, clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse mid-wives) in the BBA of 1997. Subsequently, the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA) extended private contracting to podiatrists, dentists, and optometrists, effective December 2003. Physical therapists do not currently have the ability to opt-out because they are not included in the statutory language permitting same.

PPS/APTA recommends Congress amend the statute to allow a physical therapist to collect out of pocket from a Medicare beneficiary. Such an amendment would be beneficial to PPS members, afford beneficiaries the freedom of choice they deserve, without resulting in any greater expenditure for the Medicare program.

PPS/APTA recommends That Section 1802(b)(5)(B) of the Social Security Act be amended as follows:

> ***Inclusion of physical therapists under private contracting authority.***
> *Section 1802(b)(5)(B) (42 U.S.C. 1395a(b)(5)(C)) is amended by striking ``the term practitioner has the meaning given such term by section 1842(b)(18)(C)'' and inserting ''In this subparagraph, the term ''practitioner'' means an individual defines at section 1842(b)(18)(C) or an individual who is qualified as a physical therapist.''*

Therapy Cap Repeal
Congress can and should take a related step to correct an injustice in the Medicare system that punishes the beneficiaries who are the most impaired and disabled. The arbitrary, per beneficiary annual therapy caps were authorized as part of the Balanced Budget Act of 1997. Since their scheduled implementation date of January 1, 1999, Congress has intervened numerous times to place a moratorium on therapy caps or, since 2005, extended a broad-based exceptions process. These caps were intended to be temporary until "an alternative payment method" could be developed. But such an alternative has not materialized in 14 years. Yet one is possible if Congress and the Centers for Medicare and Medicaid Services (CMS) would commit to collecting the necessary descriptive data upon which such an alternative could be predicated.

A limited (and targeted) extension of exceptions process for 2012, 2013, and 2014 combined with instructions to CMS to grant the therapy cap exception for care delivered in any setting that is collecting and reporting functional outcomes data would result in a database containing sufficiently robust information to design the alternative payment method envisioned by the 1997 BBA. Most importantly, such a payment model would not be based on an arbitrary limit but rather on the amount and type of care to achieve the desired optimal outcome.

Implementation of the above policy need not be costly. In fact, when done thoughtfully and fairly, it may even generate modest savings. PPS is eager to work with the Committee as well as CMS in advancing this short-term transition that can ultimately result in the therapy cap issue being put behind us.

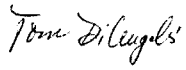
Curbing Overutilization of Therapy
Currently under Medicare Part B there are various ways to bill for services. One policy in particular -- the Stark II in-office ancillary services exception to the self-referral law -- carries a proven propensity for overutilization. PPS believes, and evidence shows, that elimination of this exception could provide potential cost-savings and improve the integrity of the services delivered and paid for by the Medicare program. The Office of the Inspector General of the United States Department of Health and Human Services has continued to identify a high rate (78 to 91 percent) of inappropriate billing of physical therapy services billed incident to a physician's professional services. Elimination of

these practices must be addressed in an effort to provide a sustainable payment system for providers that serve the Medicare Part B program and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

Conclusion
The above-discussed issues have beneficial effects on the PT providers, the patient, and the Medicare system in the following ways. Repealing the SGR and allowing private contracting have major impacts on the provider but secondary benefits for the patient. The therapy cap repeal (extending the exceptions process) is primarily a Medicare beneficiary issue. Enabling nonphysician providers to access health information technology is beneficial to both PTs and their patients, and to the degree to which it creates efficiencies, the Medicare program. The benefits of curbing overutilization inure specifically to the Medicare program.

On behalf of the Private Practice Section of APTA, thank you for your continued efforts to create a more stable, predictable and effective Medicare payment system.

Sincerely,



Tom DiAngelis, PT, DPT
President
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American Physical Therapy Association

APTA
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Statement for the Record
by
American Physical Therapy Association

United States House of Representatives
Committee on Ways and Means
Subcommittee on Health

American Physical Therapy Association Perspectives and Recommendations for Medicare Payment Reform

May 20, 2011

Chairman Herger, Ranking Member Stark and Members of the House Subcommittee on Health:

On behalf of more than 77,000 physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) thanks you for the opportunity to submit official testimony regarding reforming payment under the Medicare physician fee schedule. APTA commends your bipartisan effort to address this issue in 2011 and appreciates the opportunity to weigh in on this critical matter. Physical therapists are significantly impacted by the Medicare Physician Fee Schedule and its payment policies. In 2008, outpatient therapy services under Medicare Part B resulted in $4.8 billion (2.6%) in program expenditures for services provided to 4.5 million beneficiaries (10.5%) at an average per patient cost of $1,057. Outpatient physical therapy (PT) services accounted for 73.5% of the outpatient therapy expenditures followed by occupational therapy (OT) services at 19.5% and speech language pathology (SLP) services at 7.0%. Specifically, outpatient physical therapy services accounted for almost $3.5 billion in program expenditures for services provided to 3.9 million beneficiaries at an average cost of $884 per patient.

Physical therapists provide critical health care services to beneficiaries under Medicare Part B to assist individuals remain in their homes, communities and society at their highest potential functional level. The Medicare Physician Fee Schedule is used in claims to report outpatient physical therapy services and therefore, physical therapists are acutely aware of the pending 29% reduction, the cost to repeal this flawed sustainable growth rate (SGR) formula and its impact on beneficiaries' access to health care providers.

APTA believes a strong Medicare Part B program is essential to provide cost-effective, accessible and high quality health care to our nation's seniors and individuals with disabilities. The payment policies established under the Medicare program dramatically impact payment policies established by private payers, Medicaid, workers compensation, and others payers.

The opportunity to address these fundamental policy problems under Medicare Part B is vital to move towards a sustainable delivery system that is supported by sound payment policies. There are three areas of potential reforms which APTA believes should be considered in the current dialogue regarding reform of payment policies under the Medicare physician fee schedule.

A) Replacement of the Sustainable Growth Rate with an annual index of health care inflation. APTA believes that off-setting the cost of repealing the SGR should be done through reforms to payment policies under the Medicare program that ensure high quality health care is delivered by professionals licensed and qualified to provide those services thereby reducing fraud and abuse. APTA would welcome the opportunity to provide the Subcommittee with a list of policies it believes would strengthen Medicare Part B and provide savings towards the cost of repealing of the SGR. APTA strongly supports the expansion of quality reporting, value based purchasing, and use of electronic medical records under Medicare Part B as part of this reform. APTA requests the Subcommittee consider policy changes needed to ensure that all providers that are eligible in the statute to participate in quality reporting can do so. Currently, only physical therapists in private practice (PTPPs) can participate in the Physician Quality Reporting System due to issues with the claims form for other Part B settings in which physical therapists practice, such as rehabilitation agencies and skilled nursing facilities. In addition, APTA would encourage the expansion of the Medicare and Medicaid incentive program for the adoption of health information technologies that meet the meaningful use criteria to all eligible Medicare Part B providers and suppliers. Improving quality of care while also decreasing costs will require participation by all providers, including broad adoption of health information technology. Expansion of the health information technology incentive program to include other qualified health providers would facilitate the goals of health care reform to improve quality. As it exists, the capacity is limited in its ability to provide a truly integrated system across critical transitions of care across providers and settings.

B) Repeal of the therapy cap on outpatient physical therapy services. Similar to the SGR policy, the therapy caps were authorized as part of the Balanced Budget Act of 1997. Since their scheduled implementation date of January 1, 1999, Congress has intervened numerous times to place a moratorium on therapy caps or, since 2005, extended a broad- based exceptions process. The therapy caps were designed to be a temporary measure until the Centers for Medicare and Medicaid Services (CMS) provided an alternative payment methodology for therapy services for Congress' consideration. Without significant development in this alternative, APTA proposes that Congress extend a limited exceptions process for 2012, 2013, and 2014 and instruct the Centers for Medicare and Medicaid Services to develop a per visit payment system for outpatient therapy services that controls the growth of therapy utilization for implementation by January 1, 2015. Limiting the exceptions process is only meant to provide some temporary reductions in spending while providing a bridge to a long-term solution. APTA has begun work to provide a reformed payment system for outpatient physical therapy services that could be implemented as early as 2014 and stands ready to work with the Subcommittee to solve this issue in the 112th Congress.

C) Policies that would improve the integrity of services paid for by the Medicare program. Currently under Medicare Part B there are various ways to bill for services. We believe that in regards to physical therapy services, modification to the Stark II in-office ancillary services exception to the self-referral law as well as changes to "incident to" billing could provide potential cost-savings and improve the integrity of the services delivered and paid for by the Medicare program. Specifically, APTA recommends the elimination of physical therapy services from the in-office ancillary services exception to the physician self referral law and reforms to the incident to requirements for physical therapy services. The Office of the Inspector General of the United States Department of Health and Human Services has continued to identify a high rate (78% to 93%) of inappropriate billing of physical therapy services billed incident to a physician's professional services. Elimination of these practices must be addressed in an effort to provide a sustainable payment system for providers that serve the Medicare Part B program and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

Conclusion

Again, thank you for your attention to this pressing health and payment policy issue under the Medicare Part B program. APTA stands ready to assist the Subcommittee and is happy to provide more specifics on the three areas of reform listed above. If the Subcommittee has questions or needs additional resources, please contact Mandy Frohlich, Director of Federal Government Affairs, at mandyfrohlich@apta.org or 703-706-8548.

Thank you for the opportunity to submit comments and provide recommendations for the record.

Association of American Medical Colleges

May 12, 2011

The Honorable Wally Herger
Chairman, Health Subcommittee
Committee on Ways & Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Herger:

On behalf of the Association of American Medical Colleges (AAMC), I write to thank you for your efforts in exploring how Congress might reform the Medicare physician payment system. The AAMC recently submitted similar comments to the House Energy and Commerce Committee, and greatly appreciates Congress' recognition of the serious challenge facing all health care providers as we work together to replace the Sustainable Growth Rate (SGR). The AAMC is a not-for-profit association representing all 134 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members, 75,000 medical students, and 106,000 resident physicians. The clinical practitioners at AAMC member medical schools account for one-sixth of all physicians in the Medicare system.

The AAMC believes it is absolutely crucial that Congress reform the SGR formula to ensure access for beneficiaries and stability for providers. However, often overlooked in the discussion on how to preserve access for Medicare beneficiaries is the need to ensure that our nation's medical schools and teaching hospitals are able to train enough physicians to meet an increasing demand. The AAMC estimates that by 2020 the United States will face a shortage of more than 90,000 physicians, equally distributed between primary care and subspecialist physicians that Medicare beneficiaries disproportionately rely upon for health care. For this reason, it is critical that the 112th Congress, specifically this Committee, address the need for additional Medicare Graduate Medical Education (GME) funding.

We also agree that Congress cannot solve this problem on its own, and it's critical that the physician and broader provider community play an integral role in examining new proposals to replace the flawed SGR formula with a permanent, sustainable solution. The AAMC supports your efforts, and looks forward to working with you to implement a system that preserves care access for Medicare beneficiaries, responsibly slows the Medicare growth rate, and pays physicians and all providers fairly. **However, I must stress that we cannot support any new payment system or extended patch that is financed by simply redirecting funds currently supporting other critical health care expenditures, including those that support the nation's teaching hospitals.**

Although the method for physician payment must be changed, it also is important to acknowledge that the current system engenders large administrative costs—both for providers and the government—and that reducing these expenses is a sensible way to reduce Medicare spending. I am pleased that President Obama has ordered each federal agency to review its rules to determine those that can be eliminated, streamlined, or revised as this should result in large savings and reduced burden.

As you know, teaching physicians and hospitals play a critical role in providing care for Medicare beneficiaries. Adequate reimbursement for these clinical services is vital to sustain the education, training, safety net, and community service missions of academic clinical physicians. Teaching physicians and hospitals care for the sickest, most complex Medicare patients and provide primary care, as well as highly specialized services that may not be available elsewhere in the community. Additionally, academic physicians often serve as a resource for other health care providers in communities and across regions, providing consultations and care for Medicare patients who need their specialized expertise, while teaching the next generation of physicians. Without reliable, sufficient, and fair physician payments from Medicare, beneficiaries' access to many of these services could be placed in jeopardy.

The AAMC has long supported replacing the SGR formula with a payment system that, at a minimum, adequately compensates physicians based on such factors as the services provided, complexity of the patients served, and geographic area where the physician practices, while also accounting for increased costs due to inflation. As we continue to strive to create a health care system that improves patient care by providing appropriate, high quality care, we believe an appropriate case management fee in addition to Medicare payments for services may achieve this goal by ensuring and incentivizing coordinated care. Incorporating these preventive medicine incentives through case management payments could help meet the long-term goal of slowing the growth of Medicare expenditures. Finally, as Medicare moves to a new physician payment model Congress should help ease this transition by enacting a period of stable and predictable physician payment updates. This will help ensure that beneficiaries continue to have adequate access and alleviate providers' concerns.

Again, thank you for your leadership in working to address this long-standing problem of replacing Medicare's physician payment system with a sustainable solution. The AAMC looks forward to working with you and Congressional leaders to address this important issue.

Sincerely,

Darrell G. Kirch, M.D.
President and Chief Executive Officer
Association of American Medical Colleges

Coalition of State Medical and National Specialty Societies

Statement for the Record of

The Coalition of State Medical and National Specialty Societies

on the subject of

"Reforming Medicare Physician Payments"

before the

Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

May 12, 2011
2:00 pm
1100 Longworth House Office Building

Coalition of State Medical and National Specialty Societies
c c/o Medical Association of Georgia ♦ 1849 The Exchange Suite 200 ♦ Atlanta, GA 30339 ♦ www.mag.org

Executive Summary

The current sustainable growth rate (SGR) physician payment system is failing to serve our nation's seniors and physicians, and as the gap between government-controlled payment rates and the cost of running a practice grows wider, it is increasingly difficult for seniors and the disabled to find doctors who accept new Medicare patients.

The Coalition of State Medical and National Specialty Societies is therefore convinced that the key to preserving our Medicare patients' access to quality medical care is overhauling the flawed Medicare payment system, and to address this problem, Congress should include the Medicare Patient Empowerment Act as an essential part of any Medicare reform. This legislation would:

- Establish a new Medicare payment option whereby patients and physicians would be free to contract for medical care without penalty;
- Allow these patients to apply their Medicare benefits to the physician of their choice and to contract for any amount not covered by Medicare; and
- Physicians would be free to opt in or out of Medicare on a per-patient basis, while patients could pay for their care as they see fit and be reimbursed for an amount equal to that paid to "participating" Medicare physicians.

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

The day the Medicare Patient Empowerment Act becomes law, **every** physician will become accessible to **every** Medicare patient. Private contracting is a sustainable, patient-centered solution for the Medicare payment system that will ensure our patients have access to the medical care they need.

Introduction

Chairman Herger and Ranking Member Stark, the Coalition of State Medical and National Specialty Societies, which includes sixteen associations representing some ninety thousand physicians from across the country, appreciates the opportunity to comment on the critical issue of Medicare's broken physician payment system.

The SGR is Fatally Flawed

Medicare is the nation's largest government-run health care program, and it represents the most glaring example of the need for reform. The current sustainable growth rate (SGR) physician payment system, in particular, is failing to serve our nation's seniors and physicians. Enacted as part of the Balanced Budget Act of 1997, the SGR is a formula utilized by Medicare to limit the growth of physician services. This formula is fatally flawed and is structured in a way that does not appropriately account for the costs of caring for Medicare beneficiaries.

Since 2002, the SGR formula has called for reductions in Medicare reimbursements to physicians. In 2002, physician payments were cut by 5 percent, and since then, Congress has intervened 12 times to prevent additional cuts. Unfortunately, Congress has not yet adopted a permanent solution to fixing the SGR; rather it has passed short-term, stop-gap measures that only temporarily prevent steep payment cuts. Once again, on January 1, 2012, physician payments are scheduled to be cut – this time by 29.5 percent -- and these cuts will continue well into the future.

Medicare's physician payment system is not sustainable for physicians, nor is it fiscally stable for the federal government. The cost of repealing the SGR has now ballooned from just under $50 billion in 2005 to nearly $300 billion today, and the price tag continues to grow each year that Congress puts off permanent reform. Before the costs of reform become financially prohibitive, it is essential that Congress act to reform

Medicare's flawed physician payment system in a manner that will also give the government increased budget certainty now and into the future.

Patient Access to Care is at Risk

Existing Medicare underpayments, coupled with the threat of continued steep payment cuts, present serious access to care problems because more and more physicians cannot afford to furnish services to Medicare patients. Baby boomers are now entering the Medicare program, and a shrinking pool of primary care and specialty physicians are making it increasingly difficult for seniors and the disabled to find doctors who accept new Medicare patients. The American people are well aware of this problem, and according to a survey conducted by the American Medical Association in October 2010, the overwhelming majority – 94 percent – of American adults feel the looming Medicare physician payment cut poses a "serious problem for seniors who rely on Medicare."

Numerous surveys of our nation's physicians have also established the Medicare access to care problem.

- A 2008 survey conducted by The Physicians Foundation found that 82 percent of primary care doctors nationwide believed their practices would be "unsustainable" if proposed cuts to Medicare payments were made and nearly half of all primary care doctors were planning to either reduce the number of patients they saw or stop practicing entirely.
- A 2008 survey conducted by the American Medical Association demonstrated that if Medicare payment rates were cut by 10 percent, 60 percent of physicians would limit the number of new Medicare patients they treat, and if payments were cut by 40 percent, 77 percent of physicians would limit the number of new Medicare patients they treat.
- A 2010 survey conducted by the Surgical Coalition found that 29 percent of surgeons would opt out of Medicare, and of those surgeons remaining as

> Medicare participating physicians, 69 percent would limit the number of Medicare patient appointments and 45 percent would stop providing certain services.

In order to preserve patient choice and timely access to care, the SGR formula must be repealed.

My Medicare, My Choice

As noted above, as the gap between government-controlled payment rates and the cost of running a practice grows wider, physicians are finding it increasingly difficult to accept Medicare patients. The Coalition of State Medical and National Specialty Societies is therefore convinced that the key to preserving our Medicare patients' access to quality medical care is overhauling the flawed Medicare payment system.

To address this problem, our Coalition supports including H.R. 1700, the Medicare Patient Empowerment Act, as an essential part of any Medicare reform. Sponsored by Rep. Tom Price, this legislation would establish a new Medicare payment option whereby patients and physicians would be free to contract for medical care without penalty. It would allow these patients to apply their Medicare benefits to the physician of their choice and to contract for any amount not covered by Medicare. Physicians would be free to opt in or out of Medicare on a per-patient basis, while patients could pay for their care as they see fit and be reimbursed for an amount equal to that paid to "participating" Medicare physicians.

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

Private contracting is also one way that the federal government can achieve fiscal stability while fulfilling its promise to Medicare beneficiaries. A patient who chooses to see a physician outside the Medicare system should not be treated as if they don't have insurance. Medicare should pay its fair share of the charge and allow the patient to pay the balance.

It is also the only way to ensure that our patients can maintain control over their own medical decisions. The government has the right to determine what it will pay toward medical care, but it doesn't have the right to determine the value of that medical care. This value determination should ultimately be made by the individual patient.

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

The day the Medicare Patient Empowerment Act becomes law, **every** physician will become accessible to **every** Medicare patient. Private contracting is a sustainable, patient-centered solution for the Medicare payment system that will ensure our patients have access to the medical care they need.

In summary, Medicare patients should be free to privately contract with the doctor of their choice without bureaucratic interference or penalty. This will empower individual patients to make their medical care decisions, while providing the federal government with fiscal certainty.

Thank you for the opportunity to comment today.

Members of the Coalition of State Medical and National Specialty Societies

Medical Association of the State of Alabama
Arkansas Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association
Medical Association of Georgia
Kansas Medical Society
Louisiana State Medical Society
Mississippi State Medical Association
Medical Society of New Jersey
South Carolina Medical Association
Tennessee Medical Association
American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American Society of General Surgeons
Congress of Neurological Surgeons

Past Presidents of the American Medical Association

Daniel H. Johnson, Jr., MD
AMA President 1996-1997

Donald J. Palmisano, MD, JD, FACS
AMA President 2003-2004

William G. Plested, III, MD, FACS
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Garrison Bliss

Statement of Garrison Bliss, MD

Chief Medical Officer, Qliance Medical Group

Seattle, WA

Ways and Means Subcommittee on Health

Hearing on Reforming Medicare Physician Payments

May 12, 2011

Chairman Herger, Ranking Member Stark, distinguished members of the Subcommittee on Health. It is my pleasure to present testimony to subcommittee today regarding ideas to help the Federal Government move beyond the Medicare Sustainable Growth Rate (SGR) payment formula. First and foremost, I hope to bring a primary care physician's perspective to the debate and offer some concrete and rather simple solutions to the huge problems facing primary care providers with Medicare and private insurance alike.

I have lived on the front lines of primary care for over 30 years, working as a primary care internist in Seattle. I have witnessed the gradual deterioration of primary care and the growth of unsustainable inflation in health care, an inevitable consequence of a fundamentally flawed payment system for primary care.

In 1997 I walked away from the world of fee-for-service medicine, not to seek my fortune, but to explore the possibility of creating a *direct* primary care model that can provide high functioning care that focuses on quality treatment rather than volume. Primary care is the foundation of all health care and the health of primary care drives the health of the rest of the system. It was the best decision I have made in my life. Our highly efficient, flat monthly fee pricing was based on age, not health status—then ranging from $35 to $65 per month. We provided unrestricted access to our care. We stopped all fee-for-service billing to our patients or their insurers. And, we limited our practice to 800 patients per physician in order to be able to focus on quality and promised same day care.

In 2007, utilizing these same principles, I co-founded a new health care company called Qliance, which I believe represents the next generation in direct primary care. It too was built on a monthly fee concept, currently ranging from $49 to $89 per month depending on age. It is constructed to meet or exceed the objectives of the much discussed Patient Centered Medical Home model, but it is also is designed to eliminate the incentives which have brought US healthcare to its knees. All services we provide are included in our monthly fee. A few expensive supplies are charged at our cost. Our providers have the luxury of spending a minimum of 30 minutes with each patient. We limit our patient panels to 800 per provider (compared to 2500 to 3500 in the fee-for-service world). We are open 7 days per week and 12 hours per day on weekdays, giving patients same or next day appointments for any urgent issue, plus 24x7 after-hours phone access to a physician on call. And, our patients have a personal physician who knows them as an individual. We are also deploying an electronic medical record that optimizes clinical care, not billing reimbursement. In sum, we have removed all of the health care misdirection produced by fee-for-service, along with the built-in 40% transaction costs that plague primary care under that system, a system that drives physicians to see 25 to 35 patients a day to cover reimbursement overhead. Our physicians typically see 10-12 patients a day plus provide a handful of phone and email consultations. They have the time to fully treat their patients instead of rushing from one abbreviated appointment to the next.

The result of this effort has been a simple, effective, efficient and humane kind of primary care delivery system, a rarity in America today. Our patients use primary care voraciously (we estimate at least 4-8 times as many face-to-face hours per patient each year). That translates into a dramatic drop in the need for emergency room, hospital and specialist care as well as procedures, surgeries, advanced imaging and the attendant costs and risks these entail (see our 2010 data below). It also translates into

happier patients and providers, and holds the promise to give graduating medical students a reason to aspire to being primary care physicians again.

Direct Primary Care Medical Homes (DPCMH)

Utilizing the direct primary care medical home (DPCMH) model described above, our physicians have the time to provide the 90% of care most people need to see a doctor for, including routine primary and preventive care, urgent care, and chronic disease management. We also coordinate all care beyond the scope of the primary care we provide directly, an increasingly important service in achieving better medical outcomes at affordable cost in our currently fragmented health care system. We intend to reinsert the concepts of value and humanity back into the health care system. We track not only the quality of our work, but also the quality of patient experience in our clinics. Our patient satisfaction levels put us in the top 1% of all businesses in the United States and far ahead of the general health care sector. We are also building into our next generation health information systems tools that will assess the quality, efficiency, price and patient satisfaction of those we refer to. Our patients will have transparency not only for their costs in our system, but for those outside our system. We intend to put patients in the driver's seat and empower them to make decisions that work for them. We wish to be their trusted advisor, not their gatekeeper. As patients accept more financial responsibility for their care, they are interested in spending their money wisely and getting optimal health, not just the most expensive care their insurer will allow. We believe that by putting Direct Primary Care Medical Homes on the front end of the delivery system, health care will be more effective and patient-centered while driving down costs and unnecessary utilization. And our early data strongly support that conclusion.

Analysis of our internal data on our under-65 patients' utilization of downstream, non-primary care services shows that, under the Qliance model, the utilization of emergency room, hospital, specialty care, advanced radiology and surgical care are greatly diminished, as seen below in Table 1. This decrease in utilization translates to a net savings of approximately 22% in overall healthcare costs.

Table 1: Utilization Data – Qliance Members Under 65 (2010)

Type of Referral	Qliance # per year/1000**	Benchmark*	Difference
ER Visits	56	158	-65%
Hospitalizations (visits)	34	53	-35%
Hospitalizations (in days)	105	184	-43%
Specialist Visits	670	2000	-66%
Advanced Radiology	300	800	-63%
Surgeries	22	124	-82%
Primary Care Visits	3540	1847	+92%

*Based on regional benchmarks from Ingenix and other sources.
**Based on best available internal data, may not capture all non-primary care claims

Source: Qliance Medical Group non-Medicare patients, 2010 (n=3,088)

Why not make DPCMH available to Medicare Patients?

There is no provision to cover monthly fee based payments to primary care physicians who treat Medicare patients. Section 1301 (a) (3) of the Patent Protection and Affordable Care Act (Public Law 111-148) () would allow state-based healthcare exchanges to offer coverage through a DPCMH plan operating in combination with a wrap-around insurance policy as long as the two together satisfy all exchange coverage requirements. There is, however, no option to offer the DPCMH model to patients enrolled in Medicare. Despite this, many Medicare patients choose to pay DPCMH plans like Qliance directly out of pocket —above and beyond the cost of fee-for-service Medicare. This has the strange effect of patients subsidizing Medicare with reduced downstream costs—funded by their own contributions. Not all Medicare patients can afford this. Clearly, Medicare patients would benefit from these innovative arrangements, and if the Qliance data holds, the Federal Government would benefit through cost savings.

DPCMH plans are now offered in as many as 24 states—and provide all primary care services. Under a DPCMH model providing primary care services, insurance would be required only for hospitalization, advanced radiology, surgery and specialty care—to which it is better suited. But as the data in Table 1 suggests, Medicare patients would likely use a lot less of these more expensive services, saving Medicare significantly in the form of administrative expenses and downstream costs.

We think it is imperative that in any redesign of the current payment system incentivize Medicare patients to get as much primary care as they can consume by enrolling in a DPCMH plan. Rather than just trying to fix the SGR yet another time, we urge Congress to consider innovative Medicare payment reforms, such as the flat monthly fee DPCMH model. Only by fixing the underlying problem of relying - exclusively upon a fee-for-service model to finance primary care will Congress truly be able to rein in costs and improve health outcomes in the Medicare population.

* The intent of the provision is to require the Secretary to permit state exchanges to offer health plans with a Direct Primary Care Medical Home (DPCMH) operating in conjunction with a wrap around insurance product as qualified coverage, so long as the two together meet all the applicable requirements for plans in the exchange.

PTPNSGR

PTPN
Setting The Standards in Rehabilitation

WITH NETWORKS IN:
Arizona • California • Colorado • Florida • Louisiana • Maine
Maryland • Massachusetts • Michigan • Mississippi • Missouri • New Hampshire • New Jersey
New York • Ohio • Oklahoma • Pennsylvania • Rhode Island • Tennessee • Texas • Vermont • West Virginia

May 16, 2011

The Honorable Wally Herger
The Honorable Pete Stark
Subcommittee on Health
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Herger and Ranking Member Stark:

As the nation's first and largest specialty network of rehabilitation therapists in independent practice, PTPN and its members who function as small businesses are pleased to offer this statement to the Health Subcommittee of the House Committee on Ways and Means with respect to the May 12 hearing that focused on the Medicare payment system. PTPN has led the rehabilitation industry in national contracting, quality assurance and provider credentialing since 1985, elevating the standard of therapy practice. PTPN continued its role as a rehab pioneer by becoming the first organization of its kind to launch a mandatory third-party outcomes measurement program in 2006. The network has more than 1,000 provider offices (including 3,500 physical therapists, occupational therapists and speech/language pathologists) in 23 states. PTPN contracts with most of the major managed care organizations in the nation, including insurers, workers' compensation companies, PPOs, HMOs, medical groups and IPAs. All members of PTPN must be independent practitioners who own their own practices.

As you proceed with your efforts to reform and ensure stability of the Medicare program -- particularly the Physician Fee Schedule -- we would urge you to be continuously mindful of the independent rehabilitation therapy providers and suppliers who function as small businesses and who are an important, integral element of our delivery system. PTPN members provide a valuable service to communities across the nation and they do so in a convenient, cost-effective manner. But as is typical for small businesses, narrow margins are jeopardized when a significant sector of its market cuts reimbursement without regard to the value of the service provided. Moreover, when such an action is unpredictable and is taken by an influential payer such as Medicare, the effect is to negatively influence the business environment and create an untenable situation for the providers. More importantly, the Medicare beneficiaries are left in a vulnerable position, unable to depend on the access to convenient, cost-effective, high-quality care to which they have become accustomed.

PTPN provides critical health care services to beneficiaries under Medicare Part B to enable individuals to return to their highest functional potential. Yet, PTPN member practices will be among those who will see Medicare reimbursement rates cut by 29 percent on January 1, 2012, unless Congress takes some important and necessary action. As the Committee on Ways and Means considers legislative options for reforming Medicare payment policies, PTPN is pleased to offer the following guidance and suggestions:

SGR Repeal
A 29 percent cut in Medicare reimbursement, if allowed to take effect next year, would have a crippling impact on private practice physical therapists and their small businesses. Since many private insurers benchmark their payment rates to Medicare, the impact of such a significant cut would be felt far beyond the Medicare community. The recent history of extending a minimal rate increase for a few months or even a year is an unwise and detrimental way to run an insurance program for 47 million beneficiaries. It is time for Congress to repeal the flawed and dysfunctional formula known as the sustainable growth rate (SGR) which has created an unpredictable and untenable business environment for Medicare Part B providers.

In doing so, PTPN would urge Congress to consider placing more emphasis on the value of the service provided, including the resultant effect of the care on the patient.

Electronic Health Records
Congruent with this notion is the need for Congress to expand the incentives for providers to establish electronic health records. Non-physician providers such as independent physical therapists were not included in the federal programs that encourage and reward the adoption of health information technology. Yet, our members provide an important and valuable service that should be coordinated and communicated electronically. What sense does it make to encourage an information superhighway, but only allowing a certain select type of car to drive on it? The sooner Congress and the administration can set the standards for an interoperable electronic health records the sooner waste and redundancy can be wrung out of the system.

Therapy Cap Repeal
Congress can and should take a related step to correct an injustice in the Medicare system that punishes the beneficiaries who are the most impaired and disabled. The arbitrary, per beneficiary annual therapy caps were authorized as part of the Balanced Budget Act of 1997. Since the scheduled implementation date (January 1, 1999), Congress has intervened numerous times to place a moratorium on therapy caps. And, since 2005, Congress has extended a broad-based exceptions process. These caps were intended to be temporary until "an alternative payment method" could be developed.

And while such an alternative has not materialized in 14 years, one is possible if Congress and the Centers for Medicare and Medicaid Services (CMS) would commit to collecting the necessary descriptive data upon which such an alternative could be predicated.

A limited (and targeted) extension of exceptions process for 2012, 2013, and 2014 combined with instructions to CMS to grant the therapy cap exception for care delivered in any setting that is collecting and reporting functional outcomes data would result in a database containing sufficiently robust information to design the alternative payment method envisioned by the 1997 BBA. Most importantly, such a payment model would not be based on an arbitrary limit, but rather on the amount and type of care to achieve the desired optimal outcome.

Implementation of the above policy need not be costly. In fact, when done thoughtfully, fairly, and a scientifically sound manner, it may even generate modest savings. PTPN is eager to work with the Committee as well as CMS in advancing this short-term transition that can ultimately result in the therapy cap issue being put behind us.

Curbing Overutilization of Therapy
Currently under Medicare Part B there are various ways to bill for services. One policy in particular -- the Stark II in-office ancillary services exception to the self-referral law -- carries a proven propensity for overutilization. PTPN believes, and evidence shows, that elimination of this exception could provide potential cost-savings and improve the integrity of the services delivered and paid for by the Medicare program. The Office of the Inspector General of the United States Department of Health and Human Services has continued to identify a high rate (78 to 91 percent) of inappropriate billing of physical therapy services billed "incident to" a physician's professional services. Elimination of these practices must be addressed in an effort to provide a sustainable payment system for providers that serve the Medicare Part B program and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

On behalf of PTPN, thank you for your continued efforts to create a more effective and more efficient Medicare payment system.

Sincerely,

Michael Weinper

Michael Weinper, MPH, PT, DPT
President/CEO

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