PHYSICIAN ORGANIZATION EFFORTS TO PROMOTE HIGH QUALITY CARE AND IMPLICATIONS FOR MEDICARE PHYSICIAN PAYMENT REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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CONTENTS

HEARING ON PHYSICIAN ORGANIZATION EFFORTS TO PROMOTE HIGH QUALITY CARE AND IMPLICATIONS FOR MEDICARE PHYSICIAN PAYMENT REFORM

TUESDAY, JULY 24, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
WASHINGTON, DC.

The Subcommittee met, pursuant to notice, at 10:02 a.m. in Room 1100, Longworth House Office Building, the Honorable Wally Herger [Chairman of the Subcommittee] presiding.

[The advisory of the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Herger Announces Hearing on Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform

Washington, July 24, 2012

House Ways and Means Health Subcommittee Chairman Wally Herger (R–CA) today announced that the Subcommittee on Health will hold a hearing to explore physician organization efforts to promote high quality patient care. Understanding these initiatives will inform the Subcommittee as it continues to examine how to reform the Medicare physician payment system. The Subcommittee will hear from organizations representing the physicians who are at the forefront of patient care and therefore most knowledgeable about what may be needed to optimize care for Medicare quality and beneficiary health outcomes. **The hearing will take place on Tuesday, July 24, 2012, in 1100 Longworth House Office Building, beginning at 10:00 A.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:

Medicare currently reimburses nearly every physician on a fee-for-service (FFS) basis. While the physician fee schedule generally takes into account the work, time, and effort associated with each service, it does not account for the quality and efficiency of the care provided. Furthermore, the mechanism used to annually update the fee schedule—the Sustainable Growth Rate (SGR) formula—limits spending growth to growth in the economy but does not recognize value or quality. There is broad acknowledgement of the shortcomings of the current payment system, including the disruptive role of the SGR, and the growing importance of incentivizing patient-centered, high-quality, and outcomes-oriented care.

Physician organizations generally support the notion of incorporating quality, efficiency, and patient outcomes into the Medicare physician payment system. Many physician organizations, especially those representing the various specialty disciplines, are involved in a range of activities that increase the likelihood that these aims can be accomplished in a meaningful way. Examples of these physician-led activities include establishing evidence-based guidelines for treating common conditions, using information on actual patient encounters to measure health outcomes, and helping physicians organize their practices to be more responsive to patient needs.

In this third in a series of hearings on Medicare physician payment reform, the Subcommittee will learn more about physician-led quality initiatives such as those described above. In previous hearings, the Subcommittee heard about innovative private sector delivery models and payment reform initiatives payers are using to reward high quality and efficient care. Specialty-specific initiatives designed to support practices that are testing different payment models in the private sector can also provide a foundation from which to reform Medicare FFS payments. Recognizing that physician input is key to successfully incorporating quality and efficiency, the Subcommittee seeks to understand what physicians believe is meaning-

ful to measure, what constitutes good practice in the care of patients, and what changes are needed to improve their practice environment.

In announcing the hearing, Chairman Herger stated **"The Subcommittee is committed to reforming the Medicare payment system so that it brings more value to beneficiaries while remaining viable for physicians. I am pleased that many organizations representing different physician specialties are far along in establishing quality improvement programs including measures of quality that are important to beneficiaries and fair to physicians. Understanding what physicians have already accomplished in this area, what is underway, and what is on the near horizon will be helpful as we explore how to ensure the Medicare physician payment system incentivizes and rewards the care that results in optimal beneficiary outcomes."**

FOCUS OF THE HEARING:

The hearing will focus on how physician organization efforts to promote quality and efficiency can inform Medicare physician payment reform.

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 Wednesday, August 8, 2012**. 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 physician organizations who are working to improve the quality of care delivered to patients.

These initiatives have been shown to be successful and may hold promise as we seek to reform and update the Medicare Physician Payment Formula.

For the past 18 months, we have been seeking both formal and informal input on physician payment reform from the physician community and other relevant stakeholders.

At our last hearing on this topic, we heard about private sector approaches to reforming payments.

Today's hearing is a third in a series on reforming the flawed SGR and focuses on quality improvement activities developed by medical societies and the practical implications of these activities across physician practice settings.

We will hear shortly from physician executives, physician organizations representing both primary and procedural care, and the leaders of two group practices, all of whom are engaged in efforts that focus on improving the quality of care delivered to patients.

A common theme will be that providing optimal quality and outcomes requires setting appropriate standards, building the right infrastructure, and using the right data to measure performance.

Our intent is to hear from the physician community about how to reform the Physician Payment System so that quality, efficiency, and patient outcomes are accounted for in a fair and fiscally responsible manner.

As I have noted before, merely averting sustainable growth rate cuts each year is not a fix. A permanent solution has been elusive in large part because of the substantial costs associated with repealing SGR, currently estimated at nearly $300 billion over ten years.

However, this Committee must do more than just simply repeal the SGR. We must also determine how to improve the existing Medicare payment system and work with physicians to develop other payment models that preserve and promote the physician-patient relationship and reward physicians who provide high quality and efficient care.

Many are concerned about the lack of alignment among Medicare's current incentive programs to enhance quality, such as e-prescribing, meaningful use of electronic health records, and the so-called "value based modifier."

Such programs were not developed nor led by the physician community. While some feel these programs are a step in the right direction, I am concerned about taking a top down Government centered approach to defining and rewarding quality of care.

Physician organizations have been working with their members for many years to build a solid foundation for defining and operationalizing high quality care.

For example, many groups are actively developing evidence based guidelines, quality performance measures, data collection tools, and clinical improvement activities.

It is my hope we can learn from and build upon these efforts as we work with the physician community to develop a 21st Century payment system.

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 five minutes for the purpose of his opening statement.

Mr. STARK. Thank you, Mr. Chairman, for holding this hearing today and exploring ways that we can promote high quality patient care.

As we try to replace the SGR Medicare Formula, it is important that we understand what is happening in the private sector and learn how to incorporate that into any Medicare Formula change.

I look forward to hearing the suggestions of our witnesses today.

We have avoided replacing the SGR in favor of easier reforms, and if we do not fix it, we are going to find that many of our outstanding physicians will begin to turn away from Medicare.

We have tried to reform SGR for over a decade. You are quite right, 200 to $300 billion to pay for it is tough. We do have an opportunity to pay for it, the Overseas Contingency Operations Fund, basically war spending, could be used this year for a permanent SGR fix.

There is a good deal of bipartisan support for the idea, and I would like to insert without objection a letter signed by America's physician professional societies supporting the use of these OCO funds to permanently resolve the SGR problem.

Three of the organizations are represented by today's witnesses, the American College of Physicians, the American Gastroenterological Association, the American Association of Orthopedic Surgeons, who have joined in signing this letter.

[The information referred to follows: The Honorable Pete Stark]

January 23, 2012

The Honorable Dave Camp
Chairman
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Camp:

We are writing to encourage the conferees to take advantage of the very real opportunity to repeal Medicare's sustainable growth rate (SGR) formula. This long stated goal of Congress is now within reach and we urge you to take advantage of it immediately by using excess baseline projections for Overseas Contingency Operations (OCO) to help offset necessary Medicare baseline changes.

Using the OCO baseline as an offset for the accumulated SGR bad debt amounts to "cleaning the books," by eliminating one flawed budget gimmick with another and allowing for a more accurate accounting of future government expenditures without increasing the federal deficit. It also provides an opportunity to immediately repeal the SGR and to establish a pathway toward a truly sustainable physician payment system that focuses on improving quality and value for our nation's Medicare beneficiaries.

Under current procedures, CBO is required to score mandatory spending according to current law, resulting in massive scheduled cuts of more than $290 billion that are included in the current budget baseline for physician services provided to Medicare beneficiaries. Despite the fact that members of both parties have stated time and time again that these cuts will not be allowed to occur, CBO is required to mask the size of the real deficit and debt with these imaginary and unreasonable future savings.

Moreover, the cost of repealing the SGR gets worse over time. In 2005, CBO projected that the cost of repealing the SGR was $48 billion. That cost is now $290 billion and growing rapidly. Temporary patches that continue to assume even deeper future cuts add to this challenge, regardless of their duration. For instance, an SGR patch of two years will cost $39 billion in 2012, increase the cost of repeal to $346 billion, and increase the size of the next scheduled cut to physician payments to 36%. Pushing off this problem continues this reckless pattern of spending billions of dollars only to make future cuts deeper and more expensive to solve.

We agree that our nation faces significant fiscal challenges, and that Medicare is not immune. However, it is impossible to implement commonsense programmatic reforms while an immediate and constant threat of massive cuts hangs over the program. Accordingly, we urge you to utilize the opportunity provided to this conference committee to eliminate the SGR permanently.

Sincerely,

American Medical Association
AMDA - Dedicated to Long Term Care Medicine
American Academy of Family Physicians
American Academy of Home Care Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology—Head and Neck Surgery
American Academy of Sleep Medicine
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Neuromuscular and Electrodiagnostic Medicine

American Association of Orthopaedic Surgeons
American Association of Physicians of Indian Origin
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Mohs Surgery
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Phlebology
American College of Physicians
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Geriatrics Society
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society for Reproductive Medicine
American Society for Surgery of the Hand
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Hematology
American Society of Nuclear Cardiology
American Society of Pediatric Nephrology
American Society of Plastic Surgeons
American Society of Transplant Surgeons
American Urological Association
College of American Pathologists
Heart Rhythm Society
Infectious Diseases Society of America
Joint Council of Allergy, Asthma and Immunology
Medical Group Management Association
National Medical Association
North American Spine Society
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Gynecologic Oncology
Society of Hospital Medicine
Society of Nuclear Medicine
The Endocrine Society
The Society of Thoracic Surgeons

Medical Association of the State of Alabama
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society

Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society

Mr. STARK. I look forward to hearing from our witnesses, and the discussion that follows, and I yield back.

Chairman HERGER. Thank you, Mr. Stark. Today we are joined by six witnesses.

Dr. Lawrence Riddles, who is a recently retired Command Surgeon for the U.S. Air Force and current President of the Board for the American College of Physician Executives.

Dr. David Bronson is President of Cleveland Clinic Regional Hospitals, and serves as the President of the American College of Physicians.

Dr. Michael Weinstein, a practicing gastroenterologist in the D.C. metro area, and Chair of the American Gastroenterological Association's Registry Board.

Dr. Peter Mandell, who is a practicing orthopedic surgeon, and Chair of the American Academy of Orthopedic Surgeons Council on Advocacy.

Mr. Aric Sharp, CEO of Quincy Medical Group in Quincy, Illinois.

Dr. John Jenrette, the CEO of Sharp Community Medical Group in San Diego, California.

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

Dr. Riddles, you are now recognized for five minutes.

STATEMENT OF DR. LAWRENCE RIDDLES, PRESIDENT OF THE BOARD, AMERICAN COLLEGE OF PHYSICIAN EXECUTIVES

Dr. RIDDLES. Good morning, Chairman Herger, Ranking Member Stark, and members of the House Ways and Means Subcommittee on Health.

I am Dr. Larry Riddles, a retired military surgeon and President for the American College of Physician Executives, commonly known as ACPE, the nation's largest health care organization for educating physician leaders.

It is my privilege to share some of ACPE's thoughts on Medicare physician reimbursement challenges which you and your colleagues are wrestling with.

We are not here to make an argument to preserve physician income, rather, we are here to move towards a desired end point that must to achieve timely and equitable access to high quality health care that is physician led and reimbursed fairly.

Thousands of ACPE physician leaders are implementing innovative cost saving initiatives. Based on these experiences, ACPE proposes nine essential elements that we believe must be part of any successful future physician payment system.

First, the reimbursement system must be quality centered. Any new reimbursement system must include compensation strategies providing high quality care.

ACPE believes that there should be ongoing efforts to drive quality improvement that occurs in part through physician reimbursement reform.

Current fee for service systems are based primarily on volumes of patients seen and number of procedures completed. This prevents achieving higher quality health care.

Second, health care must be safe for all. ACPE believes physicians should be rewarded for making safety a priority. Examples of safety improvements led by physicians can be found in many hospitals and health systems. These initiatives, however, have largely been un-reimbursed.

A new payment system should take into account reductions in adverse events and reward for successes with a range of other relevant patient safety indicators and clinical measures.

Third, a streamlined system, strive for simplicity. We frequently hear from the ACPE members about the burden of reporting requirements for Medicare payments.

Efforts toward common measures, common data elements, and common reporting requirements are underway and should be encouraged.

Simplified measurements and reporting allows for transferability and scalability of information so that local, state, and national data collection analysis can occur more rapidly.

Four, the system must be measurement based. As a science, health care measurement is immature. Measures endorsed by the National Quality Forum should be refined and publicly reported.

Measurements directly related to physicians is highly complex, but ACPE encourages ongoing development of physician focused measurement and public reporting.

Efforts to interpret outcomes must be clinically relevant, balanced, and realistic, and must not create unfounded negative connotations.

Five, the system must be based on evidence based medicine. Physicians are much more likely to comply with guidelines if strong data are available. Many professional societies are generating evidence based guidelines and there is a Federal clearinghouse of guidelines, but utilization remains low.

While evidence based medicine is an emerging field, physicians should be rewarded for improving and following guidelines and clinical pathways that are proven to provide safe and reliable care.

Six, value based care. Value equals quality over cost. Reimbursements must be focused on value based care. The Centers for Medicare and Medicaid Services have already established pilot projects exploring value based purchasing and other public and private entities also have projects underway.

ACPE believes any new reimbursement system should compliment these programs.

Seven, innovation. Instilling a culture of innovation not creative billing within physician practices should be a priority. The payment system should encourage physicians to implement processes that save money and contribute to safer care.

There are a variety of successful innovative programs in hospitals and health care systems at the local level. There needs to be a mechanism to raise them up to the national level so that innovative ideas can become best practices.

Number eight, the system should be fair and equitable. The payment system must not create conflict between the primary care physicians and cognitive and procedural specialists. Each member of the health care team must be fairly remunerated for their overall long term care of patients and not just focused on individual episodes of care.

Finally, the ninth element is the system should be physician led. Physicians are much more likely to accept a revised reimbursement plan if it is developed with physician input.

The most progressive health care organizations tend to be physician led and physician leaders not only have a strong understanding of the health care on the clinical side but they also know how to lead and run successful enterprises.

ACPE recommends the creation of a new independent commission composed of physicians, health care providers, experts in finance and quality, business leaders and patient representatives to

study Medicare's funding dilemma and analyze the best practices and bring them to you for consideration.

ACPE strongly believes that our nine essential elements in the next payment system will be critical to a successful outcome.

Thank you for inviting us here today to provide testimony.

[The statement of Dr. Lawrence Riddles follows:]

TESTIMONY IS EMBARGOED UNTIL 10:00 AM TUESDAY, JULY 24, 2012

American College of Physician Executives

The Home for Physician Leaders

Statement from:

The American College of Physician Executives (ACPE)

Presented by:

Dr. Lawrence M. Riddles

Before:

Committee on Ways and Means - Health Subcommittee

Regarding:

Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform

Tuesday, July 24, 2012

Executive Summary

The American College of Physician Executives (ACPE) is the nation's largest health care organization for physician leaders and executives. Since its founding in 1975, the primary focus of the College is providing superior leadership and management education to physicians and facilitating their engagement with active leadership roles inside health care organizations of all types and sizes. These physician leaders come to ACPE from virtually all disciplines.

Beyond the thousands of physicians who have received ACPE training, the organization has grown to 11,000 U.S. members – including chief executive officers (CEOs), chief operating officers (COOs), chief medical officers (CMOs), vice-presidents of medical affairs (VPMAs), chief medical information officers (CMIOs), chief quality and safety officers, medical directors and a host of other physician leadership positions from across the entire industry.

Especially, ACPE is nationally and internationally recognized for its expertise with change management, physician engagement and physician integration, and has:

- More than **65** faculty across dozens of disciplines
- More than **50** physician leadership courses
- More than **3,100** online courses sold annually
- **150** in-house leadership courses taught onsite each year at hospitals and health systems
- **4** Master's degree programs with **1,000** graduates
- More than **2,000** physicians with ACPE board certification as Physician Executive (CPE)
- More than **20,000** physicians who have completed Physician in Management Seminars

ACPE believes the following ***nine elements*** are pivotal components for the next Medicare physician payment system and critical to a successful outcome for true patient-centered care. The ***nine ACPE elements*** are: 1) quality-centered; 2) safe for all; 3) streamlined and efficient; 4) measurement-based; 5) evidence-based; 6) value-driven; 7) innovative; 8) fair and equitable; and 9) physician-led.

Chairman Herger, Ranking Member Stark, and Members of the House Ways and Means Health Subcommittee, on behalf of the American College of Physician Executives (ACPE), representing nearly 11,000 high-level physician leaders and executives in all types of health care organizations across the U.S., we thank you for inviting us to testify before the Subcommittee and to share our insights about the Medicare reimbursement solution. While ACPE itself does not provide direct patient care, many of our thousands of physician leaders are successfully implementing innovative and cost-saving initiatives in their hospitals, health systems, group practices and other types of health care organizations. We include some examples of these experiences throughout our testimony.

As we all know, the Sustainable Growth Rate (SGR) is not working. We encourage your Subcommittee to take an entirely fresh look at physician reimbursement issues in order to create a permanent solution that is value-based and equitable across physician disciplines.

Up front, ACPE wants to emphasize that preserving physician income is not the primary focus of this complex policy discussion. The desired endpoint needs to be timely, open access to sustainable, high-quality health care that is physician-led. ACPE believes we are uniquely positioned to assist with implementation of a new reimbursement plan, especially in the areas of physician buy-in and physician engagement, which are critical to the success of a new payment system.

ACPE recommends development of a new payment system that is transferable and scalable across geographic regions while emphasizing patient-centered care and focusing on ***nine key elements***:

1. Quality-centered

Consistent delivery of high quality care has remained elusive despite intense efforts and numerous initiatives to create the needed improvements. Our health care system is highly fragmented and its alignment of financial reimbursements within the system contributes to the problem. Current physician reimbursement that is primarily based on volumes of patients cared for and numbers of procedures completed, perpetuates the ineffectiveness of transforming to higher quality health care. A new reimbursement system must include compensation strategies

for providing high-quality care. ACPE believes there should be ongoing efforts to drive quality improvement that occurs, in part, through physician reimbursement reform.

Hospital readmissions can be viewed as an indirect marker, among many, of poor quality. When high-quality care is being delivered across the continuum of care, there are fewer hospital readmissions and improved outcomes for patients. Although readmissions may occur for reasons beyond physicians' control (e.g., patient resources and lifestyle choices), physicians and physician leaders are well positioned to address this costly issue. Specifically, physicians with the combination of clinical skills, leadership expertise and management knowledge are best qualified to employ quality measures, ensure compliance and evaluate the success of patient outcomes based upon the constellation of issues present during patient care episodes.

There are documented ways to reduce readmissions. For example, in 2005, a large, North Carolina-based nonprofit hospital system showed that patients 65 and over were twice as likely as other patients to be treated in the emergency room for an adverse drug event and more than seven times as likely to be readmitted. Based upon physician leadership, a new team-based approach was designed and created to improve referral processes, reduce ER wait times, and streamline care after discharge. The results of this program were overwhelming. Readmissions due to adverse drug events were reduced dramatically, and the overall costs of care in patients with chronic disease and multiple medications were reduced by more than 20 percent.

2. Safe for all

Likewise, physicians should be rewarded for putting patient safety first and avoiding costly medical mistakes. Examples of safety improvements that improve care and reduce costs can be found in many hospitals and health systems. These initiatives, however, have largely been unreimbursed efforts. A new payment system should take into account reductions in adverse events, days without safety-related problems, and success with a range of other relevant patient safety indicators or clinical measures.

Based primarily on physician leadership passion and commitment that was able to be translated into system management support, a children's hospital in Michigan has been on a five-year journey to transform the patient safety culture at their 212-bed facility. The results have been

outstanding: the serious safety event rate has decreased in the entire hospital by more than 90 percent in four years. The Pediatric Critical Care Unit (PCCU) went two years without a case of ventilator-associated pneumonia (VAP) and the Neonatal ICU went more than one year without one case of VAP. There were no central line associated blood stream infections (CLABSI's) in the PCCU for more than 12 months while hand hygiene rates remain over 95 percent hospital-wide annually. Incident reporting rose more than 148 percent from 2010 to 2011. The efforts for instigating these initiatives, plus maintaining the buy-in from other participating physicians and clinical providers, were not supported by physician reimbursement. For propagation across health care of other successes similar to this example, physician reimbursement reform is critical.

Safe for all implies more than safety for patients. When errors occur in health care, the physicians and other providers are also at risk for physical and emotional harm. A well-functioning system has streamlined reporting in order to become aware of the errors and provides a supportive infrastructure to manage the adverse outcomes that directly impact these providers. Organizations that follow the principles of high reliability are pre-occupied with safety and the protection of all within their environment and processes. Overall safety improves as a result.

For quality and safety issues, ACPE is particularly well positioned to make an impact. ACPE works with expert faculty from across the country to produce numerous courses on quality, high reliability and safety. Thousands of physicians have completed these courses and learned to implement quality and safety programs. Most recently, ACPE partnered with Thomas Jefferson University to create a Master of Science degree in Health Care Quality and Safety Management.

3. Streamlined and Efficient

The new payment system and the information required to execute it must be streamlined, making it as easy as possible for physicians and health care organizations to collect reimbursement. We frequently hear from ACPE members about the burden of reporting requirements surrounding Medicare payments – especially with the collective burden imposed when coupled with those from other non-Medicare payers. Time, effort and money spent on highly detailed reporting could be much better spent providing quality patient care.

The majority of physician time, and the clinical teams' efforts, should be focused on patient care. Overuse, underuse and misuse of resources are common problems recognized as creating an excess utilization rate of 25-30 percent. Inefficiencies magnify this problem.

Strive for simplicity. The more complex a payment system, the greater possibility for error and confusion. Efforts toward common measures, common data elements and common reporting requirements are underway and should be encouraged. Simplified measurement and reporting allows for transferability and scalability of information such that local, state and national data collection can occur with a more rapid evaluation process that is efficient and streamlined.

4. Measurement-based

While measurement as a science in health care is immature and continues to evolve, available clinical and patient care measurements that have been endorsed by the National Quality Forum (NQF) should be publicly reported and should represent all types of relevant measures (e.g., structural, process, outcomes and composite). ACPE recognizes that measurement directly related to physicians is highly complex due to the multiplicity of variables and uncontrollable factors (e.g., patient lifestyle choices). However, ACPE encourages ongoing development of physician-focused measurement and reporting, but it must be clinically relevant, balanced and realistic in its interpretation of outcomes. Efforts from initiatives by entities such as the AQA alliance (originally known as Ambulatory Care Quality Alliance) and Physician Consortium for Performance Improvement (PCPI) should be supported and measurement results collated in order that those results can contribute to the evolving nature of a new payment system.

Public education efforts regarding the ongoing evolution of measurement and reporting should be developed in order for the public to better understand and comprehend these components of health care. Ultimately, health care delivery and clinical care practices should have outcome measures related to wellness and health. The potential for development of patient outcome oriented measures and reporting remains untapped, however. This is due in part to the immaturity of measurement science as well as the slow progression of developing supportive evidence in this regard.

5. Evidence-based

All health care is based on scientific research and, clearly, evidence-based approaches are becoming more popular. While evidence-based medicine (EBM) is an emerging field, physicians, in particular, are much more likely to comply with guidelines if strong data are available to support them. Physicians should be rewarded for following evidence-based guidelines and clinical pathways that are proven to provide safe, reliable care to patients.

One area that continues to need further clarification with evidence-based medicine, however, is the balance between following EBM guidelines and allowing for innovation with evolving research, implementation of technologies or clinical care practices. Accommodation for managing this balance between EBM and innovation should be considered at some level within next generation physician reimbursement models.

Many professional societies and specialty organizations are generating evidence-based guidelines and clinical pathways of care. But in most circumstances, unfortunately, the proven guidelines are not effectively implemented within health care organizations or by physicians. A federally sponsored guideline clearinghouse has a large reservoir of guidelines but utilization remains comparatively low. Financial incentives within physician reimbursement would help improve this low utilization rate and should be seriously considered.

A good example of how following clinical pathways can improve patient outcomes and reduce costs was recently shared by an ACPE member: A 2010 study by US Oncology and Aetna of 1,409 patients with lung cancer showed 35 percent lower costs for those patients treated on the clinical pathway versus those patients who were off the pathway ($18,042 versus $27,737).

6. Value-driven

Future reimbursement models must be focused on value-based care, not volumes of patients seen or procedures conducted. The Centers for Medicare and Medicaid Services (CMS) has already established numerous pilot projects exploring value-based purchasing, and other government groups have trial programs under way, as well. Similarly, numerous private sector initiatives have also begun to spring up around the country. Clearly, value-based care and reimbursement is gaining traction and ACPE believes any reimbursement system should support this new focus.

The shift toward value drives innovation with different models of care that orient toward patient-centered care and improved outcomes. Ongoing attention to clinical care improves, while simultaneously creating increased attention to health care systems efficiencies – a double win.

7. Innovative

Instilling a culture of innovation (not creative billing) within physician practice settings should be a positive outcome from a new payment model. The payment system should take innovative practice strategies into account and encourage physicians and health care organizations to implement new processes and procedures that create cost savings while simultaneously improving quality and keeping patients safe.

As one example, prevention of errors in health care can result with concerted efforts towards identification of inherent risks already present within health care organizations that are related to process flaws and the potential for error related to inherent human behaviors. Once identified, proactive risk-mitigation can then be planned into health care system redesign in order to decrease and prevent errors from occurring. So-called systems engineering and human factors engineering are highly successful disciplines in other industries and financial incentives for their implementation by physicians within health organizations should be promoted.

A host of innovative activities are in motion across the country. Developing a method to nationally scale the successful efforts and to have them promulgated should be a priority. ACPE supports and encourages the efforts emanating from both the public and private sectors.

8. Fair and Equitable

Any new payment system must be fair and equitable for all physicians, and should not create conflict among procedural specialties, cognitive specialties and primary care physicians. ACPE again stresses, however, that preserving physician income is not at the heart of this complex predicament. While reimbursing providers in a fair, equitable manner is critically important, we do not believe our physician members—and indeed most physicians across the country—are primarily concerned about payment for their services. Physicians are altruistic at their core and truly want to do what's best for optimal patient care outcomes.

Physician efforts toward the promotion of population health, individual wellness and support of public health initiatives are a composite in this equation if full success is to occur. Reimbursement models should take these aspects of health care into consideration. Fair and equitable access to care for patients with an improved distribution of resources is certainly paramount in support of these aspects as well.

9. Physician-led

Creation of a new physician payment system must, ideally, be physician-led. The most successful and progressive health care organizations throughout the U.S. tend to be physician-led. This occurs because physician leaders not only have a strong understanding of the clinical side of health care, but they also have a deep understanding of how to lead and run a successful enterprise. The ability to relate with peer group physicians and other clinical providers enables a level of trust and confidence to be more readily accomplished compared with non-physician leadership. Physicians are much more likely to accept a revised payment and delivery system if it is developed with physician input.

An ACPE recommendation toward SGR reform would be establishing a new independent, non-partisan commission—composed of physicians and other health care providers, health care financial experts, quality and patient safety experts, business leaders, and patient representatives—to further evaluate the overall Medicare funding dilemma with a fresh perspective. This commission would research and analyze best practices, deliberate on the evidence and then bring physician-developed recommendations to the Health Subcommittee for consideration. Obviously the expected outcome would be oriented to creating a payment system and situation that is beneficial to the health care economy and not be focused on embellishing physician compensation.

ACPE's cadre of physician leaders throughout the U.S. is perfectly positioned to engage all disciplines of physicians in contributing ideas to formulate an improved reimbursement plan and our members are also well-suited to influencing fellow physicians to follow the plan's guidelines and meet its goals. ACPE's recognized expertise is with physician engagement and integration.

We strongly believe in the importance of including the ***nine ACPE elements*** within the next payment system and that they are pivotal for a successful outcome. Again, ACPE is pleased to offer these insights to the House Ways and Means Subcommittee on Health and stands ready to assist further on this most important initiative to bring a permanent, measured, disciplined, bi-partisan and fair approach to Medicare funding. Thank you for this opportunity to provide comment for the Subcommittee and its members.

Chairman HERGER. Thank you.
Dr. Bronson, you are recognized for five minutes.

STATEMENT OF DR. DAVID BRONSON, PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS

Dr. BRONSON. I am President of the American College of Physicians, the nation's largest medical specialty organization representing 133,000 internists, internal medicine subspecialists, and medical students pursuing careers in internal medicine.

I am a Board certified practicing internist, a Professor of Medicine at the Lerner College of Medicine at Case Western Reserve University, and President of the Cleveland Clinic Regional Hospitals.

Repeal of Medicare's sustainable growth rate is essential, but repeal by itself will not move Medicare to better ways to deliver care. We need to transition from a fundamentally broken payment system to one that is based on value of services to patients.

We recommend the following steps to start such a transition. First, Congress should establish a transitional value based payment initiative where physicians who voluntarily participate in physician led programs to improve quality and value will be eligible for higher Medicare updates.

Second, this transitional initiative specifically should provide higher updates to physicians and recognize patient centered medical homes and patient centered medical home neighborhood practices.

The patient centered medical home, or PCMH, has several important features described in the joint principles of the patient centered medical home adopted by ACP, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association.

These features include a personal physician for each patient who is leading a team of individuals trained to provide comprehensive care that work together to ensure quality, safety, and enhanced access to care, while arranging all the patient's health care needs and coordinating care across all elements of a complex health system.

Many insurers are now offering PCMH practices to tens of millions of patients, achieving major quality improvements and cost savings. It is time to make them more available to Medicare patients by providing higher updates to physicians, independently certified practices that are PCMH practices.

Third, Medicare should support the contributions of subspecialists and ensure high quality coordinated care through collaborative arrangements with PCMH practices.

This concept called the PCMH neighborhood, offers financial and non-financial support to specialty practices that have demonstrated that they have the information systems, formal arrangements, and other practice capabilities needed to share information and coordinate treatment decisions with their primary care medical home.

Congress should facilitate rapid expansion of this model by providing higher updates to recognize PCMH neighborhood practices.

At least one major health care accreditation group is now in the process of establishing a PCMH neighborhood recognition program.

Fourth, Medicare payment policies should support efforts by the medical profession to encourage high value cost conscious care.

For example, ACP's high value cost conscious care initiatives help physicians and patients understand the benefits, harms and

costs of intervention and whether it provides good value to patients.

Through this program, ACP has released clinical advice focused on three areas, low back pain, oral pharmacologic treatments of Type II diabetes, and colorectal cancer.

Using a consensus based process, ACP has also identified 37 common clinical situations in which screening and diagnostic tests are used in ways that do not reflect high value care.

To get the information to patients, ACP and Consumer Reports have agreed to a series of high value care resources to help patients understand the benefits, harms and costs of tests and treatments for common clinical issues.

Medicare payment policies could support the professional societies' efforts to educate and engage clinicians in high value cost conscious care by number one, reimbursing physicians appropriately for spending time with patients, to engage them in shared decision making, and number two, develop ways to recognize with higher payment updates physicians who can demonstrate they are incorporating advice from their professional societies' programs into their practices and engaging in the shared decision making with their patients.

Fifth, Congress should improve Medicare's existing quality improvement programs, including the meaningful use standards, physician quality reporting system, and e-prescribing.

The measures, incentives and reporting requirements for these programs should be harmonized to the extent possible.

CMS needs to do a better job in providing timely performance data to physicians participating in these programs.

In addition, these programs should be aligned with the regular practice assessment, reporting, and quality improvement activities required by a physician specialty board's Maintenance of Certification process.

In conclusion, ACP believes that fundamental reform of the Medicare payment system should build upon effective, physician led efforts to improve quality.

The PCMH and PCMH neighborhood practices exemplify this approach.

I would be pleased to answer your questions.

[The statement of Dr. David Bronson follows:]

TESTIMONY IS EMBARGOED UNTIL 10:00 AM TUESDAY, JULY 24, 2012

ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | Doctors for Adults®

Statement for the Record

American College of Physicians

Hearing before the House Ways and Means Health Subcommittee

On

Physician Organization Efforts to Promote High Quality Care

July 24, 2012

The American College of Physicians (ACP) applauds Chairman Herger and Ranking Member Pete Stark for holding this hearing on how initiatives by ACP and other physician organizations to improve quality could contribute to a solution to Medicare's physician payment system. We share your view that Medicare is in need of a new system that "brings more value to beneficiaries while remaining viable for physicians." In that spirit, ACP's statement will focus primarily on how Congress could build upon physician-led initiatives to transition to a new value-based payment and delivery system.[1] We will discuss delivery and payment reform models that we view as the most promising in any post-SGR environment, as well as noting the kinds of structural and reporting capabilities, payment incentives, and measurement systems needed for them to work.

My name is David L. Bronson. I am President of the American College of Physicians, the nation's largest medical specialty organization, representing 133,000 internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults, internal medicine subspecialists, and medical students who are considering a career in internal medicine. I reside in Cleveland, OH, and am board-certified in internal medicine and practice at the Cleveland

[1] More detailed information on ACP's activities and policy related to how Congress can work with ACP and others in the medical profession to advance comprehensive, patient-centered, and value-based payment and delivery system reforms can be found in our May 23, 2012 letter to The Honorable David Camp, Chairman of the House Committee on Ways and Means. This letter can be accessed at http://www.acponline.org/advocacy/where_we_stand/medicare/src_acp_response.pdf.

Clinic. I am also President of the Cleveland Clinic Regional Hospitals and a professor of medicine at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University.

Our testimony offers the following for the Subcommittee's consideration:

1. Discussion of why fundamental payment and delivery system reform is imperative.
2. Principles for transitioning to value-based payment and delivery system reforms, based on physician-led initiatives in the private and public sector to improve quality and lower costs.
3. Assessment of specific payment and delivery system reform models, in both the private and public sectors, which could be the basis for transitioning to fundamental reform.
4. Summary of ACP's many initiatives to develop evidence-based guidelines of care; to help physicians incorporate evidence-based, high value care into their practices; and to assist practices in moving toward value-based models.
5. Developing payment policies to support physician-led programs to promote high value care.
6. Leveraging and improving existing quality improvement/value-based payment programs.
7. Suggestions on a legislative framework to transition to better payment models.

WHY FUNDAMENTAL PAYMENT AND DELIVERY SYSTEM REFORM IS IMPERATIVE

Fundamental reform of the Medicare payment system is long overdue, including repeal of Medicare's Sustainable Growth Rate (SGR). For more than a decade, the SGR has caused annual scheduled cuts in payments to physicians, endangering access to care, destabilizing the program, and creating barriers for physicians to develop the practice capabilities to improve clinical quality and effectiveness. Repeal of the SGR is essential, and we hope that it can be achieved this year.

But repeal of the SGR alone will not move Medicare to better ways to organize, deliver, and pay for care provided to Medicare enrollees. Accordingly, our testimony will focus on how to get from here to there, from a fundamentally broken physician payment system to one that is based on the value of services to patients, including immediate and longer-term steps that build upon successful physician-led initiatives in the private and public sectors.

PRINCIPLES TO CREATE A TRANSITIONAL VALUE-BASED PAYMENT INITIATIVE

ACP believes that steps can be taken over the next 1-5 years, while providing physicians and patients with a necessary period of stable payments, to start more physicians on the road to better payment models, and reward "early adapters" who already have taken the leadership and risk of participating in new value-based payment and delivery models. During such a transitional period, we propose that physicians get higher updates for demonstrating that they have successfully participated in an approved transitional quality improvement (QI) or value-based payment (VBP) program. We begin by offering the following principles for developing a transitional QI/VBP program, and then we provide an assessment of specific physician-led models that could be incorporated into such a transitional QI/VBP program:

1. ACP supports, in concept, the idea of providing an opportunity for performance-based updates based on successful participation in an approved transitional QI/VBP initiative that meets standards relating to the effectiveness of each program, building on successful models in the public and private sectors.
2. Transitional performance-based update programs should be incorporated into a broader legislative framework to stabilize payments and transition to new models. This is important so that physicians and the Medicare program have a clear "destination" and pathway to achieving it, even as physicians begin the journey through the transitional QI/VBP initiative.
3. The transitional QI/VBP program should include models for which extensive data and experience already exist, and that can more readily be scaled up for broader adoption by Medicare. Specifically, these could include participation in the Patient Centered Medical Home (PCMH) and Patient-Centered Medical Home Neighborhood (PCMH-N) models, as determined by practices meeting designated standards through a deemed accreditation body and/or standards to be developed by the Secretary with input from the medical profession. Participation in other established models that have demonstrated the potential to improve care coordination, such as Accountable Care Organizations (ACOs), bundled payments, and global primary care payments should also be considered for inclusion in a transitional QI/VBP program. In addition, physicians who agree to incorporate programs, like ACP's High Value, Cost-Conscious Care Initiative, into their clinical practice through shared decision-making with patients, might also qualify for a transitional QI/VBP payment. We discuss these initiatives in more detail later in our testimony.

4. Existing QI/VBP payment models—the Medicare Physician Quality Reporting System (PQRS), e-prescribing (e-RX), and meaningful use (MU) programs—if included in a transitional performance-based payment update program, should be improved to harmonize measures and reporting to the extent possible and to establish a consistent incentive program across all elements. Efforts should also be made to align them with specialty boards' maintenance of certification programs. Later in our testimony, we provide specific recommendations on leveraging and improving such programs.
5. Transitional performance-based updates could be tiered so that programs that provide coordinated, integrated, and patient-centered care get a higher performance update than less robust programs built on the current, silo-ed fee-for-service system.
6. Performance-based payment updates should be in addition to a higher "floor" on payments for undervalued primary care/preventive/and coordinated care services, not limited by physician specialty, so that any physician who principally provides such undervalued services could qualify for the higher update. This is important to address the continued under-valuation of these critically important services, even as payments also begin to reflect physician participation in the transitional QI/VBP initiative.
7. For a transitional QI/VBP program to be effective in improving quality, CMS will need to improve its ability to provide "real time" data to participating physicians and practices. A method will need to be created to map practice-level participation in a transitional QI/VBP initiative to the individual physician updates under the Medicare Physician Fee Schedule.

ACP welcomes the opportunity to work with the Subcommittee and other physician organizations to develop the details of a transitional QI/VBP initiative that builds upon the successful physician-run models, including PCMHs and PCMH-Ns, as discussed below.

SPECIFIC PAYMENT AND DELIVERY REFORMS THAT CAN SERVE AS THE BASIS FOR A TRANSITIONING TO FUNDAMENTAL REFORM

1. ***Patient-Centered Medical Home (PCMH)***

The PCMH is an approach to providing comprehensive primary care in a setting that focuses on the relationships between patients, their primary care physician, and other health professionals involved in their care. Key attributes of the PCMH promote health care delivery for all patients though all stages of life. It has its origins in the "Joint Principles of the Patient-Centered Medical Home" adopted by ACP, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA), and in the American Academy of Pediatrics' (AAP) decades-long efforts to create medical homes for children with special health care needs.[2] Care through a PCMH is characterized by the following features: a personal physician for each patient; a physician-directed medical practice, where the personal physician leads a team of individuals trained to provide comprehensive care; whole person-orientation, where the treatment team directly assists the patient in meeting their specific health care needs; care coordinated across all elements of the complex health care system; quality and safety; and enhanced access to care. Several accreditation groups have developed accreditation or recognition programs that can be used in determining if a practice provides care that is consistent with these expected features. And an increasing number of payers and physicians are engaged in PCMH initiatives throughout the country, offering PCMHs to tens of millions of patients through thousands of physician-led PCMH practices.

Scaling Up the PCMH Model

ACP believes that the PCMH model has advanced enough that it could be scaled up for widespread implementation throughout Medicare in the immediate future. The growing amount of experience in both the public and private sectors on how to organize care around PCMHs, the thousands of physician practices that have already achieved certification or accreditation as a PCMH, and the growing amount of data on its effectiveness in improving care and lowering costs, makes it a logical model to scale up to the broader Medicare program. **This could be done, for instance, by providing higher Medicare payments to physician practices that have achieved recognition by a deemed private sector**

[2] AAFP, AAP, ACP, and AOA. The Joint Principles of the Patient-Centered Medical Home. March 2007. Accessed at http://www.acponline.org/advocacy/where_we_stand/medical_home/approve_jp.pdf?hp.

accreditation body. At a subsequent stage, PCMH performance metrics (now under development) could be added and incorporated into Medicare payment policies.

At the same time, ACP recognizes that there are challenges to the PCMH model. Some of these include:

- The need for care coordination across settings and the continuum of patient care.
- Related to the issue of care coordination is the lack of real- or near-time data being provided to practices on their patients, which makes it extremely challenging for them to provide proactive, patient-centered care. This is exacerbated by the lack of effective data and information sharing across sites of care.
- Finally, in many cases, practices are transforming to provide services to their patients in line with the PCMH model, but are only paid to do so for a subset of their patient population (e.g., Wellpoint and Aetna are paying them a per member per month payment for their beneficiaries, but they are not receiving payment from CMS for their Medicare patients). This issue is being addressed in some areas of the country, particularly those that will be selected to participate in the CMS Innovation Center's Comprehensive Primary Care Initiative (CPCi), but many other practices across the country are not being "made whole" in terms of payment for the work they are doing.

2. ***Patient-Centered Medical Home – Neighborhood***

The Patient-Centered Medical Home-Neighborhood (PCMH-N) concept was initially described by ACP in a position paper, developed by our Council of Subspecialty Societies.[1] The paper observes that the effectiveness of the PCMH care model is dependent on the contributions of the many subspecialists, specialists, and other health care entities (e.g., hospitals, nursing homes) involved in patient care. Specialty and subspecialty practices, hospitals, and other health care professionals and entities that provide treatment to the patient need to be recognized and provided with structural support—both non-financial and financial—for engaging in patient-centered practices that complement and support the efforts of the PCMH to provide high quality, efficient, coordinated care.

[1] American College of Physicians. The patient centered medical home neighbor: The interface of the patient centered medical home with specialty/subspecialty practice. 2010. Accessed at http://www.acponline.org/advocacy/where_we_stand/policy/

The NCQA is in the process of developing a "medical neighbor" recognition process that identifies specialty and subspecialty practices that engage in activities supportive of the PCMH model—with particular emphasis on care coordination and integration. This decision was made following the conclusion of a comprehensive feasibility study in which this concept was strongly supported by multiple health care stakeholders. In addition, the American Board of Internal Medicine and the NCQA are now collaborating to align aspects of Maintenance of Certification and the new "medical neighbor" recognition process.

This new NCQA program, and similar efforts, can serve to encourage specialty/subspecialty practices and other "neighborhood" health care entities currently not involved within an integrated system—settings in which most care is currently being delivered—to implement these important processes. This is already happening in several areas of the country. For example:

- The Vermont Blueprint for Health program is implementing a program in which medical home and related, anchored subspecialty practices engaging in efficient, integrative processes will be sharing a monthly care coordination fee for the treatment of chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes, and asthma.
- The Texas Medical Home Initiative will require participating primary care practices to establish care coordination agreements with their most frequently referred to specialist and hospital settings.
- Programs in both the Denver and Grand Junction areas of Colorado are in the process of implementing "medical neighborhood" programs that promote increased integration among primary and specialty care practices.

Given the significant and rapid growth of activity to advance the PCMH neighbor concept, ACP believes that the PCMH-Neighborhood model will be ready to be scaled up for implementation throughout Medicare in the near future—and therefore could be incorporated into a transitional value-based payment approach.

DEVELOPING PAYMENT POLICIES TO SUPPORT PHYSICIAN-LED PROGRAMS TO PROMOTE HIGH VALUE CARE

Medical specialty societies, including ACP, are taking a leading role in developing and implementing programs to improve the value of care provided to patients. These programs could also be considered for incorporation into a QI/VBP model.

ACP's High Value, Cost-Conscious Care Initiative (HVCCC), which includes clinical, public policy, and educational components, was designed to help physicians and patients understand the benefits, harms, and costs of an intervention and whether it provides good value, as well as to slow the unsustainable rate of health care cost increases while preserving high-value, high-quality care.[4]

For the clinical component of the HVCCC Initiative, ACP has released materials focused on three areas: low back pain, oral pharmacologic treatment of type 2 diabetes, and colorectal cancer. Furthermore, as part of this initiative, ACP convened a workgroup of physicians that identified, using a consensus-based process, 37 common clinical situations in which screening and diagnostic tests are used in ways that do not reflect high-value care.[5] Furthermore, on July 10, 2012, ACP and the Alliance for Academic Internal Medicine (AAIM) unveiled a high-value, cost-conscious care curriculum to help train internal medicine residents about how to avoid overuse and misuse of tests and treatments that do not improve outcomes and may cause harm. The free curriculum, available at www.highvaluecarecurriculum.org, is designed to engage internal medicine residents and faculty in small group activities organized around actual patient cases that require careful analysis of the benefits, harms, costs, and use of evidence-based, shared decision making. The flexible curriculum consists of ten, one hour interactive sessions that can be incorporated into the existing conference structure of a program.

[4] Additional information on ACP's High Value, Cost-Conscious Care Initiative (HVCCC) can be found at http://www.acponline.org/clinical_information/resources/hvccc.htm.
[5] Qaseem A, Alguire P, et al. Appropriate Use of Screening and Diagnostic Tests to Foster High-Value, Cost-Conscious Care. *Ann Intern Med.* 2012;156:147-149. Accessible at http://www.annals.org/content/156/2/147.full.pdf+html?sid=10a2df33-7fa3-45e1-a01d-dc7ecd1b98bc.

ACP has also joined other leading professional medical organizations in the Choosing Wisely campaign,[6] which complements our HVCCC Initiative. An initiative of the American Board of Internal Medicine (ABIM) Foundation, the goal of the Choosing Wisely campaign is to promote thoughtful discussions among physicians, patients, and other stakeholders about how to use health care resources to improve quality of care. In April 2012, ACP unveiled our list of "Five Things"[7] internists and patients should question in internal medicine.

On April 19, 2012, ACP and Consumer Reports announced a new collaborative effort to create a series of *High Value Care* resources to help patients understand the benefits, harms, and costs of tests and treatments for common clinical issues. The resources will be derived from ACP's evidence-based clinical practice recommendations published in *Annals of Internal Medicine*. The initial pieces of the *High Value Care* series will be two patient brochures about diagnostic imaging for low back pain and oral medications for type 2 diabetes. The *High Value Care* resources will be available on the websites of ACP (ACPonline.org), Consumer Reports (ConsumerReports.org), and *Annals of Internal Medicine* (Annals.org).[8]

Programs like ACP's HVCCC initiative could be supported by Medicare payment policies by: (1) reimbursing physicians appropriately for spending time with patients to engage them in shared decision-making based on the recommendations from those programs and similar efforts by other specialty societies and (2) developing a way to recognize, with higher payment updates, physicians who can demonstrate that they are incorporating such programs into their practices and engaging with their patients. For instance, under a transitional VBP program, physicians might qualify for higher updates if they can demonstrate that they have a plan to use evidence-based guidelines on high value care, developed by their own professional societies, to inform, educate, and engage patients in shared decision-making on clinical treatment options. The goal would be to provide ongoing structural payment support to such physicians and patients in shared decision-making based on the guidelines, not to link payment for any specific test or procedure to the clinical guidelines.

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[6] More information on the Choosing Wisely campaign can be found at: http://choosingwisely.org/.
[7] ACP's list of "Five Things" internists and patients should question in internal medicine can be found at: http://choosingwisely.org/wp-content/uploads/2012/04/5things_12_factsheet_Amer_College_Phys.pdf.
[8] More information on this effort can be found at: http://www.acponline.org/pressroom/high_value_care_ed_materials.htm.

ACP also has a long and multi-faceted history of promoting patient-centered high quality care, through the publication of original scientific research, the provision of critical reviews and advice on performance measure development and use, the development of evidence-based guidelines, clinical decision aids, and quality improvement programs. These efforts serve to support comprehensive value-based approaches like the HVCCC Initiative that is described above.

Original Scientific Research

The *Annals of Internal Medicine* is ACP's flagship scientific publication and forms one of the most widely cited peer-reviewed medical journals in the world. The journal has been published for 80 years and accepts only 7 percent of the original research studies submitted for publication.

Quality and Outcome Measures

While ACP does not develop performance measures, the College is deeply involved in the critical review and provision of comments on performance measures developed by other organizations. The goal is to ensure that the measures are based on high quality clinical evidence. ACP also reviews performance measures that are currently under development or endorsement at national organizations like the NCQA, CMS, and the American Medical Association Physician Consortium on Performance Improvement. Furthermore, ACP reviews performance measures related to ACP's Clinical Guidelines, Guidance Statements, and Best Practice Advice papers.

In addition, ACP educates its membership on performance measurement initiatives through the development of policy papers and performance measurement commentaries in peer reviewed scientific journals. Most recently, ACP produced a policy paper on "The Role of Performance Assessment in a Reformed Health Care System".[9] This paper discusses in detail ACP's support for payment and delivery system reforms that promote high-value care, improved patient experiences, better population health, improved patient safety, and reduced per capita spending.

[9] Available at: http://www.acponline.org/advocacy/where_we_stand/policy/performance_assessment.pdf.

Evidence-Based Guidelines

ACP has been producing evidence-based clinical practice guidelines since 1981 and is one of the oldest programs in the country.[10] ACP's goal is to provide clinicians with recommendations based on the best available evidence; to inform clinicians of when there is no evidence; and, to help clinicians deliver the best healthcare possible. Published guidelines are publically and freely available on ACP's website and are represented in databases such as the National Guideline Clearinghouse and the Guidelines International Network library.

LEVERAGING EXISTING QUALITY IMPROVEMENT/VALUE-BASED PAYMENT MODELS

Physicians with a demonstrated commitment to quality and efficiency, who are not able to participate in the more comprehensive models during the transitional period and possibly in the longer term, could be offered the ability to receive incentives for their participation in existing programs, such as meaningful use (MU), the physician quality reporting system (PQRS), and e-prescribing (eRX), and by harmonizing such programs with specialty boards' practice improvement programs..

Major improvements in the MU, eRx, and PQRS programs are needed, though, if they are to be part of a transitional QI/VBP program. Currently, there is no true alignment among these programs in their measures, reporting requirements, and payment incentives. CMS has been unable to provide timely feedback to physicians regarding whether they are successfully satisfying program requirements, leading to frustration and distrust. ACP has been deeply involved in the national policy issues surrounding the use of health information technology to facilitate effective clinical data sharing—including the EHR Incentive Program as initiated with the HITECH Act. In our most recent comments on the notice of proposed rulemaking from both CMS[11] and ONC[12] on Stage 2 Meaningful Use, we highlighted our support of the government's vision to use EHRs and health IT to improve care, but believe that more needs to be done to align the measures across all of the initiatives currently underway including CMS' PQRS and e-prescribing programs. While CMS

[10] Qaseem A, Snow V, Owens DK, Shekelle P; Clinical Guidelines Committee of the American College of Physicians. The development of clinical practice guidelines and guidance statements of the American College of Physicians: summary of methods. Ann Intern Med. 2010 Aug 3;153(3):194-9.

[11] ACP's comments on Stage 2 Meaningful Use to CMS can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf.

[12] ACP's comments on Stage 2 Meaningful Use to ONC can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf.

has made strides in aligning the measures at a high level, the technical requirements in each of the programs are different enough that dual processes must be undertaken. We are also concerned about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, the eRx program, and PQRS by requiring that the activity to avoid the penalty must be completed in the prior year or even two years in advance of the legislated deadline. As a result, CMS has effectively moved up the legislated deadline beyond what the market can bear and what is meaningful and actionable by the physicians.

In addition, ACP recommends that measures and measure strategies be thoughtfully aligned with – and where possible leverage – the regular practice assessment, reporting, and quality improvement activities that individual physicians already are required to undertake as part of their specialty board Maintenance of Certification (MOC). For example, the ABIM, which is the largest of the certifying boards, includes in its MOC program a suite of quality measurements, and reporting and improvement tools specifically focused on patient-centered primary care/specialist communication, and will soon introduce a care coordination module developed by several of the experts who also helped shape the PCMH-Neighbor concept, described earlier in this testimony. Aligning PCMH-N practice accreditation standards with professional MOC assessment and improvement activities will send a powerful signal to physicians about the significance of the PCMH model, reduce redundant reporting requirements, and facilitate participation by smaller practices.

ACP is attempting to help primary care clinicians, including those in small practices, apply the distilled scientific and clinical data to their every day practice through registries, practice improvement programs, and technologically advanced tools including tablet- and smart phone-based applications. Patient registries, which involve a systematized method for collecting patient-based data that are often used to help clinicians understand and improve their practice, are being developed and applied by ACP.

- In partnership with the New York-ACP Chapter and Dr. Ethan D. Fried, MD, MS, MACP (the Vice Chair for Education and Residency Training Program Director, in the Department of Internal Medicine at St. Luke's-Roosevelt Hospital and Associate Professor at Columbia University's College of Physicians and Surgeons), ACP's Center for Quality is being certified as a Patient Safety Organization (PSO), as it nationally expands a

registry of "near miss" events, by which physicians and their teams can examine instances in which patient safety was put at risk but averted, so as to understand the factors that contribute to and protect from risks.

- In partnership with the American College of Cardiology, ACP is piloting the PINNACLE Registry for primary care. The PINNACLE Registry not only interfaces with various EHR systems, but also has received the designation of EHR data submission vendor (DSV) permitting submission of PQRS data to CMS, linking quality improvement to pay-for-performance.
- ACP is piloting *MedConcert™*, the first multi-tenant cloud-based platform for QI, including registry, performance measure calculation, and secure communication capabilities. Multiple options for uploading registry data, including data from EHRs and administrative claims databases are permitted with *MedConcert™*. Educational and quality improvement resources are tagged to specific performance gaps on this platform.

Beyond registries, ACP's newly formed Center for Quality is revitalizing its network of physician-quality improvement champions, known as ACPNet. Including nearly 2,000 internists nationwide, this practice-based research network (PBRN) is being surveyed about the methods by which quality improvement and research in the real-world environment can be more readily integrated into the busy practice environment, including the whole medical team. While PBRNs emerged as a tool for understanding real world practice, a still important goal, they are becoming a resource for identifying, testing, and rapidly spreading powerful quality improvement strategies. Accordingly, ACPNet will become the QI laboratory and trendsetter in internal medicine, guided by a national steering group of experts and grassroots leaders.

SUGGESTIONS FOR LEGISLATION TO TRANSITION TO A BETTER PAYMENT MODELS

ACP understands that the Ways and Means Committee and other committees of jurisdiction, will need to consider a wide range of legislative options to move forward from the current broken payment system to one that achieves fundamental reform. We offer the following suggestions for the key components of such a framework for your consideration.

1. The framework should repeal the SGR, once and for all, or at the very least, create a pathway to full repeal.
2. It should halt the 27% SGR cut (29% cut with sequestration) scheduled on January 1, 2013.

3. It should replace scheduled SGR cuts in subsequent years with positive updates for all physicians, providing stable payments at least through 2017, and with higher payment updates for undervalued primary, preventive, and care coordination services.
4. It should begin the transition to new payment models by establishing a Transitional Quality Improvement/Value-Based Payment Initiative, as described in the principles offered earlier in this testimony, built upon physician-led efforts to improve payment and delivery systems (including PCMHs and PCMH-Ns) and to promote evidence-based, high-value care.
5. It should leverage and improve the existing MU, eRx, and PQRS programs, and harmonize them with specialty boards' practice improvement programs to the extent possible, as discussed earlier.
6. It should support further evaluation and testing of a wide variety of payment and delivery system reforms.
7. It should outline a process and timetable to achieve fundamental payment reforms.

ACP is encouraged that several legislative proposals have been developed that include many of the above elements, including the bipartisan Medicare Physician Payment Innovation Act, H.R. 5707, introduced by Reps. Allyson Schwartz and Joe Heck, and a proposal being developed by Rep. Tom Price, a member of this subcommittee, and Rep. Charles Boustany. ACP appreciates Drs. Price and Boustany's efforts to reach out to ACP and others by asking for our input on their draft legislative framework, and we have shared our suggestions with them. We look forward to continuing to work with this Subcommittee on Health and other committees of jurisdiction on legislation to transition from the current broken payment system to one that achieves fundamental reform, based on physician-led quality improvement initiatives.

SUMMARY AND CONCLUSION

The College specifically recommends that:

1. Congress and the Medicare program should work with ACP and other physician organizations to develop a transitional QI/VBP initiative that would provide higher updates to physicians who successfully participate in a transitional QI/VBP initiative, consistent with the principles discussed above.

2. Congress should look to the PCMH as being one of the most promising models for improving outcomes and lowering costs; learning from the extensive and growing experience in the private sector and through the CMS Innovation Center, as well as from private sector recognition and accreditation programs. We are confident that the PCMH model, and the related PCMH-Neighborhood, can be scaled up in the more immediate future, as part of a transition to better payment and delivery systems to replace the SGR and pure fee-for-service.
3. Congress and CMS should work with the medical profession on reducing barriers to the PCMH model, including facilitating the coordination of care among physicians and across settings; facilitating the use of health IT in meaningful ways; aligning the multiple federal initiatives with the goal of health care transformation, including timely payment to those physicians that meet the requirements of these initiatives; recognizing existing professional quality reporting and improvement activities where applicable, and facilitating participation in these initiatives by all payers.
4. Medicare should adopt payment policies that support the efforts by ACP and other physician membership organizations to provide guidance to physicians on high-value, cost-conscious care, including payment policies to support shared decision-making strategies to engage patients in making decisions with their physician on their care, informed by evidence on value and effectiveness.
5. Congress should support continued evaluation of Accountable Care Organizations, Advanced Payment ACOs, Global and bundled payments, and other promising alternative payment models that could be offered to physicians, following a transition period, along with PCMHs.
6. Medicare should make improvements in the existing Medicare physician fee schedule to create incentives for care coordination.

The College appreciates the opportunity to share our observations, experiences, and recommendations on how Congress can work with ACP and others in the medical profession to advance comprehensive, patient-centered, and value-based payment and delivery system reforms that build upon successful physician-led quality improvement initiatives in the private and public sectors.

Chairman HERGER. Thank you.

Dr. Weinstein, you are recognized for five minutes.

STATEMENT OF DR. MICHAEL WEINSTEIN, CHAIR, REGISTRY BOARD, AMERICAN GASTROENTEROLOGICAL ASSOCIATION

Dr. WEINSTEIN. Chairman Herger, Ranking Member Stark, and distinguished Members of the Subcommittee, thank you for soliciting input from the physician community as you craft the Medicare physician payment reform proposal.

Reforming the broken Medicare physician reimbursement system and giving gastroenterologists the tools to help them to provide

high quality patient care are top priorities of the American Gastroenterological Association.

My name is Dr. Michael Weinstein. I am here today as representative of the 16,000 physicians and scientists who are members of AGA, the largest organization representing gastroenterologists.

AGA helped found the Alliance of Specialty Medicine, which shares our goals of delivering high quality patient care.

My medical training is as a gastroenterologist. I am the Vice President of Capital Digestive Care, a 56 physician practice here in the D.C. area. I have also received on-the-job training as a businessman and it seems in recent years as a health policy analyst.

In my brief remarks, I will focus on AGA programs and partnerships that could be instructive as Government considers how to reform the Medicare physician reimbursement system.

I must first note that any quality based reimbursement system must be based on clinical guidelines and patient outcome measures that are developed with physician input and based on scientific evidence.

I refer you to AGA's written testimony for more on our approach.

In 2010, AGA created the Digestive Health Outcomes Registry. I currently chair its Management Board. The AGA Registry helps users optimize quality of care by giving them a secure and scientifically valid way to collect, analyze and report clinically relevant data related to inflammatory bowel disease and colorectal cancer prevention.

Payers have shown an interest in using the AGA Registry and our newly launched Digestive Health Recognition Program to acknowledge and possibly financially reward high quality providers.

We recently launched a program with United Healthcare and expect other payers to follow suit.

AGA advocates that a reformed Medicare reimbursement system provide incentives for physicians who report on quality measures through outcomes based registries.

As the health system changes, we see that quality and efficiency go hand in hand. Patients and physicians need to be wise stewards of health care dollars and ensure that care is given to the right patient at the right time.

To that end, AGA is part of the Choosing Wisely campaign, and has identified five common G.I. tests, medications and procedures whose necessity should be questioned and discussed between physician and patient.

This program will help physicians be better stewards of finite health care resources.

AGA recognizes that private payers are moving toward population based reimbursement. In response, we are developing alternative payment models.

For instance, AGA is working with a claims case logic company to develop a colonoscopy bundled fee. AGA physicians are developing components of the bundle including screening, diagnostic and therapeutic colonoscopy, time frames, complications, and associated carve out's.

This will help physicians to demonstrate value and negotiate for the services they provide to a population of patients.

AGA is also developing clinical service lines to help physicians with population management. Our vision is to collect guidelines, measures, payment bundles, and other resources to create a "how-to manual" for common G.I. diseases.

Bundles will sync with electronic medical records, registries, PQRS, and other systems, providing physicians tools to show how coordinated care can be delivered, measured and improved.

In closing, AGA applauds your efforts to move physicians to a more viable reimbursement system that rewards physicians for improving the quality of care they provide to their patients.

AGA shares this goal and stands ready to work with you. Thank you.

[The statement of Dr. Michael Weinstein follows:]

TESTIMONY IS EMBARGOED UNTIL 10:00 AM TUESDAY, JULY 24, 2012

PREPARED TESTIMONY
of the
American Gastroenterological Association
Before the
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

July 24, 2012

Chairman Herger, Ranking Member Stark and Distinguished Members of the Subcommittee, thank you for inviting the American Gastroenterological Association to testify today regarding physician organization efforts to promote high quality care and how they can inform the Subcommittee's approach to Medicare physician payment reform. I am Michael Weinstein, and I am a practicing gastroenterologist in the Washington, DC metro area and serve as chair of the AGA Digestive Health Outcomes Registry® Executive Management Board.

The AGA is the largest society of gastroenterologists, representing more than 16,000 physicians and scientists who are involved in research, clinical practice and education on disorders of the digestive system. With other specialty societies, we founded the Alliance of Specialty Medicine, a 12-member coalition of medical specialty societies. The alliance wholly supports efforts to improve the quality and efficiency of health-care delivery, and continues to seek improvements in government-sponsored quality initiatives that are misaligned, lack sufficient flexibility to accommodate different specialties, and rely on measures that are inadequately risk-adjusted and have no demonstrated link to improved outcomes. I thank you and your Ways and Means colleagues for reaching out to the physician community to solicit our input as you craft a Medicare physician payment reform proposal to replace our unsustainable and broken system. AGA applauds your efforts to move physicians to a more viable system that rewards physicians for improving the quality of care that they provide to their patients.

Over the past decade, the AGA has made considerable investments in the development of quality outcomes measures, patient registries, collaborations with private payors and other quality improvement initiatives to provide gastroenterologists (GIs) with the tools necessary to improve patient outcomes and also prepare them for a changing health-care marketplace.

In 2005, we launched the AGA Center for Quality in Practice, with a mission to enhance quality and safety in the practice of gastroenterology through the following activities:

- Identifying key quality-of-care indicators in the treatment of digestive diseases and determining how the indicators will be measured.
- Developing resources to support quality management in GI practice, including information on quality improvement processes, evidence-based guidelines, performance measurement and customer satisfaction.

- Conducting a continuous review of emerging national quality and patient safety standards, as they might be applicable to GI diseases.
- Developing programs, tools and training programs for members to help them implement evidence-based guidelines and measure and report adherence to quality indicators.
- Developing patient education materials to ensure that patients have appropriate expectations regarding high quality, patient-centered, evidence-based care.

The following is a summary of our key initiatives:

STEPS TO MEASURING AND REWARDING QUALITY AND EFFICIENCY

AGA is committed to ensuring that Medicare and private payors measure physicians against standards that are scientifically valid, fair, realistic and linked as closely as possible to patient outcomes. We offer the following steps to achieving this goal, which sets a foundation for a payment system that rewards care based on science, avoids waste and inappropriate services, and identifies known opportunities for quality improvement.

STEP 1: Develop evidence-based clinical guidelines that identify gaps in care.

The AGA has a long history of developing evidence-based guidelines and medical position statements. In 2011, the AGA redesigned its medical position statement development process and adopted the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system of rating guidelines, which has been adopted by a wide range of national and international professional medical societies, health-related branches of government and health-care regulatory bodies. We continue to refine the implementation of this rigorous process.

The AGA guideline development process aims to address specific clinical questions for the practicing gastroenterologist and other providers. We first analyze, compare and rank the scientific evidence to create a technical review paper. A multi-stakeholder group then develops recommendations based on the evidence. This process is scientific, evidence-based and rigorous, unlike a consensus statement process that relies on the expert opinion of a panel of physicians.

STEP 2: Create measures based on evidence-based guidelines.

The AGA supports the delivery of efficient quality GI care with a focus on improved health outcomes. To incorporate these elements into a payment system (Medicare or others), care outcomes need to be measurable and incorporated into a single set of performance measures. To this end, AGA is developing a Gastroenterology National Quality Measure Set, which currently includes 24 measures with several more pending.

We develop these measures through the AMA's Physician Consortium for Performance Improvement (PCPI) standard and independent measure development processes. Our

performance measures for adult and pediatric populations include the following conditions: hepatitis C, inflammatory bowel disease (IBD), gastroesophageal reflux disease (GERD), endoscopy and polyp surveillance, and colorectal cancer screening. Many of these measures have been included in the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI)/PQRS programs since 2007. The AGA often collaborates with patient advocacy organizations on the development of evidence-based guidelines and quality measures such as the Crohn's and Colitis Foundation of America, which helps make these processes transparent. We inform and educate gastroenterologists about measures, measure development and related CMS incentive programs through our various print, electronic and social-media communication vehicles.

As part of our commitment to measures development, the AGA will participate in the National Quality Forum (NQF) pilot of its two-staged endorsement process. To be endorsed, a measure submitted to NQF must satisfy four criteria — importance to measure and report (must pass), scientific acceptability of the measure properties (must pass), feasibility to implement, and usability of the measure results — and must be judged to be "best in class." Since measure developers are currently required to submit fully specified and tested measures for consideration, this leads to costly investments of developers' time and resources to specify and test a measure that does not achieve NQF endorsement.

In the redesign, the consensus development process would be conducted in two stages. Measure "concepts" would be evaluated against NQF's importance criterion (addresses a high impact area, gap in care, or opportunity for improvement exists, and evidence is sufficient to support the focus) in stage one. Potential related and competing measures would also be identified during this stage. All measures, regardless of their stage of development (e.g., concept, fully specified measure, fully specified measure with testing, undergoing maintenance review with NQF) would be required to undergo concept review. Once the importance threshold has been met, a measure or concept could move into the second stage. Stewards such as the AGA would have up to 18 months to complete testing and full specification of their measures and bring back the measure for stage two review. Stage two would evaluate fully specified and tested measures against the remaining three criteria: scientific acceptability, usability and feasibility. At the end of stage two, measures that are ratified by the board will receive NQF endorsement. The AGA has been selected by the NQF to submit our adult IBD measure set through this revised measure endorsement pilot.

STEP 3: Facilitate collection of data related to quality measures through Web-based, manual and electronic means so that all physicians can participate.

There is variation among practices in the ability to collect data, e.g., rural providers vs. large integrated delivery systems with advanced electronic medical record (EMR) systems. Reliable electronic infrastructure will facilitate efficient and accurate communication, data exchange and translation of documented quality actions (patient care) so that financial incentive programs can be implemented.

To help gastroenterologists collect data, the AGA created the AGA Digestive Health Outcomes Registry[SM] (AGA Registry), which is a national outcomes-driven registry with the mission to improve patient health outcomes and the cost effectiveness of digestive care. It uses scientifically valid methods to collect, analyze and report clinically relevant data, empowering the health-care community to optimize quality of care. Through the AGA Registry, gastroenterologists can monitor and improve the care they provide to their patients while also generating data to compare the efficacy of treatments.

The AGA Registry launched in May 2010, with an initial focus on guidelines-driven management of IBD and effective strategies for colorectal cancer prevention. The AGA Registry is certified by CMS to submit PQRS data on behalf of providers reporting the hepatitis C measures group. The AGA Registry is designed to interface with practices that have a robust health information technology infrastructure (such as gMed) who wish to have a comprehensive program for quality measurement and improvement and have already made a substantial commitment to demonstrating value. To date, 369 clinicians have enrolled in the AGA Registry. With our collaboration with UnitedHealthcare and other payors, we anticipate that the number of reporting physicians will increase to more than 1,000 by early 2013.

The AGA Registry provides participants with:

- Tools that fit into practice workflow and enable efficiencies in the delivery of care.
- Access to quality and performance indicators.
- National and in-practice comparative benchmarking.
- Online and in-person educational and professional development opportunities.
- Integration with existing health-care software systems.
- Professional networking and knowledge sharing.

The AGA Registry accepts direct submission from EHRs. The AGA Registry offers two paths to system integration:

- The registry is integrated into gMed's gGastro v4, the most common Certification Commission for Health Information Technology (CCHIT) certified EMR utilized in community-based gastroenterology practices, which allows users of this EHR to participate in the registry using their existing platform and clinical workflows.
- The AGA partnered with FIGMD, a company that specializes in integrating clinical systems regardless of their platform, version or specialty, to provide a low-cost solution for integrating a practice's EHR with the AGA Registry.

In addition, the AGA gathered the step-by-step advice of gastroenterologists with informatics expertise in its *EMR Field Guide for Gastroenterology*. Published in 2009, this guide provides physicians with the information needed about the essential clinical and functional elements of EMR systems that will meet the specialized needs of a gastroenterology practice.

STEP 4: Develop financial incentive programs based on evidence-based measures that translate into improved patient outcomes.

AGA has developed partnerships with private entities that may be instructive:

- In April, the AGA entered into an agreement with UnitedHealthcare to incorporate GI physician data from the AGA Registry into its physician performance measurement program. This program allows the comparison of individual treatment practices with regional and national treatment recommendations created by gastroenterologists. Data from the AGA Registry will support UnitedHealthcare's expanding portfolio of physician incentive programs that reward medical groups and physicians who demonstrate high quality, cost-effective, and improved patient care and outcomes.

- In May, Blue Cross Blue Shield of North Carolina recognized the AGA Registry as an approved mechanism for gastroenterologists to demonstrate their commitment to quality. The AGA is actively engaged in discussions with a number of other regional and local payors to incorporate data from the AGA Registry into their physician performance measurement programs.

- In mid July, the AGA launched the Digestive Health Recognition Program (DHRP), in partnership with the Healthcare Incentives Improvement Institute (HCI3). The DHRP, which is simple to access and use, will allow physicians to report clinical data, which is then assessed by an independent third party, and scored based on quality performance. Physicians who meet scoring requirements are recognized as quality providers of GI care by the AGA and the Bridges to Excellence (BTE) program administered by HCI3.

  BTE has been adopted by numerous health payors as a model for assessing quality of care and determining reward and recognition status for providers. The program was built to allow practices to easily look back on 25 to 30 consecutive patients and provides an opportunity to achieve a two-year recognition of excellence. The DHRP will begin with a program measuring quality in the treatment and management of inflammatory bowel disease (IBD) and will expand to include other clinical domains, such as hepatitis C, in the future. The IBD module will allow academic medical centers, which have been shut out of most pay-for-performance programs, and the AGA Registry to participate in this program. The DHRP measure set for IBD is the same set approved for reporting 2012 PQRS data to CMS, allowing providers to meet requirements for both quality-reporting programs through a single mechanism.

CLINICAL IMPROVEMENT ACTIVITIES

Supporting the steps to measuring and rewarding clinical efficiency and quality are clinical improvement activities. I will provide an overview of some of AGA's key activities in this area.

The AGA developed a Procedural Sedation/Patient Safety Practice Improvement Module (PIM), which has received approval from the American Board of Internal Medicine (ABIM) to be part of ABIM's Approved Quality Improvement (AQI) Pathway.

The AGA Procedural Sedation/Patient Safety PIM is the first independently developed PIM in the field of gastroenterology to be approved by the ABIM for Maintenance of Certification (MOC) for points toward the self-evaluation of practice performance requirement. These programs have been built to coordinate with licensure requirements and each cross-fertilizes the other.

The AGA's Procedural Sedation/Patient Safety PIM is an online portal that guides physicians through a chart abstraction of de-identified patient data, compiling this information to help physicians identify patterns and select changes or interventions that should improve performance. Participating physicians then implement an improvement plan, followed by another chart extraction several months later. The PIM generates a report comparing the two sets of charts, allowing physicians to easily assess the impact of their improvement plan and recognize opportunities for ongoing improvement in practice.

The sedation PIM focuses on practice-based evaluation of five quality indicators: risk assessment, informed consent, depth of sedation, patient safety (managing medication) and patient satisfaction.

In April 2012, the AGA collaborated with other specialty societies to launch a major education campaign focused on curbing overuse or misuse of tests and procedures.

Our list of "Five Things Physicians and Patients Should Question" is part of the prominent Choosing Wisely® campaign, which is an initiative of the ABIM Foundation. The list identifies five targeted, evidence-based recommendations that can support wise choices by physicians and patients. AGA's list makes the following recommendations:

- For pharmacological treatment of patients with gastroesophageal reflux disease (GERD), long-term acid suppression therapy (proton pump inhibitors or histamine2 receptor antagonists) should be titrated to the lowest effective dose needed to achieve therapeutic goals.
- Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals.
- Do not repeat colonoscopy for at least five years for patients who have one or two small (< 1 cm) adenomatous polyps, without high-grade dysplasia, completely removed via a high-quality colonoscopy.
- For a patient who is diagnosed with Barrett's esophagus, who has undergone a second endoscopy that confirms the absence of dysplasia on biopsy, a follow-up surveillance examination should not be performed in less than three years, as per published guidelines.

- For a patient with functional abdominal pain syndrome (as per ROME III criteria) computed tomography (CT) scans should not be repeated unless there is a major change in clinical findings or symptoms.

The medical profession is in the midst of major changes to the manner in which it is reimbursed for its services. It is the AGA's intention to lead this discussion instead of having to react to changes implemented by outside forces. The immediate focus for the practicing gastroenterologist is to initiate a dialogue with patients when these five topics arise. These statements allow primary care and GI providers to discuss the best course of care given a patient's situation.

For example, the statement "Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals," invites a discussion regarding a patient's risk. By facilitating the discussion of individualized risk, available science can be used as a basis for informed decision-making between providers and their patients. While the statement is based on the best evidence supporting quality health care, it is not intended to replace clinical judgment, since patient risk and colonoscopy quality may be difficult to precisely quantify.

The Choosing Wisely statements are designed to help patients and their clinicians understand which common procedures, tests and treatments are appropriate given their current health circumstances. It is hoped that by reducing overuse of common, high-volume resources, we may be able to "bend the cost curve" and ensure that resources remain available to provide the care we know will be beneficial to our patients.

The AGA is also developing Clinical Service Lines.

These are a collection of resources, combined with a "how to" manual, to help put all the pieces together so that a practice can provide the highest quality of care to its patients. These service lines will be built into an EMR for the purpose of coordinated information management and will be accessed through a single portal for the AGA Registry, our Digestive Health Recognition Program, PQRS and others as they become available. The initial clinical service line is for treatment of hepatitis C and this will be interfaced with gMed.

ALTERNATE PAYMENT MODELS

Developing a colonoscopy bundle fee is an integral component of AGA's Roadmap to the Future of GI Practice initiative. Recently, AGA was approached by a claims logic company used by most major private payors and a health plan to provide the objective clinical and scientific expertise for developing the bundles, including length of time of the bundle, complications and associated "carve outs." We have heard from members that entities in Minnesota and other payors, including Wellpoint, have approached GI groups regarding development of a colonoscopy bundle.

The project is proceeding with AGA bringing all parties to the table. AGA physicians are developing the content (e.g., screening colonoscopy, diagnostic colonoscopy and therapeutic and carve outs) of the bundles.

ADMINISTRATIVE AND REGULATORY BURDENS

Administrative and regulatory burdens continue to threaten the viability of physician practices, especially small practices and ambulatory surgery centers (ASCs). The AGA, along with organized medicine, has long advocated for administrative simplification for billing and patient information. This could save time and money for practices. Additionally, harmonization of PQRS, EHR Meaningful Use, and e-Prescribing reporting requirements could also provide a more streamlined process as physician practices comply with many of the new mandates from Medicare. It should also be noted that ASCs do not have an EHR incentive program. Most GIs perform services in the ASC setting and do not receive credit for the EHR use in this setting.

CONCLUSION

The AGA appreciates the opportunity to share our experience with quality and efficiency programs with both Medicare and private payors and believes many of these approaches can be expanded to a wider population base. Again, we share your vision to create a new payment system that rewards physicians for quality improvement and moves the Medicare system toward a more stable and viable path.

AGA's quality portfolio is intended to provide practices with multiple tools and resources to demonstrate improved patient outcomes and high quality and efficient care. We share the subcommittee's interest in developing and implementing policies and initiatives that meet these goals. Thank you, again, for the opportunity to share AGA's many programs and experiences with you and know that we stand ready to continue this dialogue.

Chairman HERGER. Thank you.
Dr. Mandell is recognized for five minutes.

STATEMENT OF DR. PETER MANDELL, CHAIR, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS COUNCIL ON ADVOCACY

Dr. MANDELL. Good morning, Chairman Herger and Ranking Member Stark. Nice seeing both of you again, and good morning to the rest of the distinguished panel.

Thank you for the opportunity to testify on behalf of the American Association of Orthopaedic Surgeons, which represents over 18,000 actively practicing Board certified orthopaedic surgeons nationwide.

I am Pete Mandell, Chair of the AAOS Council on Advocacy, and our organization is very much appreciative of the opportunity to offer our ideas on how Medicare physician payment reform can be carried out.

As the Committee knows very well, finding a long term sustainable solution for the Medicare physician payment system is a huge undertaking. We believe that a commitment to the development and adoption of best practices that provide high quality care for musculoskeletal patients while remaining cost effective is the best way to achieve that solution.

We are already involved in several quality initiatives that can be used by Congress as a model for future payment reforms.

These initiatives include the development of clinical practice guidelines, appropriate use criteria, a joint registry program, greater patient participation in their own health care decisions.

We believe the current fee for service system, although appropriate for certain types of health care services, is not the most efficient system for many services and procedures.

We also believe that policy reforms that provide incentives for the delivery of high quality health care should be coupled with payment reforms that include greater patient involvement.

There is no one size fits all when it comes to creating new payment models for Medicare. Each of the following types of payment systems has merit: capitation, episodes of care, tier based payment systems, and the traditional fee for service model.

Whatever methods Congress chooses, we strongly support efforts to incorporate quality, efficiency, and payment outcomes into the Medicare physician payment system.

Congress should provide financial incentives that reward higher quality care based on appropriately risk adjusted patient centered measures of health care outcomes. Risk adjustment is essential to account for medical and social problems, other patient comorbidities, that are beyond the provider's control.

These would include obesity, non-compliance with treatment recommendations, tobacco and alcohol use, to name just a few.

Also, quality measures should be utilized to develop a new physician payment model but only if it is developed with the advice of specialty specific input from all physician specialties who are impacted by the payment system.

The payment system should reward physicians for developing medically innovative treatments that increase quality and reduce costs.

An orthopaedic example is orthoscopic surgery, which in the past had required open procedures and several days in the hospital.

Tying payment to quality and to the savings generated by medical innovation will reduce overall Medicare costs and drive the innovation.

Coordinated care models offer another approach for payment and delivery reform. An example is the episode of care where a single payment covers all involved providers, but such arrangements may carry unintended consequences including denying care to higher risk patients.

The AOS helped form the American Joint Replacement Registry for total hip and knee data collection and quality improvement. Its goals include collecting device information and monitoring outcomes of total joint replacements throughout the U.S., creating real time survivorship curves to serve as trip wires that detect poorly performing implants and providing regular feedback to surgeons, hospitals, and implant manufacturers concerning their relative performance compared to peers.

All of the above quality improvement activities have been developed and/or supported by the AOS, and are changing the face of orthopaedic practice nationwide.

Patients can become more involved with seeking out appropriate high value care. First, in the absence of true SGR reform, Congress should permit the private contracting between patients and providers. This will help providers close the gap between inadequate Medicare payments and the ever increasing costs of providing services to seniors.

Second, Congress should consider enabling Medicare beneficiaries to assume greater responsibility by cost sharing for the Medicare program with protections for low income beneficiaries.

There is a broad range of options that policy makers can use and consider for enhancing benefit sharing.

We believe the Medicare system needs to be transformed from its current emphasis on paying for services regardless of quality or cost to a system that provides meaningful and sustained incentives for high quality, innovative and cost effective care.

Accomplishing this goal will require the cooperation of Congress, CMS, physicians, and patients.

However, we believe that it can be accomplished and that now more than ever is the right time to concentrate our efforts in this direction.

Thank you for allowing me to participate in the hearing today, and we look forward to working with all of you in the future.

[The statement of Dr. Peter Mandell follows:]

TESTIMONY IS EMBARGOED UNTIL 10:00 AM TUESDAY, JULY 24, 2012

AAOS

American Association of Orthopaedic Surgeons

Statement

of

Peter J. Mandell, MD

On

Physician Organization Efforts to Promote High Quality Care and

Implications for Medicare Physician Payment Reform

Committee on Ways and Means

Subcommittee on Health

US House of Representatives

July 24, 2012

Chairman Herger, Ranking Member Stark, and other distinguished members of the Ways and Means Health subcommittee, thank you for the opportunity to testify on behalf of the American Association of Orthopaedic Surgeons (AAOS). The AAOS represents over 18,000 board-certified orthopaedic surgeons nationwide. My name is Peter Mandell, MD, and I serve as Chair of the AAOS's Council on Advocacy. I have practiced orthopaedic surgery on the San Francisco Peninsula for the last 37 years. On behalf of the AAOS and my orthopaedic surgeon colleagues across the country, thank you for inviting our organization to testify today on Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform. AAOS recognizes the huge undertaking of developing a long-term sustainable solution to the Medicare physician payment system and we are happy to aid in this effort. We are committed to the development and encouragement of best practices that provide the highest quality of care for musculoskeletal patients while remaining cost effective. We are already involved in several quality initiatives that we believe can be used by Congress as a model for future payment reforms. These initiatives include the development of clinical practice guidelines (CPG), appropriate use criteria (AUC), our joint registry program, and patient safety measures. Policy reforms that provide incentives for the delivery of high quality health care should be coupled with payment reforms that include greater patient involvement in order to preserve the Medicare program.

Quality-Based Payment Reform Models

There is no "one-size-fits-all" when it comes to creating new payment models for the Medicare system. Each of the following types of payment systems has merit: capitation with warranties and floors, episode-of-care, tier-based payment systems and traditional fee-for

service. The AAOS created a Health Care Systems Committee to keep abreast of efforts to test alternative payment systems specific to orthopaedic care. The AAOS has held seminars at several recent meetings to provide education to our members about various payment models that incorporate quality-based payment.

The AAOS strongly supports efforts by Congress to incorporate quality, efficiency and patient outcomes into the Medicare physician payment system. Congress should provide financial incentives that reward higher quality care based on appropriately risk-adjusted, patient-centric measures of health outcomes. This approach must be risk adjusted to account for the medical, social, and personal patient co-morbidities that are beyond a provider's control. These would include factors such as obesity, diminished mobility, noncompliance with treatment recommendations, poor nutrition, tobacco and alcohol use, and disparities in health care access.

A payment model that is based solely on the cost of procedures and their outcomes, without consideration of the above factors or the quality of life benefits derived by patients, would be ineffective. One payment model that could provide appropriate incentives for high quality care would establish different payment tiers based on appropriately adjusted outcomes so that the highest quality care is paid at a higher rate than lower quality care. This system would be built upon factors such as evidence-based guidelines, appropriate use criteria, risk-adjusted performance measures, and mandatory participation in national registries.

The majority of specialty societies, including AAOS, have created a foundation of quality measures and continuously evolving evidence in virtually every area of medical practice. The AAOS has a sufficient foundation of outcomes research to begin to determine what constitutes

a high quality orthopaedic outcome compared to a low quality outcome. Quality measures should be utilized to develop a new physician payment model, but only if the development process includes specialty-specific input from all physician specialties who are impacted by the payment system.

New payment models that provide positive financial incentives for higher quality care would lead to better patient outcomes with improved patient involvement in decision-making. Payment systems should reward physicians for developing medically innovative treatments that increase quality and reduce costs. Orthopaedics has long been a driver of medical innovation such as arthroscopic treatments for conditions which formerly required open surgery and inpatient hospital stays. These types of innovative technological advances have saved employers, patients, Medicare, and other payers billions of dollars per year in reduced costs, principally through reductions in hospital stays. Tying payment to quality and to savings generated by medical innovation will reduce overall Medicare costs and drive innovation.

Coordinated care models offer another approach for payment and delivery system reform. The AAOS supports efforts to develop and evaluate payment methodologies that will incentivize coordination of care among providers (including physicians and hospitals) and help curb health care inflation. As the demand for musculoskeletal care increases with a more active society and an aging population, it is imperative for orthopaedic surgeons to be included in the discussions and to take a lead role in the development and deployment of such programs.

Currently, hospitals are paid under a Diagnosis Related Groups (DRG)-based prospective payment system which adjusts for severity and resource use in the discharge diagnosis. Physicians have traditionally been separately paid under a fee-for-service schedule without

incentives to control volume or cost. The Centers for Medicare and Medicaid Services (CMS), along with multiple other stakeholders, believe that there are savings to be realized if the hospital and the physicians are paid and incentivized by the same methodology. With a single payment issued for the entire episode of care, interested parties hope to align the incentives of the facility and all involved providers, resulting in more efficient delivery of care and better compliance with standards and reporting requirements.

As traditionally defined, an "episode of care" bundled payment is a single payment made to all providers – physicians, facilities, laboratories, and all other health care professionals – for the entire episode of care provided to the patient. Episode of care payment programs may include a physician incentive or gainsharing component. Gainsharing refers to an arrangement between a physician and a hospital to share in the cost savings that result from specific actions to improve the efficiency of care delivery. Gainsharing programs may also be established independent of bundled payment programs.

Episode of care, or bundled payment methodologies and gainsharing arrangements may carry unintended consequences. One possible consequence is deliberate rejecting of complex or risky patients. The patient must be the focal point of any initiative and therefore the system must not create incentives to treat healthier patients and limit access to sicker ones. Additionally, because a bundled payment would include a specific time period defining the episode of care, a workable and reasonable re-admission policy would be an essential piece to such initiatives. The system should not create incentives for patient diversion when a discharged patient in need of re-admission is sent to a different facility or provider. Developing

a coherent risk adjustment policy is the primary method for preventing the practice of deselecting patients and addressing the readmission issues with this method of payment.

Lastly, Congress should provide incentives for care that is innovative and high quality. Musculoskeletal disorders and diseases are the leading cause of disability in the United States. The economic impact of these conditions is staggering. In 2004, the sum of the direct expenditures in health care costs and the indirect expenditures in lost wages for persons with a musculoskeletal disease diagnosis has been estimated to be $849 billion dollars, or 7.7% of our gross domestic product. [1] In addition, musculoskeletal conditions are also the greatest cause of total lost work days and hospital bed days in the U.S. At least one study has indicated that 17% of workers employed in the previous 12 months in the U.S. reported lost work time totaling nearly 437.6 million days as a result of musculoskeletal conditions. [2] Congress must recognize this reality by rewarding this type of care as more valuable than care that contributes little to societal well-being and economic productivity.

Elevating the Quality of Orthopaedic Care

Beginning in 2006, with the creation of the AAOS Guideline and Technology Oversight Committee, the AAOS introduced the concept of evidence-based medicine into our clinical practice guideline development process. The implications of this commitment to evidence-based medicine on the part of the AAOS in the development of its Clinical Practice Guidelines (CPGs) are profound. No longer are CPGs subject to the potential self-serving bias of a panel of "experts"; but, rather they are constructed on the basis of a systematic review and ranking of the quality of the literature that is then objectively used to arrive at the conclusions and

[1] Surg, *Burden of Musculoskeletal Diseases in the United States.*
[2] Ibid.

recommendations in these CPGs. Furthermore, each step of this process is clearly articulated and documented, which increases transparency. Any outside agency can take the same literature base (often up to 6000 articles reviewed for a given guideline), follow the AAOS process and, in all likelihood, come up with the same conclusions and recommendations, free of bias to the greatest extent possible. It is important to note that although AAOS supports the use of AUCs and CPGs, no guideline ought to supersede the clinical judgment of a trained physician.

The AAOS believes that one important test of whether the AAOS or any other professional organization has succeeded in producing objective guidelines is to see whether those guidelines continually serve the financial interests of the physician groups that wrote them. The AAOS understands the importance of objectivity. For instance, the AAOS has come out against the use of arthroscopy in most patients with knee osteoarthritis and against the use of vertebroplasty in patients with osteoporosis-related spinal fractures. As a result, our CPGs have gained praise from both the lay press as well as the AMA for their process of development and the objectivity of their evidence-based recommendations. The AAOS CPGs provide guidance for clinicians in a way that will benefit patients and contribute greatly to the quality of health care being provided.

AAOS CPGs have already been incorporated into payment systems, and the AAOS has been supportive of the correct application of AAOS guidelines into coverage policies. However, we have also been diligent in responding to payers who have misinterpreted or misapplied our guidelines to not cover certain procedures when the AAOS CPG did not advise against the use of the treatment. It is important for specialty societies that have CPGs to engage with payers,

both public and private, to ensure coverage policies are evidence based and appropriate for the best patient care.

In the last 18 months the AAOS has also committed to the development of Appropriate Use Criteria (AUC) which have even more applicability for payment systems based on quality of care. Appropriate Use Criteria provide specific guidance on what is and what is not the appropriate use of a particular technology or service. AUC can easily be adapted into performance and quality measures and therefore be integrated into tiered quality payment models.

American Joint Replacement Registry

The American Joint Replacement Registry (AJRR) is a not-for-profit 501(c)(3) organization for data collection and quality improvement initiative for total hip and knee replacements. The AAOS is a founding supporter of the AJRR, which is working to become the national total joint replacement registry in the US. The registry is governed and funded by a multi-stakeholder model comprised of orthopaedic surgeons, hospitals, payers and implant manufacturers. The AJRR is focused on improving the quality, outcomes, and cost-effectiveness of total joint replacement (TJR) surgeries through the achievement of several objectives:

1) Establish an infrastructure and a uniform system for collecting device information and monitoring outcomes of TJR throughout the U.S.
2) Create real-time survivorship curves to serve as a trip-wire in order to detect poorly performing implants

3) Establish a uniform system that can be used to define the epidemiology of TJR for outcomes research to improve the quality and outcomes of patient care
4) Provide regular feedback to surgeons, hospitals and implant manufacturers concerning their relative performance compared to peers (national joint registries in other countries have proven that this iterative feedback to providers improves quality and reduces cost.)

The AJRR Board of Directors will establish the policies and procedures that governs data use, dissemination, and reporting, including the relationship with organizations external to the national registry, such as Health and Human Services (HHS), Food and Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS). The AJRR believes that for the most comprehensive collection of core data, the reporting system must maximize existing data collection systems and rely upon participating hospitals for submission of data to the registry. They also believe that the analysis and interpretation of registry data must be objective and scientific.

The AJRR currently collects data on both Medicare and non-Medicare patients without distinguishing between the two types of patients. Data collected includes patient information, hospital name and NPI, surgeon name and NPI, laterality, and implant information. The goal of this data collection is to inform patients and surgeons about these procedures allowing them to optimize outcomes and reduce the rate of revisions. Even a small reduction in the rate of revisions will save Medicare dollars that can be used to increase research. We hope that the AJRR will become the national total joint registry dedicated to improving arthroplasty care in the US.

Improving the Delivery System

The AAOS has been engaged in the health care delivery reform discussions occurring across the country between physicians, payers, hospitals, and other health care stakeholders. The AAOS is actively analyzing the concept of the Accountable Care Organization (ACO) and responded to the proposed and final rules establishing the Medicare Shared Savings programs. The Medicare proposed rule was released in March of 2011, but well before that, the AAOS had held a day-long symposium on the topic, in August of 2010. This symposium brought together members of the AAOS Health Care Systems Committee and experts in payment reform like former CMS administrators Mark McClellan, MD and Robert Berenson, MD. Based on the symposium, the AAOS developed a short primer that was distributed to AAOS Fellows at the 2011 AAOS Annual Meeting and subsequently available online as a PDF. The primer was very well received and many other specialty societies used it as an introduction to the topic even before Medicare began to outline what an ACO might look like.

In 2011, the summer symposium focused on hospital-physician alignment strategies such as episode-of-care models, gainsharing arrangements, co-management relationships, and hospital employment. As in 2010, experts in the content area were invited to participate and helped develop a primer on the topic that was distributed to AAOS Fellows at the 2012 Annual Meeting. The 2012 summer symposium will focus on the concept of the Medical Neighborhood and the role of surgeons and specialists in this new approach to health care delivery. The emphasis in all three symposia has been on how to better align physician payments with initiatives that deliver the highest quality care to our patients.

Electronic Health Records

The AAOS consistently encourages all members to adopt innovative and new technologies such as Electronic Health Records (EHRs). However, there must be interoperability standards for all such systems. The AAOS also supports the development of appropriate standards for meaningful use of EHRs by Government agencies and private carriers which balance the needs of patients, physicians, and regulators. Finally, the AAOS believes these standards should be collaboratively developed by physicians through their professional organizations in cooperation with government agencies. The process should emphasize the requirements for the highest level of quality patient care while recognizing the limits and clinical specialty focus of physicians who use the systems. Since 2010, the AAOS has maintained an EHR project team which guides AAOS activity and education in the EHR arena. Among their accomplishments has been the submission of extensive written comments to the CMS Office of Technology on their Meaningful Use of EHR Stage I and Stage II standards.

The AAOS has also undertaken considerable efforts to educate AAOS members in implementation of EHRs in their practices and how to take advantage of government EHR incentives. We have published a series of articles in our journals and newsletters and have created a series of webinars on the topic. In addition, we have dedicated a section of our website to the provision of EHR related resources.

We believe the Medicare physician payment system should offer significant incentives to adopt these systems as we believe widespread utilization of EHRs will lead to improvements in patient care and in savings for payers.

Patient Safety

Patient safety is an integral part of the AAOS quality efforts. The AAOS was a leader in preventing wrong site surgery when it initiated its "sign your site" campaign in 1997 to prevent wrong site surgery. This campaign falls under the purview of the AAOS Patient Safety Committee, which is currently working on a number of other issues related to quality, including issues surrounding surgical site infections and surgical checklists. Many of their initiatives could be incorporated into payment systems that reward quality and efficiency as they provide guidance to practitioners on how to provide the highest quality care for our patients.

Additionally, as a "spin off" of Clinical Practice Guidelines (CPG) and as an implementation tool, the AAOS has recently developed clinical patient management checklists. Since the product often is not a literal checklist but rather a care process for the patient, no checklist can be applicable in every instance and each surgeon should act on a case by case basis. Checklists are particularly important because they have a direct influence on physician behavior.

All of the above quality improvement activities have been developed and/or supported by the AAOS and are changing the face of orthopaedic practice nationwide.

Patient Access and Involvement

The AAOS embraces change that improves quality and lowers cost, but the patient must be the primary focus of all initiatives. Orthopaedic surgeons need to be knowledgeable about what their medical decisions cost, while ensuring that they are able to make proper choices in the best interest of patients, consistent with the best available evidence. Orthopaedic surgeons should continuously work to improve the quality and cost-efficiency of patients' outcomes. A

facility's attempt to control costs and maintain clinical programs should not interfere with the surgeon's goal of providing the highest quality care and serving the patient's best interest. As part of a collaborative effort, orthopaedic surgeons within a facility should participate in the development of cost-containment strategies as long as patient care is never compromised and the proper safeguards are in place.

There are several ways the AAOS believes patients can become involved with seeking out appropriate, high value health care service. First, in the absence of true SGR reform, Congress should permit private contracting between patients and providers. This will help providers close the gap between inadequate Medicare payments and the cost of providing services to seniors.

Second, Congress should consider enabling Medicare beneficiaries to assume greater responsibility by cost-sharing for the Medicare program, with protections for low income beneficiaries, in order to preserve their access to quality care. There are a broad range of options that policymakers could consider for enhancing beneficiary cost-sharing.

The Medicare system needs to be transformed from its current emphasis on paying for services regardless of quality or costs to a system that provides meaningful and sustained incentives for high quality, innovative, and cost effective care for Medicare patients. Accomplishing this goal will require the cooperation of Congress, the Centers for Medicare and Medicaid Services (CMS), physicians, and patients. However, we believe it can be accomplished and that now, more than ever before, is the right time to concentrate our efforts in this direction.

Thank you for allowing me to participate in the hearing today, and we look forward to continued dialogue with your committee on this important topic.

Chairman HERGER. Thank you.
Mr. Sharp, you are recognized.

STATEMENT OF ARIC SHARP, CEO, QUINCY MEDICAL GROUP

Mr. SHARP. Thank you, Chairman Herger, Ranking Member Stark, and Members of the Committee.

My name is Aric Sharp, Chief Executive Officer at Quincy Medical Group.

The need for an SGR solution cannot be stressed enough. Every year physicians face uncertainty, an inability to budget, and at times having to spend significant resources to address retrospective patches.

As the Committee works on the SGR issue, we believe incentivizing high performance can and should be a part of the solution. At a minimum this would include measuring and improving quality, improving care coordination, utilizing information technology, and demonstrating the efficient provision of services.

These four attributes guide much of the activity at Quincy Medical Group and other multi-specialty groups and systems throughout the country.

In Quincy, we participate in the PQRS program and the e-prescribing incentive program. We actively measure patient satisfaction through a standardized CG cap survey, as well as through opinion metered Kiosk devices in our offices.

However, we are not just measuring quality. We are also aligning it with our revenue streams. We work with Humana on a Medicare Advantage product that provides reimbursement for our patient centered medical home, for 12 quality metrics, and for shared savings.

Through the Iowa Health System, Quincy participates in the Medicare shared savings program. That program's 32 quality measures introduce an even higher level of rigor.

We are also nearing completion of an intensive medical home contract with Blue Cross and Blue Shield of Illinois.

Altogether our combined efforts across all payers will link over 75 percent of our revenues to both quality and cost savings.

Quincy's medical multi-specialty medical group model utilizes physician led committees and work groups so that we can leverage good care coordination into quality.

For example, Quincy holds the highest patient centered medical home recognition from NCQA, Level 3. We also have the largest number of patient centered medical home providers in the State of Illinois.

We believe there is strong merit to follow the lead of commercial insurers by incentivizing this type of care coordination.

Quincy is also on track to meet EHR meaningful use criteria for all of its physicians. However, only half of our physicians are even able to receive the intended meaningful use incentive as well as PQRS and e-prescribing incentives due to a technical oversight.

H.R. 3458 would fix that issue, and it would end that type of discrimination in quality programs against rural physicians. That bill has bipartisan support, and is strongly supported from medical and hospital associations, providers, and leaders across the country.

Therefore, we respectfully urge swift passage of H.R. 3458.

You see, the reason it is so critical to have all physicians in both urban and rural areas on EHRs is because it is a prerequisite to advanced solutions, like patient registries, patient portals, telehealth solutions, and predictive analytics, through products like Explorus and Anseta.

At Quincy, we are already using or preparing to launch initiatives in each of those advanced areas.

Finally, we believe high performance includes demonstrating the efficient provision of services through cost reduction. However, it is important to keep in mind there are geographic differences in measuring baseline cost efficiency across our country, and that fact cannot be overlooked within any successful SGR solution.

In conclusion, solutions must work for all physicians and all specialties and in all parts of the country. We believe taking an approach of shaping the path could be the most successful, and that shaping can begin with appropriate incentives centered around quality and technology for high performing multi-specialty groups and systems.

Thank you.

[The statement of Mr. Aric Sharp follows:]

***TESTIMONY IS EMBARGOED UNTIL 10:00 AM
TUESDAY, JULY 24, 2012***

Statement of the
Quincy Medical Group
Quincy, Illinois

Presented by
Aric R. Sharp, FACHE, CMPE
Chief Executive Officer

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

Re: Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform

July 24, 2012

Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform

Rewarding High Performance
A Path to Addressing the Sustainable Growth Rate

Chairman Herger, Ranking Member Stark and Members of the House Ways & Means Health Subcommittee, on behalf of the Quincy Medical Group (QMG), a multispecialty clinic in Southern Illinois, Northwestern Missouri and Southeast Iowa, we are pleased to submit the following testimony to the Subcommittee on ways to improve health quality and efficiency in the Medicare program, particularly as such efforts pertain to ongoing efforts to reform Medicare's Sustainable Growth Rate (SGR) physician payment formula. QMG commends this panel for its efforts to address this fundamentally flawed system.

Founded in 1937, QMG is one of the leading multispecialty group practices in the Midwest, with a network of more than 130 physicians and providers including a primary care network of Rural Health Clinics (RHC) and specialists practicing in 27 medical and surgical specialties. Our group provides quality health care services to more than 300,000 people annually in the Tri-State area (e.g. Illinois, Missouri and Iowa), and over half of our annual revenues are from Medicare and Medicaid. QMG has recently become an affiliate of the Iowa Health System (IHS), one of the nation's most integrated health systems. Through relationships with 26 hospitals in metropolitan and rural communities and more than 200 physican clinics, IHS provides care with the vision of delivering the best outcome for every patient every time.

QMG holds itself to the highest ethical standards and subscribes to a multispecialty group practice philosophy whereby physicians and other providers are committed to working together under a collaborative model to improve the health status of the people whom we serve. It is in this spirit that we are pleased to offer testimony on initiatives underway at QMG that have shown great promise – from both a quality improvement and cost-savings vantage point – and that we believe may serve as practical case studies to the Congress as it seeks to reform Medicare's physician payment system.

High Performance Leads to Value

The rising cost of health care and the demand for better outcomes are driving an expectation among payers and patients for providers to more effectively leverage their data to improve quality, delivery and patient satisfaction. In essence, all parts of the industry are increasingly demanding higher value.

At QMG we believe that high performance includes accountability for both quality and cost. The current SGR payment mechanism under the traditional Medicare fee-for-service (FFS) construct works counter to such accountability. **We believe high performance can be measured and should be rewarded within any new physician**

payment paradigm. If appropriately constructed, rewarding high performance can shape the path toward lower overall cost with simultaneous improvement in quality. This *value* can be observed in a variety of activities being undertaken by some of the most progressive multispecialty medical groups and health care systems across the country. Specifically, we believe high performance includes a strong emphasis on measuring quality, improving care coordination, utilizing information technology, and demonstrating efficient provision of services. Below are examples, but certainly not all of the ways, QMG is working in each of these key areas.

High Performance Includes Measuring Quality

QMG measures and reports on the quality of care delivered to its patients through both internal and external initiatives. QMG operates a Physician Leadership Institute with 19 current enrollees. Each physician is an active participant in a work subgroup focused on moving the organization toward the triple aim of healthcare. One subgroup of physicians is actively working on patient satisfaction improvement initiatives within our organization.

QMG actively measures patient satisfaction via two synergistic methods. The first is a standardized Clinician and Groups CAHPS (CG-CAHPS) survey administered by Press-Ganey to patients at random. CAHPS surveys are patient experience tools used widely in the industry. The tool focuses on access to care, physician communication, office staff, and an overall provider rating. The second method is a more real-time approach to improving satisfaction through the use of Opinionmeter Kiosk surveys in our offices. The Opinionmeter provides QMG the ability to offer short surveys at the time of patient checkout in a very flexible fashion. For example, questions can be changed at any time to help the organization learn and focus on areas that have been indentified for improvement. The data is available real time for analysis enabling a more nimble approach to process improvement.

Another QMG Leadership Institute subgroup is actively working on the development of quality measurements around chronic diseases which can lead to more standardization of care. The subgroup's effort on diabetes is leading to a clinic-wide report card with quality metrics such as HbA1c, LDL cholesterol, foot exam, blood pressure, retinal eye exam and vaccine compliance. QMG recently received the distinction of being named a National Committee for Quality Assurance (NCQA) recognized site for diabetes care.

QMG is a current participant in the Physician Quality Reporting System (PQRS) initiative, e-Prescribing (eRx) Incentive Program, and Electronic Health Record (EHR) Meaningful Use Incentive Program. QMG uses several software programs to extract the required data for the reporting required within these Medicare incentive programs. These programs have helped encourage strong primary care and specialist adoption of our EHR. Consequently our patients and providers benefit from features like drug to drug interaction alerts while e-prescribing. We believe that these programs are foundational to moving the physician sector toward quality measurement and improvement.

QMG also works with commercial payers such as Humana through a Medicare Advantage (MA) product to actively incentivize quality and cost reduction. Through a value-based contract, Humana provides QMG standard FFS payments but supplements those with per member per month Care Coordination reimbursement recognizing QMGs Level 3 Patient Centered Medical Home (PCMH) model of care. In addition, the Humana contract has a series of quality rewards tied to measures including breast cancer screening, glaucoma screening, colorectal cancer screening, cholesterol management, comprehensive diabetes care, osteoporosis management, 30-day readmission rate, health risk assessment completion rates, generic dispensing rates, mail order pharmacy rates, and chart and lab data access. If these quality goals are attained, QMG has the opportunity to share in savings below an agreed upon total spending target. This program is in its first year of implementation, and due to the patient demand and popularity of the MA program, we anticipate a significant increase in beneficiary enrollment at the next plan entry date. We believe working with our commercial payers on value based models eases regulatory barriers substantially. And to the extent congressional SGR solutions can come with realistic regulations, physician acceptance should increase.

Finally, QMG is a participant in the Medicare Shared Savings Program (MSSP) via the Iowa Health System Accountable Care Organization (ACO). This program will require quality measurement on 32 elements, a high level of rigor for any health organization. With over 18,000 Medicare beneficiaries attributed to QMG primary care providers, we have a great opportunity to test the MSSP model in our efforts to advance quality and reducing cost.

High Performance Includes Improving Care Coordination

QMG believes care coordination is critical to high performance. We also believe the multispecialty group practice model has many advantages in care coordination. This model of practice typically unites a wide array of specialists with primary care physicians to work together in a more efficient fashion. This efficiency is found on many levels including better and timelier information sharing, broad quality and patient satisfaction programs, economic operating efficiency, and engaged physician leadership and governance. These attributes are critical to the work and progress that needs to be accomplished to effectively meet the triple aim of healthcare to improve quality, lower cost, and exceed patient service expectations.

For example, QMG uses a variety of physician-led committees and work groups to advance improvement initiatives. Our Physician Leadership Institute subgroup working on quality initiatives includes a pediatrician, internist, obstetrician, urologist, and neurosurgeon. This multi-disciplinary team is working specifically on ways to lead the organization toward an even higher level of quality measurement and improvement. While quality development and standardization can evolve differently in different regions

of the country, we believe there is value in such an approach particularly when it is physician led.

Another excellent example of improved care coordination resides in the PCMH model. The Patient-Centered Primary Care Collaborative recently released a report that summarized findings from PCMH demonstrations and concluded that findings from PCMH demonstrations show success in increasing the quality of care and in reducing cost of care on some measures. Recently, QMG received the highest level of recognition (Level 3) from NCQA under the PPC-PCMH Program – a coveted recognition held by only 98 physicians and providers in the State of Illinois. Under this model, 27 of the State's 98 physicians and providers with Level 3 recognition are providers with QMG. QMG has also submitted application for Level 3 recognition for its other 13 primary care physicians and providers working in its 10 clinic locations outside of Quincy, Illinois. Based upon our experience, we fully anticipate Level 3 recognition for all of our remaining 13 primary care physicians and providers. The PCMH model focuses on care coordination, improved access to care and patient satisfaction. Specifically, NCQA recognition requires meeting 10 must pass elements in the areas of: access and communication; patient tracking and registry functions; care management guidelines for important conditions; patient self-management support; test tracking and follow-up; referral tracking; quality performance reporting and improvement; and patient experience reporting and improvement. An additional 20 elements are pursued to earn enough points to reach 1 of 3 levels of recognition, with level 3 being the highest. Many commercial insurers around the country are now recognizing the benefits provided within the PCMH model of care. As such we believe part of the SGR solution can be found in incentivizing a broader deployment of the PCMH model of care.

Building upon QMG's PCMH model of care, we are about to enter into an agreement with Blue Cross & Blue Shield (BCBS) of Illinois for an Intensive Medical Home program. This program uses a Verarisk methodology to identify the most chronic patients in our BCBS insured population. Each patient is then invited to participate in the IMH program which includes a super visit for treatment plan development and education. BCBS provides funding through the program for the addition of nursing care coordinators who are responsible for daily care coordination and monitoring of the IMH patients. In addition the program provides incentives for both quality and cost management. Quality measures include LDL cholesterol screening, HbA1-C testing, depression screening, medication reconciliation, patient outreach, and physician-patient shared action plan rates.

QMG believes a population health focus is important. For that reason, QMG now offers a Medicare Weight Loss Clinic, a new service covered by Medicare in 2012. This service provides intensive weight loss counseling for Medicare beneficiaries through a team of registered dieticians and diabetes educators working under the supervision of a physician. Enrollment has grown quickly to 82 people with over 300 visits, and our data indicate that approximately 94% of enrollees are meeting the criteria of 6-pound weight loss in their first 6 months of the program. The benefits of weight loss reduction are clear and are a key contributor to overall health improvement. By coordinating this aspect of

care within routine physician examinations, beneficiaries are able to receive direct education and recommendation into the program. While this program is not reimbursed at a level that allows it to produce break-even financial results, when coupled with our diabetes self management service, we are able to job share across teams, thus achieving some economies of scale and allowing the combined services to break even, making it feasible for QMG to provide these services to patients while helping to lower costs.

QMG is developing an Intensivist Program to measure quality, reduce average length of stay, and implement standardized protocols within the intensive care unit at our local hospital. This program would provide in-hospital staffing 24/7 by either a physician or nurse practitioner assigned to the intensive care unit to ensure that care is most effectively coordinated among the attending physician and variety of consulting physicians on the case. These efforts are anticipated to reduce the overall cost of care while improving quality. The program will measure and hold physicians accountable for items including but not limited to patient satisfaction, core measures, length of stay, and meeting standards for communication during transition of care setting.

QMG has launched other care coordination efforts outside of the Medicare Physician Fee Schedule (MPFS) space that are demonstrating reduction in cost and quality improvement. These initiatives include a new Nursing Home Care Coordination model and a progressive Home Dialysis Program (HDP) that includes both home hemodialysis and peritoneal dialysis modalities. The Nursing Home Care Coordination model is a natural extension of the PCMH model and the HDP program a natural officebased model for nephrologists in any market.

We believe incentivizing care coordination for multispecialty groups and PCMHs has strong merit and can directly improve the physician cost of care. At the same time, as Congress looks to find numerous ways to fund SGR solutions, we believe it also prudent to incentivize programs with tangible savings and improved quality such as those highlighted above.

High Performance Includes Using Information Technology

We believe the use of EHR technology is vital for every physician, single specialty group, multispecialty group, or system to attain high performance. Consequently, QMG is a high level user of EHRs. Our EHR facilitates eRx among our physicians for all prescriptions, with the exception of Schedule II Controlled Substances, in addition to streamlining the care processes by enabling physicians to conduct electronic charge order entry; procedure or testing order entry; as well as order (and view) lab and imaging-related results, immunization and wellness tracking, allergies, and active problem lists. QMG continues to work diligently to draw additional application out of the EHR through the development of standardized protocols around chronic disease such as diabetes. QMG is on track to attain EHR meaningful use for all of its physicians despite only half of the physicians being able to receive meaningful use incentives.

We believe Congress did not intend that Rural Health Clinic primary care physicians be unable to receive incentives from the Meaningful Use incentive program. H.R. 3458 which was introduced by Rep. Aaron Schock (IL) and co-sponsored by Rep. Blumenauer (OR) of this Subcommittee would provide the technical correction needed to address this oversight. We respectfully urge swift passage of H.R. 3458.

QMG uses two solutions to deliver a Patient Registry type solution. Phytel is software that queries our databases to identify patients with potential gaps in both their treatment plan and wellness recommendations. Over the past eight months, QMG has used Phytel to identify 10,433 unique patients with identified Gaps in Care. Of these, 3,800 have either scheduled or had an encounter to become compliant in their treatment plan. This proactive technology-driven approach to population management is having a positive impact. Gaps in Care currently being targeted by QMG include Asthma, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, High Cholesterol, Hypertension, Thyroid Disorder, Wellness Exams and Vaccines. QMG also uses features imbedded within its EHR that alert a provider to various Gaps in Care at the time of an encounter or visit. This Health Maintenance Alert feature enables nursing and providers to provide more comprehensive data driven care at the time of service.

Physicians and nurses find these features very helpful as they manage a population. Patient registries make use of the underlying data in EHR, billing, and lab systems. The built-in intelligence allows the care team to work in a more proactive and efficient manner instead of having to comb through stacks of paper charts or click through scores of electronic screens. Another example within registries is allowing the practice to query data over a population and sort by physician or care team to determine the effectiveness of the team to attain patient compliance with standard treatment, preventive and wellness recommendations. The use of these systems has helped us identify patients delinquent on routine mammograms, screening colonoscopies, immunizations, and important chronic disease follow up visits.

QMG is completing implementation and approaching launch of a new Patient Portal. This product, which is currently available to all QMG employees, enables patients to view their lab results, appointments, problem list, medications, allergies, and wellness recommendations in a secure online platform. We anticipate launch, in August of this year, to all of our patients. Through the use of the Patient Portal, patients will also have the ability to connect to other participating health organization, thereby enabling patients to aggregate and view their medical records from multiple sources. (This unique product is offered by JarDogs, a subsidiary of the Springfield Clinic of Springfield, IL). For example, through the use of this technology, a given patient would be able to view their data from QMG, Springfield Clinic, Memorial Hospital in Springfield, IL, and eventually all Iowa Health System organizations.

QMG is also seeking a means to implement a Telehealth Enabled Care Coordination (TECC) project within its shared savings models with Medicare and other payers. This rapidly deployable telehealth solution, called the Health Buddy, would lead to large-scale

health care improvements and significant cost reductions in multiple care provider settings. Participants will have been diagnosed with at least one of the following chronic conditions: heart failure, complex diabetes mellitus and chronic obstructive pulmonary disease (including relevant co-morbidities). Prior studies performed by other multispecialty groups with the Health Buddy have demonstrated cost reduction of near 15% for chronic disease patients. Through use of the Health Buddy, these high-risk patients experience higher satisfaction, better access to care, and improved health. At a time when Medicare needs solutions, we believe that solutions like the Health Buddy offer tangible answers to many of the healthcare system's ailments.

Furthermore, as the Committee looks to advance alternative payment models to FFS, QMG would encourage you to consider where funds under the MPFS might be further expanded or better directed, particularly with respect to accelerated efforts across the country to implement telemedicine. While the Calendar Year (CY) 2012 MPFS released last November expanded the list of services that can be furnished through telehealth to include, for example, smoking cessation services, despite this strong initial foundational step, this level of coverage is far from adequate to support the more robust telemedicine capabilities that providers so desperately seek to adopt but for which significant resources are still sorely needed.

Finally, as a part of its affiliation with the Iowa Health System, QMG will also soon be using the Explorys data tool. Explorys provides a secure cloud-computing platform that empowers accelerated research, while enabling real-time exploration, performance management, and predictive analytics for the Medical Home and formation of ACOs. This type of tool adds value beyond simple registries as it can assimilate data across care settings and time. Explorys will allow QMG to leverage our data into value based initiatives and shared savings, with commercial payers, Medicare, and MA, as it brings together data from clinical, financial, and operational systems. While the Explorys tool is being made available to QMG by the larger Iowa Health System, similar tools such as Anceta are available in the marketplace and are being used by other high performing progressive multispecialty groups.

High Performance Includes Demonstrating Efficient Provision of Services

We believe that high performance requires a balanced approach and that means active engagement to develop ways to demonstrate cost reduction. At the same time, it is important to note that differing parts of the country are starting from different baselines. Some areas are high cost today while others already demonstrate a much more efficient system. These geographic differences cannot be overlooked in any successful SGR solution that rewards high performance.

QMG has another subgroup within its Physician Leadership Institute that is working to identify and implement numerous additional ways to reduce the total cost of care. This team is exploring ways to reduce emergency room visits in the community, reduce

avoidable admissions and readmissions to the hospital, increase generic prescribing, and measure appropriate use of imaging and testing services.

Patient Involvement

QMG encourages the Subcommittee to provide beneficiaries financial incentives or assist physicians in the deployment of models that utilize higher value services such as the medical home model and other chronic disease prevention initiatives discussed above.

Alternative Payment Models

QMG fully supports efforts to move away from the traditional FFS payment system to one that more accurately (and fairly) rewards physicians for care improvement and efficiencies. However, it is important that the Federal government be cognizant of the transitional costs incurred to the participating providers that are inherent in this type of change.

Summary

QMG would like to briefly reiterate our desire that any newly-devised or reformed payment system be flexible to the extent that it supports, not stifles, innovations being undertaken at QMG and other high performing multispecialty physician group practices across the country. Any reforms that are under consideration by the Committee, or that are still in the process of being implemented by CMS need to be able to "work" for all physicians, in all specialties, and across different platforms that may typically fall outside of Medicare's traditional reimbursement construct.

In closing, we believe activities like those described above are essential to high performing multispecialty groups and systems. As Congress works to cure the SGR ailment we would suggest that an approach of "*shaping the path*" be taken. Due to the extensive complexity of the SGR issue, we believe incentivizing high performance can begin to move the industry in a much needed direction. In all likelihood, we believe any solution will need to continue to be modified over time.

Chairman HERGER. Thank you.
Dr. Jenrette is recognized for five minutes.

STATEMENT OF DR. JOHN JENRETTE, CEO, SHARP COMMUNITY MEDICAL GROUP

Dr. JENRETTE. Thank you, Chairman Herger, Ranking Member Stark, and members of the Health Subcommittee for inviting me today to testify regarding physician organizations' efforts to promote high quality care.

I am pleased to testify today as Chief Executive Officer of Sharp Community Medical Group and as a physician myself trained in family medicine and geriatrics.

By the way of background, Sharp Community Medical Group is the largest IPA in San Diego County. We have a network of more than 200 primary care physicians and over 500 specialists, and we care for more than 170,000 patients, both HMO and Medicare Advantage, as well as commercial HMO, our new commercial ACO products, and we are one of the six pioneer ACOs in the State of California.

I also address you today as Chairman of the Board of Directors for the California Association of Physician Groups, CAPG, that represents over 150 physician multi-specialty medical groups and independent practice associations.

Our members serve over 15 million Californians, approximately one-half of the state's insured population.

What are the most important efforts to promote high quality care for the patients we serve at Sharp Community Medical Group as well as the 150 medical groups and IPAs at CAPG?

I must begin as many of the other speakers have with the certainly known to you, move away from payment systems that reward volume rather than value, and that is much of the fee for service system that we currently live under.

Groups like Sharp Community Medical Group have moved to global payment methods that allow services and systems of care to be established and built so that we are accountable for a population of patients, for quality, outcome, and excellence in care.

We have learned that taking care of patients at the right time and at the right setting and utilizing team based approaches to care, examples of which I could offer you now and later, results in better health and prevention, improved management of chronic disease, and also ultimately lowers costs.

Payment methodologies that incentivize physicians and other health care workers to provide the coordinated, accountable care should be forward in your thinking.

The second effort to promote quality is the alignment of incentives at the physician level that results in the quality outcomes or value that we are seeking.

Sharp Community Medical Group has developed programs and incentives to support and improve quality for our patients for over 20 years, and it has not always been easy.

We are focused through efforts like the California Integrated Healthcare Association, IHA, which is a collaborative pay for performance program in California, multi-stakeholders, including plans and medical groups, that promotes quality improvement, accountability, and affordability of health care in the state.

Sharp Community Medical Group is also focused on the five star quality metrics of our Medicare Advantage patients, the 33 quality

measurements of our pioneer ACOs, and similar metrics and goals of our commercial ACOs.

Over the years, Sharp Community Medical Group has expanded, evolved and gained sophistication in data collection and aggregation to create useful reports and registries that assist our physicians in improvement efforts in prevention, management of chronic disease, recognizing gaps in care, and in controlling overall costs.

In addition, our doctors have supported transparency and sharing their results with each other on physician specific report cards. How do they compare with each other on prevention, like mammography or colon cancer screening, or how well they manage their patients with diabetes.

This has enhanced their work together, to learn from each other, and to continue to improve their performance.

Physicians value accurate, comparable and reliable information to help them improve. The final effort to promote high quality care, on which I will close, is that of health information technology.

Electronic health records, health information exchanges, HIEs, meaningful use are all steps in the right direction to collect, aggregate and share information across and among providers of care. They are, however, only beginning to reach a level of usefulness for physicians to be better and to care for patients.

Many physicians still see EHR as fancy paper records containing volumes of information that is hard to digest and use successfully.

They will continue to struggle with this until such time as we can easily share information across a common platform and the electronic systems develop the intelligence or active clinical decision support that helps doctors, nurses, pharmacists and other health care providers use the information wisely.

Again, I thank you for the opportunity to weigh in on this very important topic this morning and look forward to your further questions and dialogue. Thank you.

[The statement of Dr. John Jenrette follows:]

TESTIMONY IS EMBARGOED UNTIL 10:00 AM TUESDAY, JULY 24, 2012

Statement of John Jenrette, M.D.
CEO, Sharp Community Medical Center
Chair, Governing Board and Executive Committee
California Association of Physician Groups (CAPG)

Testimony before the Health Subcommittee
House Ways and Means Committee

July 24, 2011

Thank you Chairman Herger, Ranking Member Stark, and Members of the Health Subcommittee for inviting me to testify regarding physician organization efforts to promote high quality care.

I am pleased to testify today in my capacity as Chief Executive Officer for Sharp Community Medical Group and as a physician. I have firsthand experience with many of the physician quality initiatives that I will speak to in my remarks today and look forward to sharing these insights with the Committee. By way of background, Sharp Community Medical group is the largest independent physician association in San Diego County. We have a network of more than 200 primary care physicians and more than 500 specialists, serving over 170,000 HMO, commercial accountable care organization (ACO) and Pioneer ACO patients.

I also address you 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.

The current Medicare fee-for-service (FFS) payment system is unsustainable. 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 to offer greater

volume and intensity of services. In order to truly fix this broken system, we must look at ways to incentivize change in physician behaviors, to encourage team-based care, and to create a culture of quality. In order to take these steps, we also must ensure that physicians have organizational supports in place to accept population-based payments[1] and engage in necessary quality initiatives.

In California, physicians have vast experience with payment models that provide viable alternatives to this failed FFS system. As I will describe today, California's care delivery model includes robust quality measurement and physician involvement in quality initiatives. The population-based payment model that has been in place in California for decades, combined with robust quality reporting and public accountability provisions, and a backstop provided by state regulation of risk-bearing entities provide a model for reforming the flawed fee-for-service delivery system. We believe that our population-based payment system can serve as a model for the rest of the country, especially as health care providers around the nation adopt delivery system reforms, like accountable care organizations (ACOs).

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 population-based payment 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. In California, between Medicare Advantage and ACO

[1] We use the term population-based payment 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.

pilots, 53 percent of Medicare beneficiaries are enrolled in models employing population-based payment. Note that the scope of services covered by population-based payments varies by the type of arrangement involved (e.g., commercial versus Medicare).

In California, medical groups and IPAs assume financial risk for patient care through population-based payment, 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 assume certain responsibilities, like utilization management and chronic disease management to a group of physicians, typically a multi-specialty group practice or an IPA. Arrangements involving global payment allow the development of programs and processes that are not seen in the fee-for-service environment. These arrangements allow medical groups to provide the right care, at the right time, including addressing the environmental, social, and behavioral services that are often omitted in the fee-for-service context.

It is important to point out that these population-based 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 downstream payments also often include payment of incentives for physician performance and outcomes, like quality incentive payments for performance on certain measures. The population-based 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 population-based payments directly to groups enable physicians to take responsibility for certain activities, such as engaging physicians and other care team members 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, Sharp and other California physician organizations 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. The population-based payment methodology allows us to hold physicians responsible for outcomes and to incentivize a team-based approach that involves partnering with other health care professionals, such as case managers, pharmacists, and mid-level professionals. This team-based approach leads to better outcomes for patients and greater job satisfaction for our professionals. The current fee-for-service reimbursement system in no way encourages team-based approaches to care and this is something that should be addressed under a new payment system.

Accountable Care in California

Our experience with receiving population-based payments tied to a specific population has naturally developed into accountable care-type contracting with commercial payers and ultimately to participation in Medicare's Pioneer ACO pilot.

Recent shifts in the healthcare environment have lead to greater incentives to control costs for fee-for-service populations. As a result, more commercial payers have sought out

opportunities to contract with sophisticated physician organizations, asking these physician organizations to take accountability for specific, identified patient populations.

On the commercial side, these arrangements have been based on certain premises: (1) measuring and improving hospital utilization; (2) measuring and reducing unnecessary emergency department utilization; (3) monitoring and lowering pharmacy costs; and (4) using cost-effective settings. The overall goal of these commercial relationships is to lower the cost trend while improving patient care. The outcome for patients is that they are able to receive support services, outreach, and preventive services they have not previously received.

In December 2011, Sharp Healthcare System was selected as one of 32 Pioneer ACOs. (Five other Pioneers are also located in California). Through the Pioneer ACO model, Sharp Healthcare is working with CMS to pursue a model that enhances the engagement between patients and providers to coordinate care across all aspects of the patient's healthcare needs.

As a result of this initiative, a new group of Medicare beneficiaries is beginning to benefit from improved quality and outcomes as a result of a more efficient and coordinated approach. Initial analysis of this population shows that the Sharp ACO has 32,500 aligned patients. These patients are now beginning to receive outreach, prevention, wellness, and post-hospital discharge follow-up services they had not previously received. In addition, Sharp provides a 24-hour nurse connection hotline to serve patients involved in the Pioneer pilot. The overall care experience is more patient-centered and we believe will lead to better patient outcomes.

Through our participation in this pilot, Sharp has seen additional evidence that the fee-for-service system is failing our seniors. For example, our population analysis shows that the bed days per thousand for this fee-for-service population are 500 above what we experience with

patients covered under population-based payment systems. The average length of stay in a skilled nursing facility is 32 days for this population as compared to 13 for seniors in population-based payment systems. We see tremendous potential to reduce costs and improve care for seniors if we can transition them from the flawed fee-for-service system to coordinated care models that involve population-based payment.

California's Quality Improvement Journey

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

Specific to our organization, Sharp uses physician report cards to measure individual physician performance. The report cards show a level of detail related to quality performance for each physician and is tailored to their specialty. The physician report card system, combined with the population-based payment methodology, allows us to tie quality to individual physician performance. The population-based payment system allows us to take this one step further - tying physician compensation to quality performance. This system has allowed us to both tailor metrics to individual physicians and use compensation-based incentives to drive the types of behaviors our organization wants to encourage. Note, however, that in terms of developing a broad-based payment system for Medicare, this type of measurement, reporting, and payment requires an organizational structure that can accept data, analyze it, and distribute results in a way that allows the physicians to be successful.

Beyond our physician report cards, Sharp also participates in a number of quality initiatives, including California's Integrated Healthcare Association (IHA) quality initiative,

Medicare Advantage 5-star quality program, Pioneer ACO quality metrics, and quality metrics associated with our commercial agreements. We also have some physician experience with Medicare Part B's Physician Quality Reporting System (PQRS). Overall, in our experience, there is some overlap among these quality initiatives and more could be done to align quality metrics, particularly for the senior population.

In California, the IHA is a statewide multi-stakeholder leadership group that promotes quality improvement, accountability, and affordability of health care in the state and has been doing so for a number of years. The IHA evaluates physician groups based on four domains: 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. Physician groups receiving these incentive payments are then free to distribute the payments to make further investments in coordinated, high quality care.

In recent years, health plans involved in this initiative have recommended focusing on cost in addition to quality. The IHA is currently developing a system to look at resource use and efficiency of physician practices by developing efficiency measures. We believe that this initiative will contain important lessons for payers shifting to value-based purchasing methodologies. As this program is formulated and adopted, we are happy to share additional information with the Committee.

Pay-for-performance programs, like IHA's, compliment the population-based payment model by providing necessary protections against potential incentives to stint on care. One criticism of the population-based 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 population-based payment model. In California we have learned that providing the right care at the right time lowers cost, while deferring treatment increases costs.

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 health care 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, 26 organizations

achieved "Elite" status by surpassing thresholds on the four domains that were measured in that year. Five organizations were recognized as "Exemplary."

Finally, I would like to add that health care provider collaboration is critical factor in successful quality initiative development. Successful quality initiatives require close relationships between the primary care team, specialists, and hospitals. In addition, I believe that successful implementation of quality and alternative payment initiatives require strong physician involvement, buy-in, and leadership.

Quality Measurement and Achieving Patient-Centeredness

In addition to the quality initiatives described above, Sharp is focused on providing patient-centered care. We achieve this result through efforts at the organizational level, CAPG's Standards of Excellence, and the statewide IHA pay-for-performance initiative.

At the organizational level, Sharp has invested in a broad-based approach to measuring patient satisfaction. Under our organizational approach, each physician receives 30 to 75 surveys each quarter to measure patient satisfaction at the individual physician level. We believe that the only way to foster an honest, open dialogue about performance is to have this type of measurement within our organization. The results of these surveys are shared by name with all of our physicians and have driven quality improvement efforts within our organization.

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 Future

I believe that our successes are achieved in part through the flexibility that is afforded to our groups through the population-based 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.

First, the Committee should continue to look for opportunities to incentivize health care teams to provide the right care at the right time, while moving away from a fee-for-service payment model. Second, I believe that the continued development of health information technology, with particular attention to standardization across systems, will be important to future development of coordinated care systems. This technology is essential to providing the foundation for data analytics that are required to successfully manage quality initiatives but more can be done to standardize these systems. Third, the Committee should continue to look for

ways to support primary care teams and their proven role in improving quality and lowering cost. Finally, we encourage the Committee to continue to support organized medicine. We believe that the types of changes that are necessary to fix the fee-for-service system can only be made through infrastructure that is built to handle population-based payments, quality data and analytics, and measuring, assessing, and acting on physician performance information. Such an approach should involve Medicare physician payments that differentiate between organizations that provide care in a more effective and cost efficient manner.

The existing legal and regulatory framework provides some opportunity for physician groups like ours to further experiment with population-based payment models, such as partial capitation and shared savings. 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. Through our participation in the Pioneer program we have begun shared learning activities with other Pioneers across the country. This is a first step in spreading our knowledge and simultaneously learning what is working in other areas of the country.

I would add that I believe that our country is facing a crisis in primary care. This crisis requires a focus on the academic pipeline, creating a better work environment, and paying critical attention to compensation for the entire primary care team. As Congress revisits the fee-for-service payment system, Medicare payment policy developments should ensure that fees for primary care providers are preferentially adjusted. By ensuring differential payment updates for

primary care and preventive services, we can accomplish two aims: (1) ensuring that seniors in Medicare have access to primary care and preventive services; and (2) ensuring that there is a robust primary care workforce that adopts a team-based approach in the future. This approach should involve primary care physicians and other care professionals, including care coordinators, pharmacists, and social workers, all of whom are practicing to the top of their license. Payment structures that recognize the critical role of primary care providers along with delivery system changes that focus on the role of primary care teams will lead to the development of a workforce capable of handling the challenges that lie ahead.

In addition, attention must be paid to the Medicare Advantage (MA) program. Operating within the broader context of quality and patient-centered care initiatives in California, Medicare patients who were enrolled in a plan using a population-based 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 population-based 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 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. Thank you, Dr. Jenrette. I want to thank each of our panelists for your testimony.

My first question is for the entire panel. The efforts of each of your organizations to use the evidence as to what works to develop and disseminate quality standards that physicians can put into practice is commendable.

Do you believe that it is appropriate to incorporate quality and efficiency into the Medicare payment system if physicians play an integral role in determining the metrics and the process?

Dr. Riddles.

Dr. RIDDLES. Yes, sir, I certainly do. That is the only way that we are going to be able to incent and work towards value, that the whole system has to move that way.

As we talked about initially, coming up with common data elements, common information, and a way to process that and tie that together, as my colleagues here have mentioned, is critical, so that it is going to be seen at not only the local and regional but national level so we can understand the patients and how best to apply the medical knowledge that we have in the way of evidence based things to help that out. Yes, sir.

Dr. BRONSON. Again, yes, sir, I agree with Dr. Riddles, but would add the importance of physician leadership and the leadership of the professional organizations in helping the penetration of these ideas out to the medical community in an effective manner.

Chairman HERGER. Thank you.

Dr. WEINSTEIN. As well, certainly agree. The AGA has worked closely with NQF and the other AQA in developing scientifically based, evidence based guidelines. I think it certainly helps with physician acceptance of guidelines, and physician acceptance of measures to control costs and improve quality are far more accepted when they are developed by their colleagues and peers using a process that involves evidence based medicine.

Chairman HERGER. Thank you.

Dr. MANDELL. Mr. Chairman, the answer is definitely yes. In addition to clinical practice guidelines, we do not have a lot of information and it is certainly very important sometimes in very expensive areas, so we are also developing appropriate use criteria for that. They take the data that is there and then combine that with what is called an "expert opinion" to come up with the best available recommendations, and that would go a long way towards increasing value as well.

Chairman HERGER. Thank you.

Mr. SHARP. I would simply echo the "yes" with all of these folks for the same reasons. I think it needs to be physician led.

Dr. JENRETTE. It sounds like you have consensus here, as I would also support and as I have mentioned, I think physicians when they have an opportunity to weigh in on the data, on the guidelines, and have input, you will get the buy in that we are all looking for and move us in the right direction.

Chairman HERGER. Thank you. Dr. Mandell, your organization supports tier payments so that physicians who provide higher quality care receive higher payments.

Do you believe the evidence and methods exist to make determinations that condition payments on outcomes?

Dr. MANDELL. In certain areas, there is a lot of good evidence to that, to support that concept. As I mentioned a minute ago, in areas where we do not have high quality evidence to provide clinical practice guidelines, the use of appropriate use criteria could be used for the tiering process, and basically as I am sure you understand, the tiering process would say for example, if you did not re-

port to the registry, if you did not follow the appropriate use criteria for whatever reason, you get paid at a certain level. If you do support and utilize these things, you get paid at a higher level.

There may be reasons why individual physicians would not want to do that at first. I would suspect that over time everybody would follow all the guidelines and go to the higher payment level.

Chairman HERGER. Thank you. Dr. Weinstein, your organization generally supports incorporating quality and outcomes into the Medicare payment system. To that end, you have developed robust quality measures.

Should these measures differentiate among physicians based on their geographical location?

Dr. WEINSTEIN. I think at the beginning of the development of guidelines, the issues that we are tackling are relatively universal and do not really depend upon the geography.

If you get deeper into nuances, that might change, but I think in general, the quality guidelines that are established should be applied throughout all areas, rural, urban, whatever.

To that end, development of a registry allows small groups and large groups to participate with any web access, either entering information in manually or through electronic data interchanges.

We do not really see any difference in the geography, particularly if the guidelines are developed with input from a wide range of physicians.

Chairman HERGER. Thank you. Mr. Stark is recognized for five minutes.

Mr. STARK. Thank you, Mr. Chairman. I thank the panel for participating with us today.

Dr. Bronson, you mentioned medical home, and I think that is an interesting concept that people are talking about. What I am wondering, I am aware that the thoracic surgeons over the past five or ten years have collected information on virtually every thoracic surgical procedure done by the members of that organization.

It has resulted in a best practices recommendation generated by the specialty so that if somebody has to have a heart transplant or something else, they can look up and see what all their colleagues feel are the best practices.

Do any of you represent a specialty that does a similar collection of data?

Dr. MANDELL. We are talking about the joint registry, and in that sense, we are collecting data for total joint replacements.

Mr. STARK. We think it would be a good idea that every physician be required to keep electronic medical records. Arguably, they will have to be reimbursed for the cost of the equipment, programming and learning.

New medical students will not have that problem. It will be taught to them.

We would then probably end up hopefully with a program like VISTA, which I think is universally acclaimed as the finest existing medical record program in the country.

It is astounding to me, and we are trying, Dr. Riddles, to see if we can straighten this out, but VISTA cannot talk to the Department of Defense. You go figure. If you are on active duty, you cannot get the information, but as soon as you retire, it is plugged in.

Maybe that is just bureaucracy that does not want to do it. It does not make any sense at least to me that these records cannot be incorporated, and further, that any of us ending up in an emergency room 1,000 miles from home, if we have our password or some way of identifying ourselves, it would seem to me it would be valuable in terms of outcome and costs for the emergency room people to punch in and get medical records as we get in VISTA.

Is there anybody who thinks we should not have a system like that?

Dr. RIDDLES. If I could offer just a comment, sir. I think you are spot on, there is nothing magic with electronic things, and that would really disappoint my children, but there is not.

The big piece is how you use it. It is a tool. If it is not interconnected and it is not integrated, it is not of any value to you. That is again part of what we and I think all the members here have been saying, we have to have the registers, we have to have the common databases, so we have the ability to use it. It is huge when you have that capability.

Mr. STARK. We are the only industrialization in the world that does not have it, I might add. I look to Canada, for instance, and let's use pharmaceuticals. That is pretty easy. Aspirin is aspirin. Tylenol is Tylenol. You do not get into a question of professional differences.

Would it not be helpful, it certainly would to me when I go to see my ortho whether I get a needle in the back or Tylenol, I know what I want, but it would be helpful to see what the results were without regard to cost and without cost to recommendation, but to see what happens to a group of people with problems or any other specialties that you all may represent. I just hope we can get there.

Dr. Weinstein.

Dr. WEINSTEIN. I will make a point. We practice different medicine. The way we record data, the efficiency of our medical records obviously very much depends on what specialty we are in, the amount of information we want to record.

The important thing that would help us is the glue that allows all of our systems to talk to each other. That is where the standards have not been set and should be part of——

Mr. STARK. It is one of the areas that some of you, more than just a couple of you is out of medical school, are going to have to re-learn. Kids in medical school will learn it. That will be the inconvenience. You are going to have to figure out if there is an universal system how to enter my weight and blood pressure, what line you put it on, a pain in the sacroiliac, but a pain.

Eventually, it would seem to me, and I think in less than ten years, we will have those records for you all to use at your convenience.

I appreciate the interest that many of you have in that field and letting us know about anything we can do to promote that.

Thank you, Mr. Chairman.

Chairman HERGER. Mr. Johnson is recognized.

Mr. JOHNSON. Thank you, Mr. Chairman. Drs. Riddles, Bronson, Weinstein and Mandell, although we have discussed the fact that reforming the current payment system cannot be an one size fits all endeavor, we still have to ensure that reform payment

systems work in various physician's practice arrangements and in geographic regions.

It seems to me there are a lot of differences just among you guys, notwithstanding all over the country.

What are your organizations doing to support small practices including those in rural areas?

Dr. BRONSON. The College is very active in working to support small practices. Almost 50 percent of our members practice in small practices. We have developed programs to help small practices become patient centered medical homes, to go through that process, and the tools and other products to help them with the HR choice and utilization.

We have a wide variety of educational programs to help staffs get better at supporting the practices.

Mr. JOHNSON. Have you seen any improvement? I know a couple of doc's in our area that do not want to use the system. They would rather use handwritten records.

Dr. BRONSON. Certainly, there is a generation of physicians that will probably—I am probably one of them—I have been using electronic medical records for ten years. I learned how to do it.

As Congressman Stark mentioned, the younger generation will be using electronic medical records. We have to prepare for the transition over that time and increasingly practices will become electronic, and the electronic systems will become more user friendly as well.

Dr. WEINSTEIN. I would add one of the main reasons that our group got together, 56 physicians, was the cost of information technology, to be able to share the cost of the start up of information technology. That is a hindrance for a small group.

The high tech stimulus money may be fine for a group of 56, but it does not work for a group of two or three. The cost certainly of implementing IT far surpassed the stimulus dollars for small groups.

Mr. JOHNSON. I have seen it not work in hospital systems either. Right in our area, Methodist and Baylor do not talk to each other. Their machines do not talk to each other. They have different systems.

Dr. WEINSTEIN. That is the standards I was talking about, the standards that allow different systems to talk. Where there are no standards, then systems are not required to——

Mr. JOHNSON. Are you saying the United States Government ought to demand that they all have the same standards?

Dr. WEINSTEIN. That the communication standards between information systems should be defined by the United States Government so any provider of IT services, be it a hospital, office or whatever, have to be required to have the standard to talk to each other. If they cannot talk to each other, they should not receive certification.

Mr. JOHNSON. You like Government control of your practice?

Dr. WEINSTEIN. I did not say Government control. I said——

Mr. JOHNSON. That is what it is if we advance something like that.

Dr. WEINSTEIN. I do not want to argue. We all submit claims the same way. The way we submit claims to Medicare has been de-

fined by CMS. The only way we can all submit claims to one entity is if somebody defines the way the data is transmitted.

Mr. JOHNSON. Dr. Mandell.

Dr. MANDELL. I just wanted to point out that the market so far has sort of decided what the basic electronic medical record was going to look like, and because there are not too many orthopaedic surgeons, I mentioned 18,000, a little more than that, to practice, the systems out there now are not very friendly to what we do.

We do not take blood pressures very often. We do not check for blood glucose and things like that, which are some of the things that may be required.

Standards would be a nice idea but hopefully when they are developed, they should be developed, they will take into account the input of all the specialty societies as well, and to that end, we have our own committee at the American Academy of Orthopaedic Surgeons that has been working with the regulators to try to get them to understand all this.

Mr. JOHNSON. You guys are making a lot of progress. You still going to use Titanium in knees and hips?

Dr. MANDELL. When it is appropriate, yes, sir.

Mr. JOHNSON. I have a couple. Thank you. Dr. Weinstein and Dr. Mandell, it is encouraging that both your groups recognize the need to address all types of practices in developing your clinical registries.

Given the value of such data and quality improvement and performance, how can we incentivize more physicians to participate in these efforts?

Dr. WEINSTEIN. I think as we talk about reforming the payment system, basing payment on larger and larger amounts of the payment on participating in quality measures and achieving levels of value and quality, we will get more and more people to participate.

Dr. MANDELL. I mentioned earlier the tier payment model, which is one of the possibilities here, requiring folks to do that, to report to registries in order to get the higher levels would be appropriate.

I think as time goes on, as some of these websites that rate doctors in the Internet now become more popular, patients will ask their doctors, are you reporting your results to the registry, can I see those results, all that sort of thing. It is just going to be what the market wants.

Mr. JOHNSON. Thank you, sir. Thank you, Mr. Chairman.

Chairman HERGER. Mr. Pascrell is recognized.

Mr. PASCRELL. Thank you, Mr. Chairman. We talk about rewarding physicians who deliver high quality care. The health care reform bill is already actually testing new payment and delivery systems. I think each of you are aware of that.

I have said many times health care reform is entitlement reform, and it will help us to transform the health care system.

Today we are here to specifically focus on physician led quality initiatives.

My first question is to you, Dr. Mandell. Many of you may know that in the last Congress we introduced legislation to create a national knee and hip registry. The intention of the legislation was

not only to focus on improving patient outcomes, but to address issues within the industry itself.

In 2007, five of the nation's biggest makers of artificial hips and knees agreed to pay $311 million in penalties to settle Federal accusations that they used so-called "consulting agreements," better known as "bribery," and other tactics to get surgeons to use their products, regardless of their effectiveness.

It was part of a deferred agreement with the U.S. Attorneys, not unlike the deferred prosecution agreements with the Wall Street folks, Enron, and all those people, AIG. Nobody ever brought to trial. No charges ever made. The cost of doing business, the penalty they paid. That is it.

Let me be clear. These five companies make a majority of the artificial hips and limbs here in America. Obviously, when a majority industry is accused of wrong doing, we need to hold that industry accountable.

Right, Mr. Chairman?

Dr. Mandell, I understand that the American Academy of Orthopaedic Surgeons is currently launching a joint replacement registry to promote patient safety and hold the industry accountable.

Originally, the goal of your organization was to recruit 90 percent of all the hospitals conducting knee and hip implant procedures to participate in the registry by the end of 2015, if I am not mistaken.

Dr. Mandell, can you speak to the development of the registry, tell me if it is on track to meet its current registration goals, and then can you expand on the importance of registries for our health outcomes that most of you talked about today?

Dr. MANDELL. Let me take the second part first. It is very important for health care outcomes to have registries. The rest of the industrialized world has such registries. They have proven very useful in finding products that were not working as well as originally designed or hoped.

We have been a little bit slow in this country to get on that band wagon. It took us something like ten years to get to the point where we are now with the American Joint Replacement Registry.

We have gotten the infrastructure in place. We have gotten some hospitals signed up. I am not on the Board of the AJR, so I do not know exactly what their projections were as to when they would get to 90 percent of the hospitals. I am sure eventually they would like to get 100 percent of the hospitals.

We are working towards that. We have not detected any problems, if that is one of the questions you are asking so far with the products that have been registered.

We had some difficulty getting some hospitals to put some of the data in, things as simple as laterality. You might ask why it matters whether it is a left total hip replacement or right total hip replacement that is done.

And the answer is, when you look at the data, that a second surgery has been done. If it is done on the same hip that the first surgery was on, that is a completely different issue than if it was done on the opposite hip, obviously. Folks often have bilateral hip replacements.

So little things like that that you think would be fairly easy to enter in the data bank are proving somewhat difficult. We also had a problem with getting folks to agree on bar coding of various devices so that it could be scanned into the electronic records.

For reasons that I do not understand, the folks here in D.C. who were supposed to come up with those guidelines for using the bar codes had a lot of trouble doing it. I think they just recently came out with at least some proposals along those lines, so that is going to help out a lot as well.

So we are working hard. We may be a little bit behind in achieving our goals. But we believe we can get there.

Mr. PASCRELL. Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

Mr. Reichert is recognized.

Mr. REICHERT. Thank you, Mr. Chairman.

I have heard a lot of phrases and words used—physician-led, patient-centered, quality care, streamlined, values-based, performance-based, performance measures. All of these things, I think, everyone on the committee agrees with, and everyone on the panel. This should be easy. It is certainly not.

I have only been on this Committee four years, and we have been talking about this, and I know you have been involved and engaged in this in your entire career, most likely. These are things that the patients out there—all of us at some time or another are a patient—understand, grab onto, all agree with, and want to hear the discussion on. But the devil is in the details, as they always say.

So from the world I come from, trying to evaluate—I was a police officer for 33 years; trying to evaluate cops is like trying to evaluate doctors and teachers—when you are dealing with people, it is not widgets and medical devices and those sorts of things. I hear you saying that. Hard to put performance measures on cops. But some of the things that we would look at is kids going back to school. Are they staying in school? Are the streets clean? Graffiti? You know, those sorts of things.

And Dr. Weinstein, in your testimony you mentioned that physicians are more comfortable being measured on things they know are important to their patients. And you mentioned that your organization is developing a quality measure set that currently includes 24 measures.

Would it be beneficial for Medicare and other payors, if they use this uniform set of measures established by the professionals providing the care, would they include some of those hard-to-grab-onto sort of things that I described in other worlds when you are trying to evaluate people working with people?

Dr. WEINSTEIN. The AGA's measures that we have worked on, the guidelines that we have worked on, have tended to be in those areas where there are large amounts of scientific data and agreement about what is best practices. Obviously, we cannot tackle everything. But if you look at where most of the dollars are spent, we can define in colorectal cancer care within inflammatory bowel disease those high-dollar, high-volume areas where there is a sufficient amount of scientific data and agreement amongst everybody as to what would be best practices and what would be a good outcome.

I can get you other information about the other measures we are developing.

Mr. REICHERT. So is your answer yes? Would it be beneficial to Medicare?

Dr. WEINSTEIN. I think it would be very beneficial to Medicare, yes.

Mr. REICHERT. Thank you. Well, there are some terms that I have heard for the first time in this testimony, and one of them particularly caught my attention, by Dr. Mandell. It is a phrased you used, "appropriately risk-adjusted." What does that really mean, appropriately risk-adjusted? I think that if you use your imagination a little bit, that can be sort of a scary thought in some minds of some patients.

Dr. MANDELL. Well, patients come in all sizes and shapes and statuses of health. And the treatment is different for each of these groups. We talk about clinical practice guidelines based on high-quality evidence. To get the high-quality evidence, you have to control for everything except a particular variable that you are looking at.

So let's say if you are studying hip replacements and comparing two different types, you want to know whether everybody is a smoker or is not a smoker; otherwise, that could be a variable. You want to know whether or not everybody has diabetes or does not have diabetes; that could be another variable.

Mr. REICHERT. I think one of the things that sort of, maybe, is the kind of scary thought here is the older you get, how does that play into adjusting risk?

Dr. MANDELL. Well, if you are on the mean, this big bell-shaped curve that most biological systems, including human beings, usually fit on, we take that into account when we develop our processes in the first place. If you are out at the tail ends of the bell-shaped curve, at the margin, so to speak, that is where we get into trouble in terms of trying to cost out, let's say, and resource out how we can treat those folks.

If you are old and you have heart disease and you have cancer, it is a different surgical procedure than if you are just old, things of that sort. So trying to risk-adjust for all of this is an important thing to do if you are going to give a certain amount of money for a certain procedure.

Dr. WEINSTEIN. I will make a point that the danger in not risk-adjusting is the feeling that if you pay the same amount for every patient, there will be cherry-picking. Why would a physician want to take care of a patient who is more sick when he can get paid the same amount for taking care of a patient who is less sick? So the need for some sort of risk adjustment has to be down to the individual basis.

Mr. REICHERT. Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

Mr. Gerlach is recognized.

Mr. GERLACH. Thank you, Mr. Chairman.

Dr. Riddles, in your written testimony, page 8, under the category of innovative approaches to dealing with these issues, you state that the payment system should take innovative practice strategies into account and encourage physicians and health care

organizations to implement new processes and procedures that create cost savings while simultaneously improving quality and keeping patients safe.

One of the things that the Government Accounting Office, GAO, put forward about a year ago was that in the Medicare program, which is about, what, $540 billion a year in expenditure, in that year of 2010 there were $48 billion of improper patients in the system.

Could be erroneous and mistaken payments. Could be phantom billing. Could be identity theft of UPIN numbers for physicians and Social Security numbers of patients. Could be fraudulent durable medical equipment billing, et cetera, et cetera. But 48 billion, almost 50 billion a year, in improper payments times 10 is 500, half a trillion dollars, over a 10-year period, money that could obviously be used for much better purposes, including dealing with physician reimbursements.

So my question to you, as representatives of different physicians' groups, have you thought about other approaches from a technological standpoint to deal effectively with phantom billing, identity theft of physicians and patients? And in particular, have you thought about utilizing what in the Department of Defense they are using, a common access card, a smart card, that from a technological standpoint better identifies the provider and the user or the purchaser of a certain kind of service to cut down on these kinds of fraudulent or improper patients within the system?

Are you, individually or collectively, looking specifically at technologies that can help do that so that, in turn, the savings generated from that can certainly be utilized to make sure physicians get the kind of reimbursements they deserve to care for our Medicare seniors?

So I will start with Dr. Riddles, but would then like to have any of the other gentlemen provide input as well on that question.

Dr. RIDDLES. Sir, the simple answer is yes. And that all lies in innovation. We have to come up with things that we do not do today that are possible and apply those to the system because, as you quite rightly point out, there is a lot of opportunity to save cost and expense here.

So those type of things is what we are talking about, to support innovation, doing things differently, not just doing a little more or a little less of what we are doing now. We have to considerably change it, whether it be smart cards or it could be something DNA-based identification.

I think we have talked a little bit here about the need for information management systems that not only exist in individual little islands, if you will, but are tied together so that you see that if somebody billed for a certain procedure, that that patient was in fact seen at that location and those diagnoses matched—so that yes, sir, the answer is yes.

Mr. GERLACH. Okay. Great. Any other gentlemen on that question? Nobody?

Dr. BRONSON. I would answer. We are very supportive of using innovation to make sure that payments are appropriate and payments are fair and payments are actually honest. And we have no

disagreement with that. We do not have a robust program to get there, but we would be supportive of looking at that.

Mr. GERLACH. Okay. Thank you.

Sir?

Dr. MANDELL. Yes. I do not think we have thought about this very much. It sounds like a very interesting idea. I think if we did consider this concept, it was probably in the context of electronic medical records, with the thought that having everything in the system, so to speak, would make it easier to tell who was doing what.

Mr. GERLACH. Well, right now, as you know, we have a pay-and-chase kind of system. A payment is made, a reimbursement is made, and then go back and chase after that payment if CMS decides that somehow it was improperly issued.

Whereas you can, through a smart card or common access card system, prevent that kind of thing very significantly by verifying the appropriateness of that physician providing the care up front through a biometric component to a card as well as the proper identification of the senior through that access card, particularly where the senior does not have his or her Social Security number on the card, which is then subject to identity theft, which then complicates and creates all sorts of problems, too.

So it is technology being used in many other places around the world, including even here in the United States with the Department of Defense. And yet we cannot seem to take what is out there from a technological standpoint and employ it in a very realistic way to cut down on very significant loss of expenditures in the program.

Anybody else on the point?

[No response.]

Mr. GERLACH. If not, thank you very much, Mr. Chairman.

Chairman HERGER. Thank you.

Mr. Kind is recognized for five minutes.

Mr. KIND. Thank you, Mr. Chairman. And I want to thank our panelists for your testimony here today. I really think this is the Holy Grail of what we need to be focused on when it comes to health care reform and how successful we ultimately are in reforming the system that has been in desperate need. So we appreciate your insight and help with this matter. I think it is going to require a true partnership to make this work well.

I, along with Senators Klobuchar and Cantwell, got included under the Affordable Care Act the value-based payment modifier that many of you may be aware of. It is going to start being implemented in 2015 for physician payments, fully implemented in 2017. CMS came out with a proposed rule in early July of this year.

So any ideas or thoughts or concerns that you might have or your membership might have in regards to that value payment modifier, my office will certainly be interested in hearing back from you. We do not have to get into it in any detail today. But it is out there, and it is happening, and it is going to have an effect as far as driving to a more value-based reimbursement system.

Obviously, the Institute of Medicine, the National Academy, again under the Affordable Care Act, has been tasked to change the fee-for-service system in Medicare to a fee-for-value payment

system. This is meant to build upon the seminal work that they did, especially in 2004 and 2005, on how best to do that.

But they are being asked this time to produce an actionable plan of what that would look like. So I would certainly encourage your groups, too, to be in touch with the Institute of Medicine panel. It is a very distinguished panel that has been comprised to do this, to give them some feedback. And I know some of you have already.

But I think there are three great revolutions happening in health care reform that need to be sustained and that momentum carried forward. One is the build-out of the HIT system that many of you have talked about to increase the efficiency of care, reduce medical errors, and, most importantly, start collecting the data that our doctors and patients need to make good decisions with.

Secondly, the transformation on how health care is delivered, so it is more integrated, coordinated, patient-centered. I have got models of care in my back yard in Wisconsin that are showing the way, from the Mayo system to Gundersen to Marshfield to Aurora to Theta Care. I mean, you go right through the list throughout the Upper Midwest, and they have shown very good models that do work.

And then finally is the payment reform so we are rewarding good value, quality care. And what I want to ask you today, and anyone can take this up, and I want you to think about it for a second, is we are asking your members to do more, get better results, but for a lower cost. Can we do that without jeopardizing the compensation system that physicians are receiving today? That is going to be my question.

But I also want to share a story with you because I spoke to a CEO of one of my major health care providers back home who invested in the Epic system, software system, a couple of years ago, the HIT system. And when he did, he was warned at the time by Judy Faulkner, the owner of Epic, that what will probably happen is you are going to end up ordering less tests, doing less imaging, less scanning, as a result of implementing this system.

Two years later, I asked him what he found out. And he said, she was exactly right. We are doing less. We are not ordering as many scans. We are not ordering as much imaging as we did in the past. But that is affecting our bottom line because the incentives are not created to reward those types of decision-making to get better results; in fact, you are penalized by doing less.

And I asked him, well, what are you going to do as a consequence? He says, we are going to continue to do the right thing. I mean, if the data does not show that we should be doing certain things or ordering certain scans or imaging, we are not going to do it, even though it is affecting the line.

And I guess that is what you guys are all testifying about today is can we ask you to produce better results, good quality outcomes, and save money in the process, but without it jeopardizing the compensation system and therefore the incentives that exist in the system today?

Dr. JENRETTE. I really appreciate your comments about both the HIT and the care coordination because I think that really is the key effort or direction in order to preserve, as you say, the compensation but do the right thing at the right time.

And so there are going to be winners and losers as we control costs. But many of the costly elements—and hospitals are one of those areas of high cost; some of the use of technology, and you have already mentioned now we are using them more appropriately in the right setting for the right patient, are really the direction we need to go.

The coordination of care, as you are referring to the ability to keep patients from being admitted in the first place or readmitted to the hospital—in our organizations in California, our bed-day performance is half of what it is in the hospital as compared to the rest of the country because of the efforts that are being made to manage the patients at home, to coordinate services with case management, pharmaceutical, medication reconciliation at discharge, those things that create the readmission and the cost of care.

Our physicians being under a global payment system actually see better reimbursement than they do on their fee-for-service because they are able to use that money correctly and wisely to create the programs that are really necessary to really make a difference to the patients' lives and the amount of dollars that we spend. So yes, I believe it can be done.

Mr. KIND. Mr. Chairman, I see we have run out of time. So if anyone else wants to, they can do it outside of this hearing, I guess. Thank you.

Chairman HERGER. Anyone else that would like to respond by letter, we would appreciate it. The gentleman's time is expired.

Dr. Price is recognized for five minutes.

Mr. PRICE. Thank you, Mr. Chairman. And I want to thank you for holding this hearing on this remarkably important issue that, when you get right down to it, is all about patients. And sometimes we lose sight of that. This is about individual patients and the care that they receive.

For at least five of the six of you, I understand that we make your job more difficult here in Washington in caring for patients. And for that, I think we all ought to take note and try to figure out a system that allows patients and families and physicians to be making medical decisions and not well-intentioned, wonderful people here in this town who cannot know the individual aspects of one patient's care. It is impossible.

That is what risk adjustment is all about. We try to figure out how one patient is different than another, even with the same diagnosis. For example, Dr. Mandell, a 65-year-old woman who is out playing tennis falls and breaks her hip is different, is she not, in terms of the treatment that she requires from an individual in your specialty than the 85-year-old gentleman who is bedridden who rolls over and breaks his hip. Yet the code is exactly the same, is it not?

Dr. MANDELL. That is correct.

Mr. PRICE. And so how do we get to the recognition under a payment system that recognizes those two different patients with exactly the same diagnosis?

Dr. MANDELL. Well, there are a number of different options, as you know, Congressman Price. My thought, off the top of my head here, would be to have some additional codes to document the fact that the 85-year-old had advanced osteoporosis and perhaps other

diagnoses which qualified for additional resources in order to treat all the other conditions that would be concomitant to treating his or her hip fracture.

Mr. PRICE. Would you not agree that the quality that we talk about for those two individuals, the quality result, are two different things, are they not?

Dr. MANDELL. Yes. You are not going to get the 85-year-old to perform like a 65-year-old any more, especially after a fractured hip. That is true.

Mr. PRICE. And so the quality definition that we seek—people have tossed around this value equals quality over cost equation all the time—the quality that we seek is defined by a patient. Right?

Dr. MANDELL. Yes.

Mr. PRICE. So if it is defined by the patient, then who ought to be in charge of the system that we are talking about?

Dr. MANDELL. Well, doctors should be in charge, in our opinion.

Mr. PRICE. How about patients?

Dr. MANDELL. In conjunction with patients. Patients do not always have all the information available, and doctors are the best folks to give them that information to make appropriate decisions for their particular case.

Mr. PRICE. As a patient advocate. Which leads me to the other words that have been put forward here by physician-led physician input, physician advice. If physicians, as the patient advocates, have input advice led but do not have the veto authority over what is right for that given patient, is that a system that we desire?

Dr. MANDELL. It is not a perfect system by any stretch of the imagination. The question really is, can we afford to have each individual person get maximum treatment all the time? If Ford wanted to build an automobile that never broke down for 20 years, they could probably do that, but it would probably cost about half a million dollars to do that.

They can build 99.9 percent of cars for what they sell them for. But to get to that last little bit, as you know, it is very, very expensive. So that is a decision that Congress needs to make as to whether or not we can afford to do it for every individual person.

Mr. PRICE. I would suggest it is a decision the patients need to make.

But Dr. Riddles, you had a comment?

Dr. RIDDLES. Yes, sir. I think we have talked a lot about evidence-based and how we come to those, and that is very, very important. But also, it is a resource base, too, which is a little bit different discussion.

And that is why we talked about building, if you will, a new, if you will, group that has in it not only the health care providers, but then leaders in other fields—the payors, political—and also to have the patients in that. Because when it comes down to it, when you are at an individual level, the physicians will advocate for the patient, as they should.

But again, looking at what is right, it is a needs versus wants discussion at a certain point, and you need to have the perspective of all the stakeholders in that discussion. And I think that may be where we might want to be going.

Mr. PRICE. Dr. Weinstein, you talked about having guidelines for those things for which there is general agreement, from a risk-based statement and from an outcome standpoint. And I see my time has expired. But I think that it is important for people to respond and recognize that there is a lot of medicine for which there is not a lot of agreement. And those decisions then have to be based upon patients and families and doctors making decisions and not wonderful people in grand white buildings in this town.

Dr. WEINSTEIN. I think the only point I will add is that the decision should be between the patient and the physician, given the amount of information, the scientific literature. How much a patient wants should be up to the patient.

But I think the question here is, who is going to pay for it? What is the basic level of care that we can afford to buy? What can that patient afford to buy? What can we afford for entitlement in Medicare?

So the decision is between the doctor and the patient. But I think we have to decide what we can afford.

Mr. PRICE. Thank you.

Mr. JOHNSON. [Presiding.] The gentleman's time has expired.

Mr. PRICE. Thank you, Mr. Chairman.

Mr. JOHNSON. Dr. McDermott, you are recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Taking off on that last business about who makes the decision, I would like to do a pop quiz because you are all reasonable people. You are all smart. You think. You plan. You are used to dealing with problems. How many of you have filled out your final directives and discussed them with your family?

[All witnesses raise their hand.]

Mr. MCDERMOTT. Not bad. Now, how much time do you spend in your practice working with patients doing their final directives? I raise this because you know and I know everybody is going to die. I mean, Woody Allen said it: Nobody gets out of life alive.

So we are all going to die. And yet those last six months, we spend the most amount of money, and the most amount of money that is of no useful purpose, because the patient is in the last days and for reasons of medical malpractice and families' disagreement and whatever, care goes on.

And I would like to hear how many, or rather, you in your practice—I have a medical home. There is a doctor who has my directives, and I discuss with him everything. But how many of you have talked with patients about final directives? Is it any part of your practice at all?

Dr. JENRETTE. I will begin. And my specialty area happened to be geriatrics, so I actually spent a significant amount of time talking about end-of-life services for the family and for the patient. And I would agree it is a role as patient advocate and trying to give them the best information that you can so that they and the family understand what the quality of life will be, depending upon the treatment that we offer. So I have had years of experience in doing that.

Within our organizations, we actually have metrics that we measure, and we actually have a goal of what patients have their final directives completed and are they on all charts. And we look

at those, and we audit for those, because we think it is such an important piece of how we treat patients and in their care for the future.

So I believe you are right on target, and I think it is one of the most important things we could do. In fact, if we were able to focus there and really not take into account and not deliver the unnecessary services, as you talk about, at the end of life, I am not sure we would need to have so many of the conversations about which hip we might use here or what procedure we might do there because most of the dollars are going in end-of-life care when it is unnecessary.

Mr. MCDERMOTT. One of the problems that we ran into in the Affordable Care Act, we put some money in so that doctors could be reimbursed to discuss end-of-life questions with patients and would be paid for it. And it became a lightning rod for an awful lot of misinformation, I think would be the nicest way to put it.

Do you force your patients to sit down and write their final directives?

Dr. JENRETTE. It is not a forced issue. It is——

Mr. MCDERMOTT. No. It is not a forced issue.

Dr. JENRETTE. Not forced.

Mr. MCDERMOTT. It is not forced by the government?

Dr. JENRETTE. No.

Mr. MCDERMOTT. So how do you bring it up with patients in a way that makes some sense?

Dr. JENRETTE. Well, it is part of, medically, what you are doing as you are going through history, as you are looking at outcomes and what kinds of either prevention or chronic care or what are we managing here together. It is a conversation that becomes part of the regular dialogue and can be with any patient. It does not matter what age group it is.

I mean, to have that conversation, if something catastrophic happened, if you found yourself in this situation, we need to have a discussion about what your wishes would be.

Mr. MCDERMOTT. One of the things we did here in this Committee, and it frustrated me then and it still frustrates me, Sandy Levin and I put an amendment into a bill in 1990, I believe it was, that would require Medicare to give final directive information to patients when they gave them their beginning of Medicare. And then we went back a year later to find out how many had filled out those final directives.

Now, this is a country where we do not like to talk about death. We will do anything to talk about something else besides death. And so it is not surprising that only 40 percent of the people in this country have wills; that is, they have decided how their whatever their wealth is is going to be distributed when they die.

When we looked in further, we found that only 20 percent of the people who we had given these forms to had filled them out. And I am puzzled about how we, as a country, come to grips with this whole issue because my mother lived to 97 and my father lived to 93, and my brothers and sister and I have been through the process on the patient's side of the bed, try to figure out what we should do.

And my experience with it was, my father said—when we were doing with him, he said, "Well, I do not want them paddles. I have seen them things on TV, and I do not want that, that jumping on the bed." So I went to the doctor who was his physician, and he said, "Well, you know, it is really a lot less traumatic to have that than it is to have some big old intern pressing on your ribs and breaking all your ribs." So my father said, "Well, okay. If that is what you suggest, that is what we will do."

But those are not easy discussions to have. And I really think that that is one of the things that we, as a profession—I am a physician. So we as a profession are going to have to come to grips with how we deal with this among our patients. Because a lot of the waste that we are talking about, the costs are going to come down. How we do that is going to have to be as humane as possible and with the patient as the center of it, in my view.

Thank you, Mr. Chairman.

Mr. JOHNSON. Thank you. The gentleman's time has expired.

Mr. Buchanan, you are recognized.

Mr. BUCHANAN. Yes. Thank you, Mr. Chairman. And I also want to thank the committee for being here. I am excited we are talking about quality care. I am from Sarasota, Florida. In that region, we got rated as the best community, middle-sized community, in the country for quality of living.

But at the top of the list, best place to live and work, top of the list was quality health care. So it is obviously critical, what you guys do every day, and it makes a big difference. So I appreciate you being here.

Let me mention, as someone new on the panel, I have been in business for 30-some years—I am all about everybody wants to be more efficient. But when we talk about quality and efficiency, looking at that fine line, as I think about it, meeting with a lot of doctor groups and a lot of doctors generally in our area, one cardiologist told me, he said, "The last 20 years I am working twice as hard and get reimbursed half."

I get a sense with a lot of doctors that I hear this, where maybe they used to see 6 or 10 patients in an hour; now they are seeing 12 to 15. They have got more staff. So where is that fine line?

When you talk about quality health care that everybody wants—I do not think it is just about electronic health records; I think that helps us be more efficient—that fine line between that and efficiency, where does that come in? Because I hear from patients as well, where they are concerned, where the doctor is under pressure, they feel, has to get in and out and he has got 10 patients waiting.

So I would just ask the panel, do you want to comment on that? Where is the fine line between doctors working harder, making less, in a sense—and I am not sticking up for doctors, but at the end of the day that is the key to health care, in my mind—where is that fine line between providing the quality we all talked about today and the efficiency—and usually it is with that doctor's time—in terms of patients? Let's start at the end here with Dr. Riddles.

Dr. RIDDLES. Yes, sir. I agree completely. The issue is, the fine line is not where we sit down. And this is why we are talking about value-based and evidence-based, to learn where that fine line is

and then make sure that we line our reimbursement system up with that.

I think part of the reason that physicians are seeing more, moving faster, and so forth is again symptomatic of—we are reimbursed for, again, for the most part, is numbers seen, procedures done, those type of things. And that is not necessarily where the best outcomes lie.

So getting back to what we have done before is we need a system where we can see that, learn where it is, where the evidence exists, do that, and if not, then coming up with appropriate use criteria as we do learn more, sir. So that would be my sense.

Mr. BUCHANAN. Dr. Bronson.

Dr. BRONSON. I could not agree more with you. The current system of paying just for individual service at a time, and then with cut payments, leads to almost a mill mentality of pushing people through. That does not serve the patient well, it does not satisfy the doctor in their practice, and that is not the system we should have.

The system we should have is to support comprehensive care in a way that provides that value. And that is what we are talking about with the patient-centered medical home concept. The concept really leads to better care coordination, a more comprehensive look at problems, and more prevention so that you are dealing with those issues early on instead of late. There are lots of opportunities to get better.

Mr. BUCHANAN. Dr. Weinstein? And again, I want to get back to this idea. Do you sense that in practices where the doctor, when we talk about efficiency, maybe they used to, on average, spend 8 minutes and now they are down to 3, is that where a lot of this efficiency is going?

Dr. WEINSTEIN. Let me try and answer.

Mr. BUCHANAN. That is what I hear.

Dr. WEINSTEIN. Yes. And I think we can define quality. You know, we all want high quality, be that patient satisfaction, lower drug costs, less hospitalizations. And I think we can measure those things and we can report on those things.

As businessmen, our job is to try and deliver that same level of quality with the right provider in the right location at the lowest cost. That means right-sizing our offices, maybe using physician extenders for certain services that do not necessarily require the highest trained person in your business.

But yet we have to maintain the quality, the patient satisfaction, the lower drug costs. And so if we can define what we want to measure and maintain that quality and then provide it through a business model that allows us to right-size the provider to the patient's need, then we can succeed.

I think one of the things that frustrates us in business is the unknown about where the revenue is coming from, and that is the broken Medicare system. As we go from 6 months to 9 months to 12 months not knowing what the revenue is going to be, if you are in business, I do not think you have that uncertainty.

Mr. BUCHANAN. I cannot imagine what you have got to deal with, the SGR and everything.

Dr. Mandell, I want to give everybody an opportunity just to comment.

Dr. MANDELL. Yes. What you talked about, obviously, is a symptom of fee-for-service medicine. And I can only talk about orthopedic surgery. Mr. Kind was talking earlier about the fact that if we do have appropriate use criteria and clinical practice guidelines, there will be less business, so to speak, down the line.

We kind of look at it as the appropriate amount of business. And at least with regard to musculoskeletal problems, there is a tidal wave of Baby Boomers coming online with Medicare right now. So I think as we focus on doing things that really work and avoid doing things that do not work very well, at least for orthopedic surgeons, there will be the right amount of folks and the right amount of procedures done, so it will not be a real issue for us.

Mr. JOHNSON. Mr. Sharp.

Mr. SHARP. Yes. I think you have hit an important point. We believe, as you look to try to find efficient ways to run practice, there is a lot to be said for and a lot of opportunity within the multi-specialty group model.

You have got interdisciplinary teams of physicians, a lot of different specialties meshed up with primary care. And there are inherent efficiencies in the business side of the practice that can afford the physician, perhaps, more time to do more good with the patient.

And so I think also, and Dr. Bronson hit on this in his oral statement, a lot about the patient-centered medical home. And that is a team-based approach using extenders and using nurse care coordinators that are managing the population health with a team-based approach, where the physician does not have to be the one doing everything. And those are things that we think can be a part of the solution.

Mr. BUCHANAN. Doctor?

Dr. JENRETTE. I think a lot has been said about, again, the patient-centered medical home. But really, it is about the team-based approach, people working at what we call the top of their license. So the physician, rather than seeing 12, 15, 20 patients and increasing what they are doing each day, it is using other extenders within the offices. It is becoming creative, new delivery models. It is about group appointments. It is around social networking for care. It is around using case manager support. It is around using pharmacists to help them with their medications. So it is not all on the physician's desk. And so we needed teams, a multidisciplinary approach to a different delivery system.

Mr. BUCHANAN. Am I out of time?

Mr. JOHNSON. You are out of time.

Mr. BUCHANAN. Thank you. I want to thank the witnesses and thank the chairman. Thank you.

Mr. JOHNSON. Yes, sir.

I want to thank our witnesses for their testimony today. Your organizations are doing promising work to improve the quality of patient care, and this work is of great interest as we seek to reform Medicare physician payments. The fact that physician organizations have developed so many innovative clinical improvement activities gives me increasing hope that Medicare can build on these

efforts and we can find the long-term solution that has been so elusive.

I appreciate the physician leadership exemplified by our witnesses because this reform effort cannot succeed without active participation by the physician community. Together we must find a better way, and we are constantly reminded the current rate of growth in Medicare spending is unsustainable.

While I, along with many of my colleagues on the Republican side, believe we ultimately need to bring greater competition and market forces into the Medicare program in order to reduce costs, we will also continue to move forward on finding the best way to eliminate the SGR and replace it with responsible reform that provides certainty for physicians and encourages optimal patient care and outcomes.

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

And with that, this Committee stands adjourned. Thank you all for being here.

[Whereupon, at 11:41 a.m., the committee was adjourned.]

[Submissions for the Record follow:]

Association of American Physicians and Surgeons, Statement

Testimony
Committee on Ways and Means

Re: hearing on physician organization efforts to promote high quality care and implications for Medicare physician payment reform:

July 24, 2012

by Jane M. Orient, M.D.
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Thank you, Chairman Herger, Ranking Member Stark, and Members of the Subcommittee. It is a pleasure to have the opportunity to submit testimony on this important issue on behalf of the Association of American Physicians and Surgeons.

The Association of American Physicians and Surgeons is a nationwide nonprofit organization of physicians in all specialties, founded in 1943 to preserve and promote the practice of private medicine. AAPS represents thousands of physicians in all states and in all specialties and millions of American patients.

The objective of the Committee is to reduce Medicare costs while improving quality through reform of the physician payment system.

The basic problem is identified in an article I wrote for *The Wall Street Journal* on February 5, 1992, entitled "Health-Care Primer":

"Before we all drown in the details, it might help to recall the last time American politicians tried to solve a 'crisis' without confronting the core problem of price controls." I referred here to the energy crisis of 1970 in which Jimmy Carter proposed tax credits, fuel subsidies, and a hundred other gimmicks to solve a problem whose roots were price controls on oil. "The result was mass confusion, and lines at the gas pump. Then Ronald Reagan removed the price controls, and the problem went away."

Medicare price controls were instituted to try to control expenditures. These rose rapidly, not because of payment FOR service, but because of payment BY third parties.

The third-party insurer stands between the buyer and seller, disconnecting the normal free-market regulatory mechanism in which the buyer is spending his own money and the seller is competing for the buyer's "vote" on the basis of both cost and quality, i.e. the value of the service.

Every Medicare transaction is governed by a rigid system of price controls called the Resource-Based Relative Value Scale. The scale is supposed to take into account the work, time, and effort associated with the service, with some variability permitted on the basis of regional variations in practice costs—but not for skill, training, or experience of the physician or other "provider." It has nothing to do with what the practitioner is willing to accept or what the patient is willing to pay, with quality, or with mutual agreement about fairness.

As this system fails, Medicare proposes to impose an even more onerous and complex system of quality measures to "incentivize" quality.

The main incentive for physicians is the joy in making a diagnosis, skillfully performing a procedure, and helping their patients. Physicians have to be the most highly self-motivated group in America to survive medical school and rigorous years of post-graduate training.

Medicare "incentives" to perform bureaucratically prescribed tasks, which are generally regarded as irksome busywork, detract from the enjoyment of the real work. They cause demoralization rather than eagerness to work or to strive for improvement. No method has ever been described by Medicare that can make a physician more intelligent, more attentive, more compassionate, or less fallible.

It is certain, however, that non-payment for service, or payment for non-service will result in less work, not more efficient work.

How should quality be measured? There is no agreement on what exactly constitutes quality. The measures that are generally proposed are process variables, such as the percentage of patients who get a certain type of drug therapy, certain laboratory measurements, and anti-tobacco and obesity "counseling." These concern physician compliance with bureaucratically established guidelines. The incentive to perform and document these factors is a slight increase in payment that probably does not even pay for the data collection hardware, software, and work. The disincentive or punishment is a decrease in pay. Many physicians respond by decreasing the number of Medicare patients they see.

"Outcomes" (patient health measurements) are generally surrogate variables, not longevity or morbid events. These are highly dependent on patients' behavior and prior health status.

Most of the (dis)incentives in non-FFS based payment are punishments for providing "excessive" (more than average) service, or treatment that is outside the "guidelines."

We suggest that the most important outcomes are not among those proposed, and may not even be measurable: 1. Timeliness of service; 2. correct diagnosis; 3. overall improvement in patient well-being.

It is assumed that all practitioners are alike, that every service with a given code is alike, and that all patients are alike. All of these assumptions are false.

An enormous problem that added administrative demands can only worsen is the looming shortage of physicians, both by driving physicians out of practice or diverting their energies away from patients. The exodus of more than 100,000 physicians is expected by 2020. One of these physicians is Dr. Constance Uribe, who wrote a column in the July 19th issue of *The Washington Times*. Dr. Uribe is a general surgeon who has taken care of about 80% of the breast cancer patients in the area surrounding Yuma, Arizona, on the California border. She states, "Since the 1980s, my career has been riddled with regulations created by a government bent on controlling every aspect of patients' lives. The coup de grâce was delivered by the Affordable Care Act."

Electronic health records are supposed to improve efficiency and quality. Dr. Uribe quotes another physician, who wrote on a blog, "It adds an hour of time to my day and makes my office notes sound like they were written by an imbecile." Like many of her colleagues, Dr.

Uribe is not saddened by the prospect of retirement, as physicians were in earlier times, but is relieved that she will no longer have to deal with "uneducated bureaucrats and medical directors committed to pigeonholing people and withholding care."

Medicare ought to be counting physicians, administrators, and the physician-to-administrator ratio. The number of physicians has increased 100% between 1970 and 2009, but the number of administrators has burgeoned by nearly 3,000%. Any method that worsens this trend should be rejected.

As the AMA points out in its publication entitled "Guidelines Reporting Physician Data," physicians are unable to understand the data in various physician profiling programs that are supposed to influence their behavior. If physicians cannot even understand them, what good are they?

As the AMA recognizes, there is a minimal sample size of patients, opportunities, and episodes required for statistical validity. But what is not so often recognized is that attempts to compare individual practices run into insurmountable obstacles to statistical validity. First are the hazards of dealing with the small sample sizes. Even less commonly recognized is the fallacy of making multiple comparisons. If one subdivides a population according to all of the important variables, or even a small number of them, one rapidly has tiny sample sizes in each category and huge numbers of comparisons being made. It ensures that no statistically valid conclusions can be drawn.

An additional enormous problem is that although there are extremely complex formulas for calculating what "reimbursements" should be, it is virtually impossible in many instances to determine either what a service cost or what was paid for it, especially in hospitals. Thus, patients cannot make cost comparisons.

The most important change in payment methodology is direct payment by the person receiving a service, who is then reimbursed by the insurer if appropriate. All costs should be transparent. The value of quality measurements should also be assessed by patients' willingness to pay for them. It is quite likely that patients will not be willing to pay for expensive machinery to make meaningless quality measurements.

Value is ultimately determined by the person receiving the service. Where is the evidence that CMS-proposed measures are any better than patient assessment or the opinion of the physicians' colleagues, coworkers, or other patients?

Costs will never be controlled without eliminating the corruption and perverse incentives inherent in any system in which a third party is paying the bills.

There is no incentive better than competition in a free market: that is, voluntary transactions, honest pricing, and low barriers to market entry.

Congress should reject gimmicks to compensate for problems caused by previous government interventions, and instead remove the cause of the problems—interference with the free market.

Respectfully submitted,

Jane M. Orient, M.D.

Gundersen Lutheran

August 8, 2012

The Honorable Wally Herger
Chairman, House of Representatives Ways and Means Committee
Subcommittee on Health
1102 Longworth House Office Building
Washington D.C. 20515

Re: Comments on "physician organization efforts to promote high quality care and implications for Medicare physician payment reform"

Dear Chairman Herger:

We appreciate the opportunity to submit our comments to the House of Representatives Ways and Means Subcommittee on Health regarding policies that move the Medicare payment system toward rewarding high quality, low cost care. On behalf of Gundersen Lutheran Health System, we strongly support policy initiatives to move away from fee-for-service healthcare and incent value.

About Gundersen Lutheran

Headquartered in La Crosse, Wisconsin, Gundersen Lutheran Health System provides high quality health services to patients at its hospital and clinics throughout predominantly rural areas in western Wisconsin, southeastern Minnesota and northeastern Iowa. Gundersen Lutheran is an integrated, major tertiary teaching hospital, providing a broad range of emergency, specialty and primary care services and consistently ranked in the upper 5% of hospitals nationwide.

Gundersen Lutheran's approach to healthcare is to improve the health and well-being of the communities served. Through this mission, we have developed innovative ways to keep our patients healthy—and out of the hospital.

Despite carrying out our mission to keep patients healthy and out of the hospital, the current healthcare system in the United States, particularly in public programs, do not reward quality and improved health. *In fact, the fee-for-service payment system rewards volumes—the quantity of procedures instead of outcomes.* However Gundersen Lutheran continues to demonstrate *value* is not a lofty, unobtainable goal, but a reality. Through this philosophy, Gundersen Lutheran has developed a unique approach to healthcare that serves as a model to where healthcare should be.

Through our innovation and approach to outcomes, Gundersen Lutheran and the La Crosse, Wisconsin region:

- Have gained recognition by the Commonwealth Fund as one of the top 10 regions in the country for overall healthcare, based on 43 different indicators of access, quality, and overall health.

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- In addition to being recognized with top quality indicators, the Medicare Payment Advisory Commission found that La Crosse, Wisconsin region has the *lowest* utilization of healthcare services in the *nation* for Medicare beneficiaries.
- Developed and implemented a care coordination program that targets optimal utilization in our sickest patients, reducing costs by $18,000 per patient over 24 months.
- Engages with patients on end-of-life planning to ensure their wishes, goals, and desires are honored. This is an effective way to utilize healthcare resources; following the directives of patients over 99% of the time is found to save 35% of costs in the last weeks of life.
- Teamed with the business community on reducing employee healthcare costs through a unique, on-site clinical partnership with major manufacturers that has significantly reduced employee healthcare costs.

Quality and efficiency

As an integrated healthcare system, Gundersen Lutheran's approach to delivering high quality care while improving efficiency and lowering costs has gained national recognition. Consistently ranked in the top 5 percent of healthcare organizations across the country by independent rating organizations such as Thomson Reuters, the Commonwealth Fund released a report scoring the La Crosse region in the top 10 in overall care provided to our patients out of more than 300 regions across the country. The study was based on 43 indicators of access, preventative care, avoidable hospital use, and population health.[1]

Gundersen Lutheran is also conscious of the resources utilized in our public healthcare programs. The Medicare Payment Advisory Commission (MedPAC) provides research and analysis to the federal government on spending patterns and reimbursement recommendations for public healthcare programs. In their study on service utilization, La Crosse, Wisconsin was found to be the *lowest* utilizer of Medicare services in the *nation*.[2] These findings strongly indicate Gundersen Lutheran is caring for patients efficiently, using a care model that emphasizes the right care at the right time. That is why Gundersen Lutheran strongly supports public policies that move the healthcare payment system away from fee-for-service and reward outcomes and efficient use of resources. It is pivotal any reforms to the healthcare delivery system need to address quality and patient outcomes on how services are reimbursed. If this approach is not implemented, Medicare and other government subsidized insurance products will continue to misuse scarce funds and jeopardize the solvency of the Medicare Trust Fund.

Providing *value* to the patients we serve- examples of innovation

Care Coordination and the Patient-Centered Medical Home

Chronic diseases are significant drivers of healthcare costs. Gundersen Lutheran's innovative Care Coordination program guides patients with complex medical, social and financial needs through the process of healthcare, improves patient care and efficiencies, and lowers costs by helping patients manage their disease and stay as healthy as possible. We enrolled the sickest 1% to 2% of our patients who met the Care Coordination program criteria. These patients are some of our highest utilization patients. After using the Care Coordination program, patients have been shown to:

- Reduce their healthcare costs by approximately $18,000 per patient over 24 months.

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[1] The Commonwealth Fund. Rising to the Challenge, results from a scorecard on local health system performance 2012. Retrieved from http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Local-Scorecard.aspx

[2] Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Regional variation in Medicare service use. 2011. Retrieved from www.medpac.gov/documents/Jan11_RegionalVariation_report.pdf

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- Use the healthcare system more appropriately, with fewer and shorter hospital stays and more preventive care—yielding a 55% decrease in inpatient-related charges.
- Receive the assistance they need to better manage their disease as their care coordinator helps them understand their illness, physician instructions, medications, etc.
- For every dollar Gundersen Lutheran invests in the Care Coordination program, we are reducing healthcare charges for these patients by approximately $8.

Gundersen Lutheran is also pursuing National Committee for Quality Assurance (NCQA) status for certification as a Patient Centered Medical Home (PCMH). A PCMH is a care delivery model focused on primary care, where a patient is tracked by a team of professionals to ensure optimal levels of service utilization. Becoming a PCMH serving our rural service territory in Wisconsin, Iowa, and Minnesota will serve as a means of promoting continued value to our patients. In tandem with care coordination in chronically ill patients, the PCMH will improve the patient relationship with primary care providers to ensure needs are effectively met and the right care is delivered.

Advance Care Planning

As life expectancy has increased, so too have the multiple complications associated with chronic illness in the last years of life. Gundersen Lutheran leads the nation with an innovative advance care planning program, known as *Respecting Choices,* that provides the right healthcare to patients at the end stages of their lives. Featured on *Good Morning America, New York Times,* and *Washington Post,* our system improves continuity of care and quality of life while maintaining respect for patients' wishes. Understanding and honoring patients' wishes at the end of life is paramount to ensure they are receiving appropriate care that is aligned with personal choice and goals. This program was highlighted in a recently released book *Having Your Own Say, Getting the Right Care When It Matters Most,* edited by Gundersen Lutheran's Bernard Hammes and introductions by Senator Mark Warner and former Governor and Secretary Michael Leavitt.

Honoring patient desires and wishes at the end-of-life is an effective use of healthcare resources, and reduces the burden on family members that would otherwise have to make those difficult decisions. In La Crosse, 99.4% of patients at the end-of-life have an advance care plan easily accessible in their medical record, [3] compared to the national average of fewer than 50%.[4] Further research indicates following a program model similar to *Respecting Choices* by engaging with patients on their end-of-life care and following their wishes and desires reduces healthcare costs by 35%.[5]

Conclusion

Departing from the archaic fee-for-service payment system in Medicare is crucial to bending the cost curve of healthcare and achieving true health reform. With an incentive to provide volumes of care instead of value, Medicare costs will continue to substantially rise with lack of accountability. Gundersen Lutheran continues to demonstrate initiatives that are in the patient's best interest, but are counter to the economics of healthcare reimbursement that ultimately discourages such practices. As the largest payer of healthcare, we believe Congress taking an active role in public

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[3] Hammes BJ, Rooney, GL, Gundrum, JD. A comparative, retrospective, observational study of the prevalence, availability, and specificity of advance care plans in a county that implemented an advance care planning microsystem. Journal of American Geriatric Society 58:1249-1255, 2010.

[4] Kass-Bartelmes BL, Hughes R, Rutherford MK. Advance care planning: preferences for care at the end of life. Rockville (MD): Agency for Healthcare Research and Quality; 2003. Research in Action Issue #12. AHRQ Pub No. 03-0018.

[5] Zhang B, Wright AA, Huskamp HA, Nilsson ME, Maciejewski ML, Earle CC, Block SD, Maciejewski PK, & Prigerson HG. Health care costs in the last week of life: associations with end-of-life conversations. Arch Intern Med 169(5):480-488, 2009.

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programs to achieve robust reforms in the Medicare payment system will transform our healthcare delivery system.

We appreciate the opportunity to comment. Please feel free to contact me with any questions.

Sincerely,

Michael Richards
Executive Director
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July 26, 2012

Comments for the Hearing Record: *"Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform"*

Dear Chairman Herger and Ranking Member Stark,

The American College of Gastroenterology (ACG) appreciates the opportunity to offer comments and recommendations in response to the Health Subcommittee's hearing entitled *"Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform"* held on July 24, 2012. ACG also expresses its thanks for holding a hearing on an issue that is so important to our membership.

ACG is a physician organization representing gastroenterologists and other gastrointestinal specialists. Founded in 1932, our organization currently numbers over 12,000 physicians among its membership of health care providers of gastroenterology specialty care and we focus on the issues confronting the gastrointestinal specialist in treatment of patients. The primary activities of ACG have been, and continue to be, promoting evidence-based medicine and optimizing quality of patient care.

As Congress seeks a permanent solution to the flawed price controls inherent in Medicare's Sustainable Growth Rate (SGR) formula, and moves forward with reforms to the structure of Medicare Fee-for-Service (FFS) physician reimbursement, it will be critical to ensure that a commitment to preventive services is maintained and new payment systems are tied to performance on quality metrics that are supported by physician specialty societies and a wide cadre of providers. Congressional efforts to reform and improve Medicare FFS reimbursement for physicians should recognize the importance of designing a Medicare payment model based in part from the input of medical organizations and specialty societies—and the Committee has taken an appropriate, thoughtful path in seeking recommendations from physician organizations during its deliberations on possible alternatives and improvements to the current Medicare physician reimbursement model.

ACG would like to stress to the Committee that the SGR formula is based on a flawed presumption that Medicare providers actually have substantial influence over the various components in the formula itself, including: the estimated changes in reimbursement for physician services (determined by Medicare or other *payers* of health care services), the estimated change in beneficiaries enrolled in the Medicare FFS program, the estimated per capita growth in the U.S. gross domestic product (GDP), and the estimated change in expenditures due to any revision in federal law or regulation. Yet, physicians are scheduled to receive devastating cuts in Medicare reimbursement rates as a result of the SGR formula—a 27% reduction for services provided after January 1, 2013.

ACG stands ready to work with the Committee on Ways & Means, and other Members of Congress, in developing a Medicare physician payment structure that more appropriately rewards quality care and outcomes, and moves away from a purely volume-driven payment structure – but that also provides stability and certainty to physicians and Medicare patients.

Quality Measurement

A wide range of experts, including the Medicare Payment Advisory Commission (MedPAC), the Institute of Medicine (IOM), and the Government Accountability Office (GAO), have urged Congress and the Centers for Medicare and Medicaid Services (CMS) to adopt Medicare provider payment policies that more adequately link payment levels to performance on a range of quality measures. ACG agrees on this point. Adherence to best practices and physician cognizance of quality indicators are improved through quality measurement and tying physician payment levels to the quality of care provided. By fostering this connection between payment and quality of care, patient outcomes can improve as a result—which should help lower the growth rate of Medicare expenditures over the long-term. The continued improvement and development of both the Physician Quality Reporting System (PQRS) and the value-based payment modifier within the Medicare Physician Fee Schedule (PFS) represent important first steps in a move towards payment for quality. However, both of these physician payment components should fully encompass the specific best practices and quality measures that can be applied to specific physician specialty services.

Quality Improvement Registry: GIQuIC

As an organization, ACG also uses these evidence-based guidelines in its own programs. An example of this is the GI Quality Improvement Consortium or "GIQuIC" which is the largest clinical quality improvement registry in gastroenterology. The project was developed as a non-profit educational and scientific partnership between ACG and the American Society for Gastrointestinal Endoscopy (ASGE). The GIQuIC registry was developed to capture quality indicators for GI procedures and disease management.

These indicators are outcome-based measures pertinent to clinical gastroenterology and help ensure the patient receives the most accurate and cost-effective colorectal cancer screening exam. GIQuIC started with colonoscopy measures as colonoscopy is by far the most common procedure performed by gastroenterologists generally and Medicare in particular. Other key procedures such as upper endoscopy and disease management issues such as inflammatory bowel disease (IBD) and Hepatitis C will also be added to the registry shortly.

GIQuIC participants volunteer their time at a substantial financial cost to their practice in order to improve patient care. Participants upload blinded patient data to the registry, and in return, receive access to reports on their own performance as well as the ability to compare themselves to national standards and other participants in the registry – *all on a real time basis*. These comparisons include provider type, facility type, geographic regions, and a myriad of other data points.

The GIQuIC registry was also developed to be easily incorporated into the electronic health records commonly used by gastroenterologists called endoscopy writers or "endowriters" as well as other electronic health records. This ability to electronically transmit all patient records for key physician/patient interactions has been a critical element to easing integration of registry participation into clinical practices. It also allows all cases to be included, thus avoiding the cherry-picking of cases to report, as well as other data reliability problems that are often associated with claims based data collections.

Congress and CMS could establish a quality-based payment system with quality measures that distinctly apply to different areas of the practice of medicine by partnering with clinically–focused physician organizations that develop specialty-specific quality improvement measures. This improved specificity in quality measurement would allow the payment system to more accurately assess the quality of care provided within each specialty practice area, and more appropriately reward physicians based on quality performance. Physician and medical societies' input is essential to assessing and defining "high quality of care."

Additional Benefits of Registries

It is important to note the utility of the data that registries could provide Medicare and Congress when assessing programmatic costs. As an example in our specialty, according to CMS statistics, more than 250,000 screening colonoscopies for average-risk Medicare beneficiaries (not at high-risk for colorectal cancer) were performed in 2010 and totaling over $50.6 million in Medicare reimbursement to providers.[1] However, a study published in May 2011 looked at a sample of 24,000 screening colonoscopies in Medicare from 2001-2003. The authors found that over 20% of this sample had repeat screenings before recommended guidelines (10 years for the average-risk patient) with no justifying explanation.[2] While there may be legitimate clinical reasons for these repeat examinations, registries capturing this information provide Medicare with helpful data to assess the issue and be a good steward of taxpayer dollars while also helping to make well-meaning physicians and their practices more aware of practice patterns that can get lost in the midst of a high pressure, busy practice environment. Registries like GIQuIC can also assist in identifying gaps among beneficiaries who may not be receiving the preventive care for their own benefit as well as to the benefit of the Medicare program by mitigating the growth of extremely high cost drivers, such as cancer treatment and end of life costs.

Alternative Payment Models

Accountable Care: Maintaining Independent Clinical Judgment

If Congress moves forward with a transition away from traditional Medicare FFS reimbursement, the new value-based payment model must ensure that quality is not sacrificed in the name of cost control. ACG holds concerns that under the accountable care organization (ACO) payment model, "cost control" may eclipse "improving quality" as the primary objective of care. Global expenditure limits per beneficiary can foster dangerous, large institutional cost control pressures that could impede a physician's clinical judgment in certain instances, when deciding what is best for the patient. The maintenance of independent clinical judgment is paramount.

Payment Bundling: Options for Savings

Additionally, while there has been some enthusiasm regarding the development of "bundled payments" across care settings for Medicare services related to a particular "episode of care," payment bundling is not a panacea to Medicare's cost-growth problem. Episode-based payment bundling for hospital services—under Medicare Part A's diagnosis related group (DRG) payment structure—has not curbed cost-growth for hospital services, and this payment system can have a negative impact on care quality. Also, unlike the inpatient hospital setting where the care is performed under one roof or campus, payment bundling in Medicare Part B may prove difficult especially when an "episode" of care is extended across multiple independent practices or over an extended period of time. However, there may be an opportunity to find savings in Medicare Part B via payment bundling depending upon the definition of the outpatient "episode." For example, by bundling a payment for colonoscopy to include the fee for the underlying procedure, as well as the anesthesia or related services that are currently billed separately by others, our members may help to control costs and save the Medicare system money.

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[1] CMS Medicare Part B Summary File; 2010 Payment Claims. http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/NonIdentifiableDataFiles/PartBNationalSummaryDataFile.html

[2] James S. Goodwin, MD; Amanpal Singh, MD, MS; Nischita Reddy, MD; Taylor S. Riall, MD, PhD; Yong-Fang Kuo, PhD Arch Intern Med. Published online May 9, 2011. doi:10.1001/archinternmed.2011.212

Focus on Proven Prevention

Any new payment structure will need to retain reimbursement incentives for physicians to provide clinically proven preventive services, as proper utilization of these services provide us with the best chance to reduce the prevalence of chronic conditions and prevent or limit the severity of certain deadly diseases, including colorectal cancer, over the long-term.

The *Supporting ColoRectal Examination and Education Now" (SCREEN) Act* (H.R. 3198), as introduced by Ways and Means Committee Member Rep. Richard Neal (D-MA), would foster increased adoption of best practices and quality care in common colorectal cancer screening procedures and make an important commitment to outcomes-based Medicare reimbursement for colorectal screenings contingent upon a provider's participation in a nationally recognized quality improvement registry measuring the physician's performance based on well-developed colorectal cancer screening quality metrics, H.R. 3198 would adjust payment policy for common colorectal cancer screening procedures, like colonoscopies.

H.R. 3198 is an example of moving the Medicare reimbursement system to a more value-based purchasing model that not only ensures providers are demonstrating a high quality of care, but Medicare providers also are rewarded for taking the initiative to improve the quality of their clinical work in performing screening procedures. Finally, without proper incentives for patients to seek out appropriate and high quality health care services, especially proven preventive services, there is little incentive to help slow the cost curve of Medicare spending.

A Role for Patients/Beneficiaries

Of course, a critical element in any prevention effort within fundamental delivery reform is patient responsibility. This cannot be overemphasized. There is no one more important to the health and well-being of patient and taxpayer than themselves. However, without proper incentives for patients to seek out appropriate and high quality health care services, especially proven preventive services, there is little incentive to help slow the cost curve of Medicare spending. This is especially important should Congress decide to move toward more care-coordination or shared-savings models. Even the most efficient care-coordination model has little control over a Medicare beneficiary's health care services if the beneficiary is neither price-sensitive nor willing to stay within the system. While ACG recognizes the difficulty in convincing constituents that there is a trade-off between cost and choice in these models, ACG urges the Committee to consider patient responsibility reforms if it intends to further develop more care-coordination or accountable care initiatives.

A beneficiary that has easily accessible, patient-friendly information on quality and services is better educated and more cost-conscious. One tactic employed in association with the GIQuIC registry is to allow participating physicians and their practices to publicize their participation in the quality registry in the various ways that our physician members interact with their patients, prospective patients, and referring physicians. In previous comments to CMS regarding the Medicare "physician compare" website, ACG has recommended that CMS include on the "physician compare" website useful information pertinent that the provider's scope of practice such as participation in a quality improvement registry and other types of credentials or awards that the beneficiary may find useful when seeking health care services.

The Path Forward

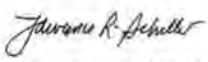
While the Congress faces significant challenges in developing Medicare physician payment reform models that balance the goals of moving toward value-based payment with the need to provide equitable reimbursement, the Committee's broad approach to gather input from physician stakeholders is a critically important first step. Congress must eliminate the SGR formula and its draconian reductions in Medicare physician reimbursement, in

order to ensure certainty to physicians participating in the Medicare program and to provide continued access to physician care for Medicare beneficiaries.

Over the longer term, the establishment of an alternative Medicare physician payment model should avoid repeating the mistakes of the SGR, and resist temptations to apply global caps on per beneficiary expenditure levels. Instead, lawmakers should build on the development of quality measurement systems and quality-linked payment adjustments in the Medicare system, while also encouraging the utilization of proven preventive services via coordinated approaches to incentivize preventive care through physician payment rates and through reductions in beneficiary cost-sharing.

ACG appreciates the Committee's thoughtful requests for physician input during these important deliberations and is eager to assist the Committee in any way. If you have any questions or would like to discuss further, please contact Brad Conway, Vice President of Public Policy, Coverage & Reimbursement at 301.263.9000 or bconway@gi.org.

Sincerely,



Lawrence R. Schiller, MD, FACG
President
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Comments for the Record

U.S. House of Representatives

Committee on Ways and Means

Subcommittee on Health

Hearing on Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform

July 24, 2012, 10:00 AM

by Michael G. Bindner

The Center for Fiscal Equity

Chairman Herger and Ranking Member Stark, thank you for the opportunity to submit my comments on this topic. This hearing allows us to highlight comments made last month on the implications of physician payment reform.

As I stated in our last comments:

> In April of 1998, (my) father, Jim Bindner, had a heart attack, due in part to either an undetected acute episode of diverticulitis (which was not detected until autopsy) and in part to a lack of oxygen resulting from successful radiation treatment for metastatic lung cancer. Had this attack occurred today, there is a chance that advances in emergency medicine, including cooling of the patient, might have resulted in a successful outcome. This strategy, however, did not exist in 1998 and is still not widely practiced. As a result, resuscitation was incomplete and Mr. Bindner was left in a coma in intensive care for almost a week before he passed.

Since these comments were made, my mother was the victim of a gas leak when her foundation shifted. Neighbors found her, roused her and moved her to safety and all was looking well until she collapsed with no vital signs once paramedics arrived. This began two days of intensive care after she was revived in the ambulance, but never regained consciousness. She died two days later when we removed life support because no measurable brain function could be detected, even after cooling was tried.

The relevant question remains as it did in my father's case, what would a results based medicine scenario pay for in situations such as this? Would the government have forced Mercy Medical Center to simply eat the costs? If so, would there have been pressure from the hospital to end care sooner? Would the alternative have been a copayment for these services for the family?

Worse yet, would someone have forced the choice on my siblings and I to either agree to payment or discontinue life support earlier to save cost? These are the questions that such modalities as results based payment bring forward loud and clear and they will hit every family with children of a certain age. This is not the specter of the death panel. It is something much worse – a demand to agree to pay or make a tragic decision at the most difficult time in anyone's life.

While some families could, of course, afford to pay for greater end of life services, the prospect that money might by longer life, or a greater chance for miraculous recovery to occur, would turn such care from what is now a right to a commodity. The Center for Fiscal Equity and my family find this unacceptable.

In fee for service medicine, this choice is simply not required. Certainly the richest society on the planet can afford to allow women facing imminent widowhood to avoid such heart breaking choices if possible. Recent reforms have essentially turned the Medicare Part A Payroll Tax into a virtual consumption tax already by taxing non-wage income above $250,000 a year. It would be as easy to shift from a payroll tax to a value added or VAT-like net business receipts tax (which allows for offsets for employer provided care or insurance) and would likely raise essentially the same amount of money, as most non-wage income actually goes to individuals now liable for increased taxes. If a VAT system is used, tax rates can be made lower because overseas labor will essentially be taxed, leaving more income for American workers while raising adequate revenue.

Premium support systems would not have any impact at all on end of life care decisions, except to the extent that they lead to cost cutting and the kind of choices mentioned above that we can all hopefully agree are abhorrent. Ultimately, this negates much of the cost savings that could come from premium support, so this idea should be dropped.

A single-payer catastrophic plan would guarantee payment by the widow of any difference between the catastrophic deductible and the accumulated health savings account. This, again, is the last thing any widow should have to face, even if the survivors have adequate insurance.

Replacing payroll taxes with Value Added Tax (VAT) funding will have no impact on whether fee for service medicine at the end of life continues, except for the fact that more adequate funding makes the need to save costs less urgent.

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related.

Thank you for the opportunity to address the committee and share what many of my generation regard as very real concerns, both as our parents age and we approach that stage of life where such decisions may apply to us. I am, of course, available for direct testimony or to answer questions by members and staff.

Contact Sheet

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Committee on Ways and Means
Subcommittee on Health

Hearing on Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform

July 24, 2012, 10:00 AM

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.

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