DEVELOPING A VIABLE MEDICARE PHYSICIAN PAYMENT POLICY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED THIRTEENTH CONGRESS

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DEVELOPING A VIABLE MEDICARE PHYSICIAN PAYMENT POLICY

TUESDAY, MAY 7, 2013

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

The Subcommittee met, pursuant to notice, at 10:06 a.m. in Room 1100 Longworth House Office Building, the Honorable Kevin Brady [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 30, 2013
No. HL-03

CONTACT: (202) 225-3943

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

House Ways and Means Health Subcommittee Chairman Kevin Brady (R-TX) today announced that the Subcommittee on Health will hold a hearing examining options for repealing the Sustainable Growth Rate (SGR) formula and reforming the Medicare physician payment system to reward quality and value. Determining the details of such a system requires close collaboration with physicians and other stakeholders. The Subcommittee will hear from organizations representing those at the forefront of patient care to inform the development of a viable, enduring reform policy that results in high-quality beneficiary care. **The hearing will take place on Tuesday, May 7, 2013, in 1100 Longworth House Office Building, beginning at 10:00 A.M.**

In view of the limited time available to hear the 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.

BACKGROUND:

Medicare currently reimburses the great majority of physicians on a fee-for-service (FFS) basis. While the physician fee schedule takes into account the work, time, and other costs that go into furnishing each service, it does not account for the quality and efficiency of the care provided. Further, the mechanism used to annually update fee schedule payments—the SGR formula, which limits spending growth to growth in the economy—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 need to incentivize high-quality, outcome-oriented care.

The Subcommittee held three hearings on improving the Medicare physician payment system in the 112th Congress. These hearings provided important information on private payer efforts to reward high quality, efficient care and physician organization programs to drive quality improvement and facilitate participation in new payment models. This information provided a

framework for which a Medicare physician payment reform can be constructed. A dialogue with physician and other stakeholder organizations has continued in the 113th Congress, with the Subcommittee receiving constructive input. On-going engagement is needed to develop a viable replacement payment policy.

In announcing the hearing, Chairman Brady stated, **"Reforming Medicare and eliminating the unworkable SGR formula is necessary to ensure our seniors have access to a strong Medicare program. This year we have an opportunity to repeal the SGR, provide predictability for physicians and ensure seniors can see their local doctors. While the timing is ripe for action, we need to be sure we get the policy right. My hope is that we can put the days of kicking the SGR can down the road behind us. This hearing will enable the Subcommittee to hear from stakeholders with experience and ideas on how to craft a policy that is fair, reliable and fiscally responsible."**

FOCUS OF THE HEARING:

The hearing will focus on physician and other stakeholder input on how to best reform the Medicare physician payment system.

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 Tuesday, May 21, 2013**. 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 BRADY. Good morning, everyone. The subcommittee will come to order. I want to welcome everyone to today's hearing on addressing the broken Sustainable Growth Rate formula by which the Federal Government reimburses our local doctors for treating Medicare patients. While this is our third hearing, the SGR has been the focal point of the first two, as well.

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

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

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

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

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

physicians to voluntarily opt for alternative payment models if they better meet their needs.

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

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

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

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

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

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

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

[No response.]

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

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

[Laughter.]

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

The Sustainable Growth Rate Formula is fundamentally broken. As Congress acted to override the formula's cuts, the hole has been

dug deeper every year. And, let's be honest, no one ever expects that we are going to cut 30 percent in fees. But the uncertainty promotes profound discomfort and instability in the system.

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

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

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

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

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

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

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

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

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

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

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

Dr. Hoyt, we will begin with you.

STATEMENT OF DR. DAVID HOYT, EXECUTIVE DIRECTOR OF THE AMERICAN COLLEGE OF SURGEONS

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

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

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

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

riod of stability. Such stability will allow physicians to make necessary capital investments in their practices to move to a value-based system.

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

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

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

In our century of experience, the college has learned that the real cost savings are best realized from coordinated care. Numerous elements of the committee's proposal relative to performance measurement are strictly specialty or service-based. In contrast, our VBU proposal, which centers on clinical affinity groups, breaks down the silos of physician care. The CAGs, which have collective quality and performance measures, are designed to be inclusive of multiple specialties working in concert to treat the patient.

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

Finally, the college believes it is incumbent upon every physician and health care provider to commit to being a responsible steward of the nation's health care resources. Physicians and other pro-

viders will work together to achieve cost savings with—and those savings cannot be constrained by the current financing silos of the Medicare program. As physicians work to bring costs down, those savings should be accessible to those who are achieving the savings, whether in Parts A, B, C, or D.

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

Chairman BRADY. All right. Thank you, Dr. Hoyt.

[The prepared statement of Dr. Hoyt follows:]

AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING TUESDAY, MAY 7, 2013 AT 10:00 AM

Statement for the Record

American College of Surgeons

Hearing before the House Ways and Means Health Subcommittee

U.S. House of Representatives

On

Developing a Viable Medicare Physician Payment Policy

May 7, 2013

Thank you Mr. Chairman, Ranking Member McDermott, and members of the committee. I am David Hoyt, executive director of the American College of Surgeons. On behalf of the more than 79,000 members of the College, I am pleased to be here today to discuss the reform of the Medicare physician payment system and to highlight some challenges moving forward that are described in greater detail in the College's February and April response letters to the joint Ways and Means and Energy and Commerce Committees' SGR Proposal, which I would like to submit for the record.

The College appreciates the committees' continued commitment to address the complex problems facing Medicare's physician payment system and applauds your work and inclusiveness.

In our February letter, the College outlined our Value Based Update (VBU) proposal to reform the physician payment system. We believe that any new payment system must be based on the complementary objectives of improving outcomes, quality, safety and efficiency while simultaneously reducing the growth in health care spending. The VBU proposal is based on the College's 100 years of experience in creating programs to improve surgical quality and patient safety, such as the National Surgical Quality Improvement Program (NSQIP). We have learned measuring quality improves patient care, increases the value of health care services, and reduces costs. The savings gained are the direct result of improving quality outcomes.

I will go into greater detail on the Joint Proposal below, however I would like to initially highlight some key points. We agree with the Joint Proposal that a full repeal of the SGR and a period of payment stability are prudent first steps in reforming the system while longer term reforms are developed, tested, and phased in over several years.

The College believes that the Phase One period of payment stability should be five years. If we are to move to a value-based system, it is imperative that we make sure the payment models and quality measures, which will serve as the backbone of the new system, are properly aligned and that will take some time.

The College urges Congress to provide statutory payment rates tied to inflation during the period of stability. Such stability will allow physicians to make the necessary capital investments in their practices to move to a value-based system.

In Phase Two of the Joint Proposal, the College believes that the most critical component to successfully establishing a base payment rate tied with a variable rate is that it incentivizes high quality care and does not just function through a withhold. Providers willingly take on risk based on performance - associated with the variable rate - must first see a starting base rate at an appropriate level to cover the work and expenses required to provide necessary care. We believe that the base payment rate should be based upon its market value at the end of five years of

stability. The College further believes that once the starting base rate is appropriately determined, subsequent base rates should account for the increased cost of providing care by increasing with inflation.

It is crucial that the variable rate not only require a level of risk by physicians that may result in reduced payment, but that it also contains a level of reward, with increased payment, for those physicians who achieve the highest quality care. The cost savings we have seen through our quality programs are in the money saved by improved outcomes.

In our experience, the College has found that offsetting higher variable payments to those physicians who perform well with lower variable payments to those who do not perform well does not serve the value-based proposition. We believe the variable rate should be determined as to whether a physician meets a specific performance threshold. For the new system to flourish, we must encourage those high performers to share their techniques with those who do not meet the performance threshold. Whether a physician experiences an increase or decrease from the base rate should be determined by performance compared to standards or thresholds known in advance, not on changing and unknown performance relative to peers or any scheme that by its design would guarantee that a set of physicians would lose. The standards and thresholds could be set considering the most recent past performance, including performance compared to peers. We would like to emphasize that a zero-sum, budget neutral scoring methodology for the variable rate could significantly hamper collaborative care, the sharing of best practices among providers, and hinder our ability to recognize all possible savings.

In our century of experience, the College has learned that real cost savings are best realized from coordinated care. Numerous elements of the committees' proposal related to performance measurement are strictly specialty or service–based. In contrast, our VBU proposal, which centers on clinical affinity groups (CAGs), breaks down the silos of physician care. The CAGs, which will have collective quality and performance measurement goals, are designed to be inclusive of multiple specialties working in concert to treat a patient.

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

The College believes it is incumbent upon every physician and health care provider to commit to being a responsible steward of the nation's health care resources. Physicians and other providers will need to work together to achieve cost savings and those savings cannot be constrained by the

current financing silos of the Medicare program. As physicians work to bring costs down, those savings should be accessible to those who are achieving the savings, whether in Parts A, B, C or D of Medicare.

Our more specific comments on the Joint Proposal are organized below according to the phased implementation presented in the committees' second draft and our full detailed comments can be found in our February and April response letters.

Phase One

As stated above, the ACS strongly supports immediate repeal of the SGR and elimination of the 24.4 percent across-the-board cut slated for 2014 as well as any future SGR cuts. Neither the current SGR formula nor any modified version of the SGR should be used to determine the physician payment update in any future year. The SGR methodology is fundamentally flawed and is no longer an effective approach to determine physician payment updates and encourage efficient, high quality care.

The ACS endorses the committees' proposal to establish stable, predictable fee schedule updates that are set in statute for a period of time sufficient to develop and implement the Phase Two measures and processes that will promote high quality, efficient care through a reformed payment system. We believe that this period of payment stability should be for five years during which physician specialties and other stakeholders will develop the quality and efficiency measures as well as clinical improvement activities that are the key to Phase Two and Phase Three of the proposal. This stable period also will enable providers to prepare for the future payment changes and to assess the applicability of private sector and Medicare alternative payment models as they make their individual decisions.

The ACS urges that the statutory payment rates during this period of stability provide for a very modest increase in payment rates, such as 1.0 percent a year. Continuation of a payment freeze would fail to recognize the fact that physician rates have increased only 4.1 percent cumulatively over the eight years 2005-2013 despite an increase of 12.8 percent in the cost of providing care as measured by the Medicare Economic Index (MEI).[1] Physicians cannot afford to see payment rates frozen while the cost of providing care escalates.

Phase Two

In Phase Two, the committees propose that payment rates be based in part on the quality of care provided to beneficiaries using an Update Incentive Program. Payment rates would be determined by a base rate and a variable rate tied to performance with providers having three alternative ways to receive credit that would determine their variable, performance-based rate:

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[1] Source: Office of the Actuary, "Estimated Sustainable Growth Rate and Conversion Factor for Medicare Payments to Physicians in 2014," dated 4-13-2013

- score on quality measures relative to their peers;
- significant improvement in their own quality score from the previous year; or
- executing clinical improvement activities.

Quality measures are to be risk-adjusted for severity of illness so that providers are not penalized for treating sicker or more complicated patients. Providers also would be allowed to choose whether the assessment of their quality occurs at the individual or group practice level.

The ACS generally supports the changes included in Phase Two and believes they will lead to a physician payment system that promotes the quality and efficiency sought by providers, payers and patients. We are pleased that in many respects, the approach complements ideas advanced by the ACS and other specialties. A critical element determining the acceptability of this approach for physicians, however, is the level of the base rate. The base rate must be set at an appropriate level to cover the work and expenses required to provide the service, with the variable rate applying adjustments, plus or minus, depending on performance. Thus, the base rate should be determined by a conversion factor that continues to provide for very modest annual increases similar to the Phase One period of stability; at the very least, the base rate in phase two should provide a zero percent increase to which upward or downward adjustments are applied by the performance-based variable rate.

The ACS strongly opposes a system in which rates are cut up front – perhaps significantly – for all physicians with any gains toward a zero update or rate increase based on performance. We believe that access, equity and performance incentives as well as physicians' acceptance of the payment reforms all would be enhanced by establishing a reasonable base rate and adjusting that rate up or down based on performance. Importantly, we agree that poor performance should lead to lower payment rates and would support reductions from the base rate for inadequate performance.

The ACS strongly opposes a performance-based variable rate methodology in which physicians can earn additional payments only to the extent that other physicians lose. The performance-based rate should not be budget neutral but should be based on performance standards or thresholds established before the beginning of the period during which performance is to be assessed. Each physician or provider's variable rate adjustment would be determined based on performance compared to the standard or threshold. Whether a physician experiences an increase or decrease from the base rate should be determined by performance compared to standards or thresholds known in advance, not on changing and unknown performance relative to peers or any scheme that by its design would guarantee that a set of physicians would lose. The standards and thresholds could be set considering the most recent past performance including performance compared to peers (for example median performance), perhaps with an increase assumed for improvement based on empirical trend data. The ACS notes that a zero-sum, budget neutral scoring methodology for the variable rate adjustment could significantly hamper collaboration, cooperation and the sharing of best practices among providers.

The ACS recommends that each provider's performance score would equal the highest value earned among these three options, which are similar to the options identified in the committees' proposal:

- performance on quality measures relative to the standards and thresholds set by the Secretary and published in advance;
- significant improvement in their own quality performance from the previous year; or
- executing clinical improvement activities, as discussed below.

Similar to the hospital value-based purchasing system, a physician or other provider would receive a score under each of the three alternatives with the highest score being designated as the determinant performance score that is used to calculate the variable performance rate.

The ACS urges that the legislation direct the Secretary to phase in the standards and thresholds used to determine the variable rate portion of the update. For example, initially the standards could be set and performance measured for a category of physicians rather than requiring individual practices to satisfy specific standards. Numerous elements of the committees' proposal are specialty or service based in contrast with the ACS VBU proposal, which centers on clinical affinity groups (CAGs), as described in detail in our February 25 letter. We recommend that the committees include CAGs, at least as an additional option. We believe that clinical affinity groups have a great potential to improve outcomes and efficiency because they would encourage collaboration across specialties. Using the CAG concept, the portion of a physician practice's services included in the definition of the CAG would receive a quality score based on the score earned by the CAG, which in turn would be determined by the quality performance of all of the services falling within the CAG across all of the physicians in the CAG irrespective of specialty. Physicians would self-designate the CAGs in which they would participate and could participate in multiple CAGs representing the various portions of their patient mix or clinical services. The ACS also supports allowing providers the option to have their assessment of quality be based on individual or group practice level.

The ACS is concerned about accurately measuring quality performance for small practices and urges the committees' legislation to require the Secretary to study options for addressing the problem working closely with providers and to report to Congress on the options studied and the agency's recommendations.

The committees' proposal directs the Secretary to ensure that providers receive timely feedback to enable them to assess their quality score relative to their peers during the performance period, but it does not specify how this might happen or what the lag time will be between the performance period and application of the results to the payment rate. Timely feedback will give physicians the ability to optimize their incentive payments. The ACS believes that the lag between the performance and payment periods should be no longer than six months and that quarterly feedback should be provided. For example, for physician payments beginning in

January, the 12-month performance period could end the previous June 30. Feedback could be required to be given 60 days after the end of each calendar quarter for the accrued portion of the performance period. The ACS supports the committees' proposal to allow providers the opportunity to review their results before they are used to determine the update incentive payment (UIP) as well as to request reconsideration or to appeal the UIP determination.

With respect to risk-adjustment, the ACS believes that all outcomes measures must be risk adjusted to avoid incentives that could discourage physicians from treating high risk, sicker or more complex patients. It might also be necessary to risk adjust certain process measures to assure equity and access, or to carefully define the type of patients, with appropriate exclusions, to which a process measure would apply. As the committees' proposal envisions, these types of details will need to be developed over the next few years, during the period of stability, working closely with physicians and other stakeholders. We strongly support the approach that the Secretary will work with provider organizations to establish the quality measures and clinical improvement activities on which provider performance will be assessed in Phase Two.

Concerning measure development, the ACS is concerned that there be sufficient measures to represent all specialties and the scope of services that they provide. To help fill gaps in the currently available measures, we urge the committees to include in their legislation funding and other provisions, such as directing the Secretary to commission measure development from appropriate entities as necessary to ensure an adequate and equitable set of measures across specialties. We do not believe that the Secretary should be authorized to adopt unendorsed measures to fill gaps except in conjunction with the relevant specialties. We understand and support the need for flexibility as measures are developed for different clinical areas, but we are concerned about establishing and maintaining consistency across specialties and avoiding competing measures promoted by different specialties. The Secretary should be directed to work with providers and other stakeholders and with national consensus organizations to minimize these problems.

In addition to working with provider organizations and consensus organizations such as the National Quality Forum (NQF) in the development of the quality measures and clinical improvement activities, the Secretary should be required to establish all measures, improvement activities and performance standards through notice and comment rulemaking. Finally, measures and clinical practice improvement activities should be updated and improved on an ongoing basis, although we believe that an annual review of all measures could be burdensome and is not necessary. Instead, CMS (with input from providers and other stakeholders) should review the latest scientific evidence to consider adding new measures and refining or dropping existing ones as needed to enhance the value of the quality measurement system for providers, patients and payers.

In addition, ACS is concerned that the committees' proposal on measure development could lead to potential conflict between measures that go through the NQF process and those that use the

proposal's suggested non-NQF process. ACS recognizes that there are challenges with the NQF approval process and it has led to frustration among specialties and physicians. However, with the possibility of multiple consensus groups approving measures, there exists the real possibility that physicians could be compared to each other while not pursuing the same measure set.

The committees' proposal directs the Secretary to solicit clinical practice improvement activities from providers and to determine a menu of activities from which providers can select. The menu is to include activities relevant to all providers and must at a minimum include several categories identified in the proposal. The ACS supports the recognition of clinical practice improvement activities for the purpose of earning credit for the variable rate portion of the payment update but is concerned that one of the suggested categories is too narrow as described. Specifically, the category of targeted utilization of patient registries for chronic conditions should be expanded to include other registries such as the ACS National Surgical Quality Improvement Program (ACS NSQIP). Also, "enhanced access to comprehensive and timely care that is delivered in the least intensive and most appropriate setting based on patient needs" requires that appropriate setting be clearly and carefully defined.

The ACS believes that the National Surgical Quality Improvement Program (NSQIP) should be recognized in the legislation as qualifying participants for quality incentive credits. NSQIP is a powerful tool for quality improvement and was named "Best in the Nation" by the Institute of Medicine (IOM). Advantages of ACS NSQIP include:

- Collects data from the patient's medical chart instead of insurance claims that are shown to have limited information for quality purposes;
- Is risk-adjusted, meaning the analysis accounts for the health of the patient and factors such as age, obesity, smoking habits, diabetes and other factors that increase the risk of complications;
- Is case-mix adjusted, meaning it accounts for the complexity of operations performed to show more accurate national benchmarking for hospitals; and
- Follows patients for 30 days after their operation. Since more than half of all complications occur after the patient leaves the hospital, ACS NSQIP uncovers more complications than many other quality programs.
- Includes National Quality Forum (NQF)-endorsed outcomes measures developed in partnership with the Centers for Medicaid and Medicare Services (CMS) with the goal of creating practical outcomes-based measures that will help hospitals achieve significant quality improvements. Further, it is in early exploration of how such measures might be captured directly within EHRs at the point of care.

A study in the September 2009 issue of the *Annals of Surgery* evaluated 118 hospitals that began participating in ACS NSQIP between 2005 and 2007. The study showed that for hospitals participating in ACS NSQIP, each:

- Prevented 250-500 complications annually;
- Saved 12-36 lives annually; and
- Reduced costs by millions of dollars annually.

If ACS NSQIP results were translated across all hospitals in the country that perform surgeries, hospitals would have the potential to prevent millions of complications a year, save billions of dollars, and demonstrate that higher quality care can cost less.[2]

The ACS also appreciates and strongly endorses the committees' intent and list of suggestions for minimizing providers' participation burden.

Phase Three

In Phase Three, provider efficiency would be added to the quality-based physician payment system implemented in Phase Two. As proposed, only providers meeting a minimum quality score threshold would be eligible to earn additional incentive payments based on efficient use of health care resources. The committees' proposal would assess provider efficiency using a risk-adjusted relative ranking system that also accounts for geographic differences. The Secretary is directed to consider both episode-based and per capita measurements of provider costs of care, but also is directed to solicit physician organization input on how to assess efficiency and to consult with physician organizations on an on-going basis. Providers could choose whether the assessment of their performance-on quality and efficiency-occurs at the individual or group practice level.

The ACS believes that incorporation of measures of efficient resource use in determining physicians' payment should employ only rewards, as the committees' draft seems to imply, and not also penalties. The ACS is concerned that measuring on a per capita basis could create a perverse incentive to withhold care. Addressing this concern will require not only effective risk adjustment but rigorous monitoring. As has been experienced with implementation of current law episode-based measurement and the value modifier, defining episodes of care and attributing services to physician practices are serious and complex issues that defy a "perfect" solution. The Secretary must engage in a process of continual evaluation and improvement in consultation with physician organizations.

The ACS supports the proposal that only physician practices meeting quality threshold should be eligible for efficiency-based incentives.

Provider Opt-Out for Alternate Payment Model (APM) Adoption

[2] ACS has other databases that could aid the transition to a new payment system based on quality, including the Trauma Quality Improvement Program (TQIP), the Commission on Cancer National Cancer Data Base, the Surgeon Specific Registry (SSR), and the Bariatric Surgical Centers (Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)).

The ACS supports providing options for physician practices to participate in alternate payment models and the exemption of services provided through these models from the physician payment system, reimbursing them instead according to the payment arrangements of the model. Payment models would need to be assessed and approved by the Secretary, but the committees' proposal provides no details about requirements.

The ACS urges that providers be allowed to participate in more than one alternate payment model so that, for selected physicians or services, for example, a physician practice might be participating in an accountable care organization, bundling project and clinical affinity group. Such flexibility will enhance physician practices' participation in these alternate models, which we believe could bring significant improvement in both the quality and efficiency of care. The Secretary should give priority to alternative models that are physician developed, physician led, and that truly improve care.

The ACS believes that clinical affinity groups (CAGs) should be considered to be an alternate payment model that is recognized explicitly in the legislation. In concept, a CAG is a group of physicians and providers who care for a specific condition, disease or patient population. CAGs might include categories such as primary care/chronic care, cancer care, surgery, cardiac care, frail elderly/end of life, digestive diseases, women's health, and rural healthcare. Each CAG would have its own patient-oriented, outcomes-based, risk-adjusted quality measures designed to foster continuous improvement and help lower costs. These measures will be crafted in close consultation with relevant stakeholders including the specialty societies, who in many cases are already developing measures and other quality programs on their own. Providers would self-select their CAG, providing they meet certain eligibility requirements based on the patients they see and conditions they treat. The Secretary would be tasked with creating CAGs and ensuring that there are a sufficient number and variety to accommodate all physicians.

Improvements upon Current Law

The ACS believes that improvements are needed in the payment adjustments for participation in current quality programs including the PQRS, EHR and e-Rx adjustments. We believe there are four areas in which Congress can act swiftly to improve these programs[3]:

- The payment adjustment year and the performance period must be tied closer together to better align behavior changes with payment incentives;
- Measures specific to specialists must be better incorporated into the programs or those specialists whose measures are not incorporated into the programs should receive exemptions from the payment penalties;

[3] The committees' proposal is unclear. It is possible that once the new system, as currently portrayed, has been fully implemented that these programs should be done away with completely as they would be repetitive of components of the new system.

- The quality measures currently used in the PQRS and EHR Incentive Program must be better aligned in order to prevent duplication and reduce unnecessary administrative burdens; and finally
- Incorporate clinical data registries into these programs since current claims data do not provide sufficient insight into the quality of care provided by a physician. Aligning clinical data with improvements to claims data is the most robust path forward toward true quality improvement. Congress began to address this issue, as related to PQRS, in the fiscal cliff legislation at the end of 2012; and CMS issued a Request for Information (RFI) seeking input on how it may deem certain clinical registries as sufficiently meeting the requirements of the PQRS program. This would allow physicians participating in approved clinical registries to be deemed to have met the PQRS requirements.

ACS NSQIP experience demonstrates that national patient registries can have a major impact in improving quality and reducing the cost of health care. Giving physicians full meaningful use credit for purposes of avoiding the meaningful use penalty is critical to investment in this mechanism. CMS has set a precedent through the e-prescribing and PQRS programs of allowing alternative methods for physicians to avoid penalties other than those required to achieve incentives. CMS should be urged to extend this practice to the meaningful use program by allowing physicians to demonstrate meaningful use in a way that requires fewer workflow changes than the CMS Stage 1 and Stage 2 objectives, such as participation in a private national clinical registry approved by CMS.

Clinical registries developed by specialty societies have the potential to collect better and more meaningful quality data than traditional claims reporting and even more importantly can provide regular and timely feedback to physicians for quality improvement purposes. By definition, true participation in a clinical registry requires that physicians (1) capture patient data, the goal of stage 1 meaningful use, (2) exchange patient data with the registry and across settings, the goal of stage 2 meaningful use, and (3) engage in quality improvement activities, the goal of stage 3 meaningful use. The decision support tools, professional improvement, longitudinal patient data and quality improvement promised by EHRs only occur with a registry overlay on the EHR. Promoting registry participation would achieve the broader goals of the meaningful use program because it more easily supports measurement in multiple domains and produces more meaningful and actionable data than the one-size fits all approach of the current meaningful use program.

We appreciate the opportunity to testify at today's hearing and look forward to continued discussions related to reforming the Medicare physician payment system. The challenges facing the overall Medicare program are complicated and carry significant fiscal implications as well as the potential for unintended consequences on access to care. ACS believes it is incumbent upon every physician and health care provider to commit to being a responsible steward of the nation's health care resources. We must find a balance between fiscal prudence, delivering high quality

care and preserving the trusted physician-patient relationship. We look forward to working, as partners, in forging a new, patient-centric, quality-based health care system.

STATEMENT OF DR. KIM ALLEN WILLIAMS, MEMBER OF THE ASNC HEALTH POLICY STEERING COMMITTEE

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

Dr. WILLIAMS. Thank you, Chairman Brady, Ranking Member——

Chairman BRADY. Can you get that microphone, Doctor?

Dr. WILLIAMS. Got it.

Chairman BRADY. Thanks.

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

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

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

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

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

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

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

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

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

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

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

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

[The prepared statement of Dr. Williams follows:]

Statement for the Record

American Society of Nuclear Cardiology

Hearing before the House Ways and Means Health Subcommittee

On

Developing a Viable Medicare Physician Payment Policy

May 7, 2013

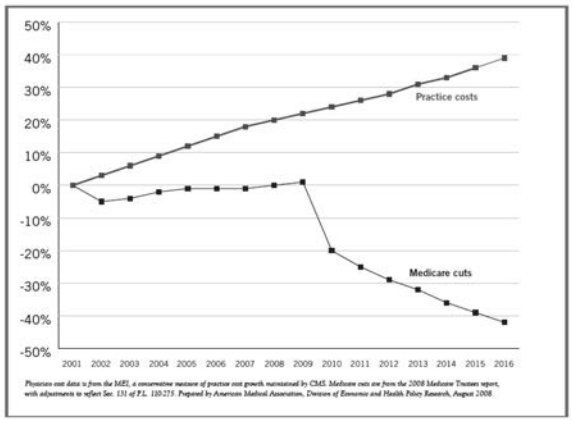
*****TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING TUESDAY, MAY 7, 2013 AT 10:00 AM*****

Chairman Brady, Ranking Member McDermott, and other distinguished members of the Ways and Means Health subcommittee, thank you for the opportunity to testify on behalf of the American Society of Nuclear Cardiology (ASNC). The American Society of Nuclear Cardiology is the leader in education, advocacy, and quality for the field of nuclear cardiology. ASNC is the voice of more than 4,600 physicians, technologists, and scientists worldwide who are dedicated to the science and practice of nuclear cardiology. Since 1993, ASNC has been establishing the standard for excellence in cardiovascular imaging through the development of clinical guidelines, professional education, and research development. While our organization is centered on the practice of diagnostic imaging, it is important to note that a significant percentage of our membership is invested in the practice of general cardiology as well.

My name is Kim Allan Williams, MD, and I currently serve as a member of the ASNC Health Policy Steering Committee. I previously served as a member of the Board of Directors and as president of ASNC. In addition, I am Vice President of the American College of Cardiology for 2013-2014. I joined the faculty of the University of Chicago in 1986 before moving to the Wayne State University School of Medicine in 2010. I chair the Division of Cardiology and I founded the Urban Cardiology Initiative, which is an effort to educate physicians on disparities in healthcare and community health screening in inner city Detroit.

The American Society of Nuclear Cardiology applauds Chairman Brady and Ranking Member McDermott for holding a hearing on such an important topic. We share your view that the instability posed by the Sustainable Growth Rate (SGR) complicates physicians' ability to make desired improvements to their practices, such as the purchase of capital equipment. Data from the American Medical Association (Figure 1) illustrate a divergent trend in practice costs and Medicare payment—declining payment makes it difficult to support a practice and staff. It is encouraging that the Committee is dedicated to finding *workable* alternative reimbursement models rather than merely searching for a quick or easy solution.

Figure 1. Physician Reimbursement Losing Ground to Inflation, Costs



Physician cost data is from the MEI, a conservative measure of practice cost growth maintained by CMS. Medicare cuts are from the 2008 Medicare Trustees report, with adjustments to reflect Sec. 131 of P.L. 110-275. Prepared by American Medical Association, Division of Economic and Health Policy Research, August 2008.

ASNC, and many other specialty societies, are further encouraged by the Committee's solicitation of physician input on SGR repeal and the development of alternative reimbursement and delivery models. This partnership is likely to lead to legislation that reflects the intricacies of clinical practice and advances best practices. Moreover, ASNC is pleased by the Committee's close consideration of clinical quality measures developed by medical specialties and medical societies. A more direct partnership with medical specialties and the registries they develop and employ will undoubtedly produce actionable quality measures.

Clinical Data Registries

Appropriate Use Criteria (AUC) were developed by ASNC in partnership with several organizations in order to reduce the number of inappropriately ordered tests. Decision support tools such as guidance on the proper use of stress protocols and tracers are important initial steps in quality imaging. ASNC will continue to collaborate in the development of decision support tools to assist referring physicians and nuclear cardiology professionals. To further ensure appropriateness and patient-centered imaging, ASNC is currently establishing the groundwork for the *Cardiovascular Imaging Registry*. This is a natural progression of prior quality initiatives such as clinical application guidelines, imaging procedure guidelines, physician certification, lab accreditation, and AUC.

We envision the that the Imaging Registry will be instrumental in developing a robust set of clinical performance metrics of interest to private payers, the Centers for Medicare & Medicaid Services (CMS), and policymakers. These metrics may add further weight to the reality that medical imaging is good medicine, and inform proper reimbursement and performance incentives. Advancements in medical imaging have changed the way cardiologists, oncologists, obstetricians and gynecologists, urologists, family practitioners, neurologists, orthopedic and other surgeons and many other physicians deliver patient care on a daily basis. By integrating medical technology into care plans, patients are receiving more prompt, efficient, effective and cost-effective care. In addition to traditional diagnostics employing medical imaging, we now use imaging to guide minimally invasive treatments and to track ongoing treatment protocols through judicious use of medical imaging. We are enabled as physicians to adjust patient care plans mid-therapy to achieve the best possible outcomes. Several specialist groups intimately integrate medical imaging in the most delicate and intricate aspects of their care. The prudent use of medical imaging to guide a patient's treatment regimen is not only excellent medicine—it also manages short- and long-term costs by reducing wasteful and ineffective invasive testing and treatments.

As stated previously, ASNC is currently establishing the groundwork and defining initial quality metrics. The initial phase of Registry development (end of 2013-Q1 2014) will be focused on data collection of foundational performance metrics that relate to radiation safety and dose protocols, timely reporting of test results, and clinical indication. Registry results will be focused on building the resources related to the implementation of patient centered imaging protocols, improved reporting and appropriate use. While we describe these metrics as foundational, they are of profound importance. A nuclear laboratory may adhere to appropriate use criteria, yet the positive contributions to patient management and care are limited if test results are not communicated in a timely and efficient manner. Many nuclear laboratories have cameras and reporting software that can seamlessly export data directly to the Registry with no additional burden to the physician.

In subsequent phases (2015-2016), ASNC intends to develop the capability to follow the patient through the continuum of care. Partnerships with other registries in the field of cardiology will assist this

initiative. By tracking adherence to Appropriate Use Criteria and resulting treatment decisions, the *Cardiovascular Imaging Registry* may illustrate that nuclear cardiology positively affects downstream costs through more appropriate selection of patients who need invasive testing or revascularization and the management of congestive heart failure. In addition, the Registry may illustrate that nuclear cardiology improves patient outcomes by more appropriate risk stratification to more advanced therapies, should they be required. Thus, the Registry may fully illustrate how diagnostic imaging informs treatment decisions to better serve both the patient population and the Medicare program.

ASNC expects that the metrics developed by the *Cardiovascular Imaging Registry* will enable Congress and CMS to gauge ongoing clinical improvement initiatives. With these data, Congress and CMS may effectively tie reimbursement to these initiatives. Credit should be given for quality improvement initiatives that are already in place and are ongoing, not just for new initiatives each year. For example, a provider should receive ongoing recognition for achieving and maintaining subspecialty board certification, lab accreditation, performing laboratory quality assurance, and participation in the ASNC Registry. These are integral quality activities. Annual "metric updates" must not ignore these ongoing quality measures and simply look for new quality initiatives each year. Financial incentives should be provided to physicians who participate in registries, receive feedback, and address any quality deficiencies that are discovered.

Reward Clinical Improvement Activities and Pay for Performance

ASNC embraces a payment methodology which rewards a specialty's advancements in care quality and clinical improvement activities. Nuclear cardiologists strive to provide high quality care and have developed a wide array of decision support tools to improve patient care. These include strategies to reduce radiation exposure, means of increasing image quality, promoting the accurate interpretation of test results through peer review, and an array of Appropriate Use Criteria for diagnostic imaging. The current fee-for-service structure does not provide adequate reimbursement for these activities. It is ASNC's contention that a reimbursement system which incentivizes the use of clinical improvement activities may more effectively encourage these initiatives in nuclear cardiology.

Differences in specialties should be based on the specific quality and improvement targets. The overall approach should strive to reward and recognize improvements rather than the development of absolute, punitive thresholds. The overall approach and framework should be similar across specialties. The concept of ***continuous*** quality improvement should be first and foremost—new payment models should improve the aggregate quality of care rather than seek to eliminate all outliers. To this end, ASNC recommends each specialty work with both CMS and private payers to determine a three-year course for necessary improvement based on known gaps and opportunities for improvements.

For example, in terms of implementing performance into the fee-for-service system, ASNC proposes awarding physicians with high levels of improvement 110% of the fee schedule, physicians demonstrating modest improvement 100% of the fee schedule, and those demonstrating no movement 90% of the fee schedule. An important element of this concept is legal indemnification. If nuclear laboratories are to be paid for AUC adherence and thus asked to perform a gatekeeper function, it is integral that nuclear laboratories receive legal protection for the decision not to perform inappropriate tests.

While we endorse this concept, a number of pertinent questions remain. What entities, in addition to the National Quality Forum (NQF), will approve physician-developed quality metrics? Will medical

societies be able to utilize metrics that are awaiting approval? Which government agency will provide independent physicians and group practices with their quality scores? Will the appeal process be formal or informal?

Alternative Payment Models

Flexibility and the provision of clear, concise information will be key variables as we transition to alternative payment models. ASNC is pleased the Committee's framework allows for flexibility and does not envision a "one-size fits all" approach to payment and delivery reform. For certain specialties and certain providers, fee-for-service may ultimately be the most appropriate payment and delivery system.

ASNC supports an approach that permits participation in multiple Alternative Payments Models (APMs). If the Committee seeks to enhance provider flexibility, it follows that this provision would be part of the legislative framework. It is feasible that a provider group may participate in multiple shared savings arrangements simultaneously. Participation in multiple models may enable providers, CMS, private payers, and policymakers to obtain additional data regarding APMs—level of patient satisfaction, utilization, the need for additional reforms, etc. Conversely, limiting participation may inhibit the flow of key data.

Data must be in real time, focused on meaningful and actionable information, and in a standard format that can be used to identify where improvement is needed. These foundational principles are applicable to meaningful provider participation in new payment and delivery models. Moreover, provider participation in the development of new models and means of educating providers will further support participation. New models may be ineffective if implemented in a top-down manner or interpreted as the government dictating the practice of medicine. National specialty societies and regional collaborative organizations may perform this education function.

ASNC asserts a clear definition of "participation in models" would support provider participation. Threshold levels of participation and the particulars of new models require clear and concise definitions. For instance, would participation in innovative programs led by private payers such as CareFirst or United Healthcare suffice? What criteria must accountable care organizations (ACOs) meet?

Stable Updates in Physician Reimbursement

In comments to the SGR framework and in discussions with multiple members of Congress, ASNC stressed the importance of stable and predictable updates as we transition to alternatives. The prospect of substantial annual reductions due to the SGR and the wait for Congressional action to temporarily avert the reductions destabilize the practice of medicine and impede investments in alternative models. We therefore endorse the Committee's proposed stable, predictable fee schedule updates during the transition period.

ASNC encourages the Committee to provide stable and predictable updates for a period of five years. This timeframe grants physicians the ability to make investments and practice modifications that may improve quality and efficiency, and to assess alternative payment models both within Medicare and the private sector. This five-year period of stability also may provide ample time and resources for CMS to prepare for and to be equipped to effectively administer alternative models.

Rewarding Quality over Time In Addition to Peer Group Comparisons

ASNC asserts it is essential to reward quality over time in addition to quality compared to peers. We urge the Committee to establish an incentive program which rewards providers for sustained high performance as well as substantial quality improvement. Limiting incentives strictly to improvement may create a ceiling for providers who start at or achieve a high level of performance. Restricting incentives to high-threshold levels of achievement may inhibit the participation of providers who start at low levels. Since the objective is to "raise all ships," ASNC encourages the Committee to implement incentives with the aforementioned nuances.

ASNC also contends successful pay-for-performance programs encourage collaboration among providers and provider groups. It is our understanding that peer groups would consist of providers focusing on the same set of three-to-five quality measures. This suggests the possibility of collaboration among providers and provider groups, yet we assert the peer group concept requires greater detail. The Committee may enhance the statistical validity of quality measures by banding together small practice groups. Establishing transparent means of evaluating providers, particularly the public disclosure of measurement specifications used to develop performance tiers, may further enhance validity. However, ASNC remains concerned that peer groups may create a set of winners and losers unless the providers in a specific group are obtaining substantial incentives from the system, either by demonstrating a high level of quality or demonstrating significant quality improvement. This concern is accentuated by a budget neutral approach to payments for quality and efficiency. Providers in a pay-for-performance program should receive a positive base payment and additional payments for meeting quality and efficiency objectives. A budget neutrality requirement threatens this concept.

Improving Geographic and Risk Adjustment Procedures

ASNC asserts current geographic and risk adjustment procedures in method are insufficient. This is shown by the recent reduction in payment for thirty-day readmissions, which disproportionately targeted inner city safety net hospitals. The stratification system should include measures of the socioeconomic status of the community which the provider serves. Non–claims based information such as functional status, socioeconomics, culture, linguistics, and geography affect how patients interact with the healthcare system. Functional status affects how a patient seeks care and follows treatment instructions. Moreover, current geographic and risk adjustment procedures do not fully account for comorbidities. This may significantly affect reimbursement under alternative payment models as two-thirds of noninstitutionalized Medicare beneficiaries over the age of 65 have two or more chronic conditions[1]. Provider groups that serve a disproportionate number of sick individuals, such as patients with coronary artery disease, will likely be underpaid, and those with healthy populations will be overpaid.

Solid and transparent risk adjustment and attribution methods will be critical in identifying and understanding variances in quality and cost across specialties, settings, and locations. ASNC encourages the Committee to develop, test and improve such methods.

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[1] Am J Manag Care. 2008;14(10):679-690

Properly Addressing Outliers

Outliers are a concern for specialty societies as well as policymakers. The Committee on Ways on Means may effectively address outliers in a variety of ways. Their conception of registries and associated clinical quality measures is encouraging. For instance, the intent of the ASNC Registry is to produce a Laboratory Report Card—an in-depth lab assessment and data collection initiative that will provide a roadmap to continuous performance improvement. The Report Card may effectively identify knowledge gaps and concrete measures labs may take for Quality Improvement. We encourage Congress to create an incentive structure which rewards labs for addressing these gaps.

ASNC contends that timely access to performance data is integral to quality improvement. Physicians respond to clinical data and will alter practice patterns accordingly. If a physician is given a feedback report with clinically relevant data, he/she may alter practice patterns to improve quality. ASNC hopes that a system heavily reliant on measures developed by medical specialties and medical societies would effectively provide timely feedback. In multiple comment letters, ASNC has urged CMS to improve the timeliness of the feedback reports delivered as part of the PQRS and Value-Based Payment Modifier programs, while understanding the practical difficulties therein. CMS intends to distribute reports containing 2012 data to physicians in the fall of 2013. This lag time makes it difficult for physicians to improve their understanding of program criteria or rules of participation and respond in a timely manner.

In alternative reimbursement models based on quality, it is our hope and expectation that all physicians will receive timely feedback reports. Actionable information is critical to improvements in the quality of care delivered by physicians, irrespective of their potential status as outliers.

The American Society of Nuclear Cardiology appreciates this opportunity to offer testimony and looks forward to further discussion with Committee members and staff. The current Medicare physician payment formula produces unrealistic savings on paper, requires Congress' consistent short-term intervention, and creates needless delays and hassles for patients. We hope this collaborative effort between Congress and the house of medicine will lead to the repeal of the Sustainable Growth Rate and meaningful reform of Medicare payment.

STATEMENT OF DR. CHARLES CUTLER, CHAIR OF THE BOARD OF REGENTS OF THE AMERICAN COLLEGE OF PHYSICIANS

Chairman BRADY. Dr. Cutler.

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

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

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

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

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

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

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

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

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

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

Medicare payment policies should also recognize the far-greater number of recognized patient-center medical-home practices that are delivering high-quality, coordinated care to all of their patients,

including Medicare practices which, nonetheless, receive no support from Medicare, other than the usual fee-for-service payment. Related, the NCQA has a new medical home neighborhood accreditation program for specialty practices that meet standards related to the coordination of care, creating a pathway for non-primary-care specialists potentially to qualify for incentive payments. The bottom line is patient-centered medical homes have the track record to be scaled up and support by Congress now.

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

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

Chairman BRADY. Thank you, Dr. Cutler.

[The prepared statement of Dr. Cutler follows:]

ACP

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Statement for the Record

American College of Physicians

Hearing before the House Ways and Means Health Subcommittee

On

Developing a Viable Medicare Physician Payment Policy

May 7, 2013

*****TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING TUESDAY, MAY 7, 2013 AT 10:00 AM*****

My name is Charles Cutler. I am Chair of the Board of Regents of the American College of Physicians (ACP), 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 Norristown, PA, and am a full-time, board-certified practicing internist. I am a member of Fornance Physicians, a multi-specialty group practice consisting of 85 doctors.

On behalf of the College, I want to express our deep appreciation to Chairman Kevin Brady and Ranking Minority Member Jim McDermott for convening this hearing and for your shared commitment to finding a bipartisan solution to the broken Medicare physician payment system. I also wish to thank Chairman Dave Camp and Energy and Commerce Chairman Fred Upton for their leadership in advancing a draft proposal to move toward a more stable and effective physician payment system. I also wish to acknowledge our appreciation for the contributions of Representative Allyson Schwartz, a member of the Ways and Means Committee, and Representative Joe Heck, in crafting a bipartisan bill, the *Medicare Physician Payment Innovation Act of 2013*, H.R. 574, which has the same goals and similar approaches as Mr. Camp's and Mr. Upton's draft proposal. ACP continues to support this legislation but also recognizes that there are different approaches to achieving the same objectives of repealing the SGR, providing stable updates, and transitioning to value-based payment (VBP) programs. Our testimony today will focus on how legislation to repeal the SGR can facilitate the ability of physicians to embrace new models of delivery and payment that provide greater value to patients.

RECOMMENDED KEY ELEMENTS OF A NEW MEDICARE PHYSICIAN PAYMENT SYSTEM

A permanent solution to the SGR problem should facilitate a transformation of the Medicare physician payment system from one that incentivizes volume to one that rewards high-quality and efficient care. Therefore, the College supports a phased approach to repealing the SGR and progressing to better, value-based payment and delivery models that include the following seven key elements:

1. Eliminate the SGR, effective with enactment of the authorizing legislation.
2. Provide stable and positive baseline annual payment updates for all physicians, during which physicians would begin to transition to VBP models over the next five years. The baseline updates should be set by statute, and provide higher baseline updates for undervalued evaluation and management services (without regard to the specialty of the physician providing such services).
3. During the period of guaranteed baseline updates described above, create opportunities for physicians to have their baseline update increased, on a graduated scale, for participating in an approved/deemed transitional VBP model or program.
4. Allow reasonable but not unlimited time for all physicians to get on a transitional VBP pathway that works for their specialty, practice setting, and patient population served, without holding back those who have already begun the journey. Those who are ready now to begin delivering care in models or programs that have shown the potential to result in better clinical outcomes, with more efficient and effective use of resources, should be able to qualify for higher VBP updates as early as January 2014.

5. The pathways to qualify for transitional VBP updates should consist of designated payment/delivery system models—including Patient-Centered Medical Homes (PCMHs), PCMH-Neighborhood (PCMH-N) specialty practices, ACOs, and bundled payments—based on specified criteria, and deemed private sector quality improvement programs. Such a deeming process must ensure that deemed programs have core capabilities to advance quality and effectiveness and can produce measurable results on performance.
6. Performance measures used in transitional VBP programs should go through a transparent, multi-stakeholder review and validation process, regardless of the source of the measure.
7. At the end of the five year transitional period, the expectation would be that most physicians would be in or on well on their way to participating in an approved program. We believe it would be appropriate to consider a mix of positive incentives but also potential reductions in payments*, after a reasonable transition period with pathways for all physicians and specialties to participate in an approved VBP program*, for physicians who decline to participate in a meaningful program by a specified date. However, there should be hardship exemptions for physicians (such as those in smaller practices, late career physicians, and physicians in underserved areas) who will be particularly challenged in making the transition. We note that a similar approach of positive incentives and penalties with hardship exemptions is included in the Medicare Physician Payment Innovation Act, which we have endorsed.

We also note that in our previous testimony before the House Ways and Means Health Subcommittee on July 24, 2012[i]—and described further in our responses to the February 7th and April 3rd draft proposals by Chairmen Camp and Upton to repeal the SGR and reform the Medicare physician payment system[ii]—we outlined a set of principles for developing a transitional quality improvement (QI)/value-based payment (VBP) program. Our testimony today reflects and provides more detail on how the principles we offered could be incorporated into a legislative framework consistent with the Camp-Upton draft proposal. Although the methodology and actual percentage updates to be specified in statute for establishing the baseline payment for physician services, including establishing a higher baseline for undervalued evaluation and management services, are important elements of the College's recommended approach, we will focus our testimony on how to design and implement a program that transitions from the current flawed payment system to one that is aligned with the value of care provided to patients (incorporating elements 3 through 7 above).

APPLYING ACP's KEY ELEMENTS TO THE COMMITTEE CHAIRS' DRAFT PROPOSAL

We believe that the approach suggested in the above principles could be incorporated into the second draft of Chairmen Camp's and Upton's proposal by:

1. Establishing positive baseline updates, with a higher baseline for evaluation and management services, by statute, for a period of five years. Negative updates, cuts or withholds would act as substantial barriers for physicians to transition to value-based models by denying practices the resources needed to successfully transition to new models and likely would force many physicians out of Medicare.
2. Allowing physicians in phase 1 to qualify for additional VBP allowances for participating in an approved or deemed transitional VBP program, starting as early as January 1, 2014—essentially, advancing phase 2 into phase

1 for those physicians who are ready to make the transition, while continuing to provide stable and positive baseline payments for others who are just getting started.

3. Establishing a graduated VBP allowance structure (or Update Incentive Program) for physicians to qualify for higher FFS payment updates, above their baseline, for participating in an approved/deemed program, with the amount of the VBP/UIP allowance being based on how much the program or programs they are participating in incorporate core elements associated with better outcomes and effectiveness of care.
4. Developing standards and criteria to be used by the Secretary for selecting and deeming programs that would be eligible for each level of graduated VBPs.
5. Specifying that approved/deemed/accredited PCMH and PCMH-N practices that meet standards for selection/deeming would qualify for the graduated VBP/UIP FFS payment allowances effective on January 1, 2014, including recognized/deemed PCMH and PCMH-N practices—including (and especially) those that are not part of one of the CMS Innovation Center initiatives and therefore have no other reimbursement support from Medicare other than FFS and the annual update applied to it. Practices that are participating in Innovation Center programs or other Medicare payment reform pilots (e.g. Comprehensive Primary Care Initiative, Accountable Care/Shared Savings, Advanced Primary Care, and bundled payments programs) also should qualify for the graduated VBP/UIP allowances at the highest levels, since FFS payment will continue to be the principal source of Medicare payments for such practices, and excluding them from the graduated VBP/UIP allowances would have the unintended effect of penalizing physicians and practices that are doing the most to advance quality and effectiveness while accepting greater accountability for results. Essentially, this means allowing physician practices in models that would qualify for the Provider Opt-Out for Alternative Payment Models to qualify for value-based payment increases as early as next year.

In this context, physicians who are in designated Alternative Medicare Payment Models including Patient Centered Medical Homes *that are part of a CMS approved and funded program* would receive (1) the appropriate level of graduated VBP/UIP update allowance for their fee-for-service payments and (2) the underlying payment support structure for their particular program, discussed in more detail later in this testimony. However, because many PCMHs, ACOs, and other innovative payment models are not formally part of a CMS-approved and funded program, even though they are delivering care to large number of Medicare patients, there needs to be a way for such practices to qualify in a graduated VBP/UIP update incentive program since that is the only support they receive from Medicare, as discussed in more detail later in our testimony.

Also attached to this statement is an appendix with excerpted responses to the questions we addressed in our response to the second version of the Camp-Upton draft proposal.

More details of ACP's suggested value-based transition program are discussed below.

A GRADUTATED APPROACH TO REWARDING QUALITY AND EFFECTIVENESS

The College believes that the groundwork is already in place for Congress to begin to facilitate a broad transition to value-based delivery and payment approaches, including PCMH, PCMH-N specialty practices, and other models as discussed in more detail later in this testimony, using a clearly laid out set of criteria for selecting/deeming programs that would qualify for additional VBP updates during a five year transition period. Such a transition must recognize that physicians are starting out in different places on incorporating best practices to achieve greater value for their patients, with some physicians already being very far down the road in redesigning their practices to achieve better value, while others are just getting started on the entrance ramp to value-based payments and delivery models. Physicians at all points along this spectrum need to have models available to them that are appropriate and realistic for their particular stage of development, but with the opportunity for them to *earn additional VBP updates* (above the baselines to be set in the statute) on a graduated VBP payment scale that *provides greater rewards for those who are doing more to improve outcomes and effectiveness of care.* Such a graduated VBP scale should be based on the extent to which a particular deemed or approved program has demonstrated core capabilities to achieve better clinical outcomes, with more effective use of resources. Studies suggest that the most effective programs have some or all of the following components associated with better outcomes and more effective care:

- Reporting on *validated* clinical performance measures appropriate for the specialty of the physician patient population being served.
- Coordinated, interdisciplinary and team-based care "best practices" to overcome fragmentation of medicine into distinct "silos" of care.
- Tracking of patient outcomes through patient-registry systems.
- Patient engagement and shared decision-making.
- Commitment to evidence-based practice guidelines to reduce ordering of marginal, ineffective, low value or even harmful care, such as ACP's High Value Care Initiative[iii], described later in this testimony and the *Choosing Wisely* effort[iv] organized by the American Board of Internal Medicine.
- Informed and pro-active clinical care management teams and empowered patients, as described in the Chronic Care Model (CCM),[v] within a practice or across a group of practices. The CCM has proven itself over the past decade as a meaningful framework for practice redesign that leads to improved patient care and better health outcomes.[vi]
- A strong emphasis on primary care and appropriate valuation of primary care services as being critical to delivering high value, coordinated care for the whole person, including programs that incorporate the elements of PCMH (primary care model) and PCMH-N (specialty practice model) practices, described in more detail later in this testimony.

Although many of the above elements may be found in integrated delivery models, they can also be incorporated into independent physician practices in a fee-for-service environment. For example, an independent FFS physician practice might employ a nurse as a care coordinator to help patients with chronic illnesses take control of their own health, develop protocols to ensure that all clinicians involved in a particular patient's care are sharing information among themselves, reporting on measures of quality appropriate to that practice and specialty, and tracking patient outcomes through a registry system.

Each level of graduated VBPs could reflect how many of the above elements each particular approved or deemed program has, as well as other criteria that may be appropriate for a particular specialty program or type of practice. Physicians who successfully participate in a program with more of the required elements would qualify for a higher graduated payment than those who participate in a program with fewer elements.

Some illustrative examples of how such a graduated VBP structure might work are outlined below. The items in each column would not all be required for a practice to qualify for that level, but are intended to propose some alternative pathways that may be available to practices of different make-ups and sizes and/or physicians of different specialties. Working across the rows, achievements at each level could be considered additive or could each be done on their own. Again, it is important to reiterate that this is illustrative—there could be fewer or more tiers of graduated VBPs aligned with participation in a program that meets the criteria applicable to each category. An important element to reiterate about these tiers is that they should allow for every physician/specialty and practice to have a pathway that works for their own specialty, practice setting, and size.

Level 1 VBP Program 0.25% VBP update above baseline*	**Level 2 VBP Program 0.50% VBP update above baseline***	**Level 3 VBP Program 0.75% VBP update above baseline***	**Level 4 VBP Program 1.00% VBP update above baseline***
Implements ACP's High Value Care Initiative	Level 1 PCMH	Level 2 PCMH	Level 3 PCMH
Implementing care coordination agreements, in line with the PCMH-N with other physicians	Level 1 PCMH Specialty Practice	Level 2 PCMH Specialty Practice	Level 3 PCMH Specialty Practice
Reporting on a limited performance measure set, primarily focused on processes; and showing improvement in those measures over time	Reporting on a more robust set of performance measures, including a mix of process and outcome measures (either within a PCMH program or independently); and showing improvement in those measures over time	Reporting on a more robust set of performance measures that are more focused on outcomes (either within a PCMH program or independently); and showing improvement and/or consistently high quality in those measures over time	Reporting on a more robust set of performance measures, focused on outcomes, (either within a PCMH program or independently) that includes composite, population, outcomes, and cost measures; and showing improvement and/or consistently high quality in those measures over time.
			Participation in an ACO or other alternative delivery model that involves robust measurement

**Baseline update assumes a positive annual update for all services and a higher baseline update for undervalued evaluation and management services. The suggested graduated VBP percentage updates are for illustration only.*

However, it is critical that these different pathways do not result in an uneven playing field, where some specialties, physicians, or practices are disadvantaged by being held to more robust standards due to the availability and comprehensiveness of relevant measures for their specialty. Additionally, it will be important to allow more time for

smaller practices, those that provide care to underserved populations, and late-career physicians to fully advance into alternative models, likely through the provision of hardship exemptions; however, there should be no free pass for anyone.

The updates described in these illustrative tiers are proposed to be applied to Medicare FFS services in the Medicare Physician Fee Schedule. The College recognizes that these updates would likely need to be modest given the current fiscal environment and would not be the true or only driver behind the efforts of the physicians in those alternative delivery models. Physicians participating in PCMH, PCMH-N, and ACO models, in particular, are often—but not always—receiving risk-adjusted care coordination payments, shared savings based on quality metrics, etc. However, even in those cases, it is important that the Medicare FFS payments also continue to provide positive incentives by allowing them to qualify for the higher levels of graduated VBP FFS updates. There are a number of reasons for this:

- As noted earlier, FFS still remains an underlying tenet for most of the alternative delivery and payment models, such as PCMHs and ACOs—some of which may be built entirely on FFS payments.
- Alternative revenue streams for formal PCMH programs typically are not entirely from Medicare—and in many cases, Medicare is not an official participating payer at all (other than providing some regular FFS payments), rather the program is funded entirely by private payers. However, the practices still need to transform the way they provide care for all of their patients regardless of payer, which involves significant investment in infrastructure improvements, workflow changes, staff team roles, etc. For example, although there are thousands of recognized (by accreditation bodies and/or private payers) PCMHs around the country, very few of them are receiving any increased reimbursement from Medicare. Medicare is supporting only a few hundred PCMH practices nationwide that have been selected for its Comprehensive Primary Care Initiative or one of the few other PCMH programs that have been launched by CMS. Allowing PCMHs that have achieved recognition through an independent evaluation process to qualify for the higher graduated payments is necessary to allow the PCMH model to grow. Conversely, if such practices were unable to qualify for higher VBPs during the transition, Congress would actually be *disadvantaging* physicians who have taken the biggest steps into incorporating the PCMH model into their practices.
- There are a number of practices across the country that are interested in, or working toward transforming to a PCMH or PCMH-N model—or are taking on other robust quality improvement activities, such as the ACP High-Value Care Initiative—and do not have a formal payment program in their region to support their efforts. Thus they are relying entirely on FFS—and a reformed FFS system should be structured to incentivize this work.
- Physicians and practices that are involved in PCMH and ACO programs are already taking on significant financial risk, both directly and via the infrastructure investments required to participate, so it is important that the underlying FFS payments involved in those programs include positive incentives and updates.

DISCUSSION OF MODELS THAT SHOULD QUALIFY FOR GRADUATED VALUE PAYMENTS

Patient-Centered Medical Home (PCMH)/ PCMH Neighborhood

ACP strongly believes that the PCMH and PCMH-N models are ready to be a part of a new, value-based health care payment and delivery system, given all of the federal, state, and private sector activity to design, implement and evaluate these models and the growing amount of data on its effectiveness in improving care and lowering costs.[vii]

The CMS Innovation Center's Comprehensive Primary Care Initiative (CPC Initiative) provides an appropriate starting point for discussing how the PCMH model could be more immediately incorporated into the Medicare physician fee schedule. The five comprehensive primary care functions that serve as the framework for the CPC Initiative project—risk-stratified care management, access and continuity, planned care for chronic conditions and preventive care, patient and caregiver engagement, and coordination of care across the medical neighborhood—are in line with the PCMH and PCMH–N concepts, championed by ACP and other national membership organizations representing physicians and other clinicians and are supported by thousands of business, consumer, and payer groups represented in the Patient-Centered Primary Care Collaborative (PCPCC).

Physician practices that were selected for the CPCI are supported by a Medicare payment structure that consists of: (1) risk adjusted per patient per month Medicare payment to cover the extensive costs and work associated with care coordination; (2) fee-for-service payments as determined by the Medicare fee schedule (RBRVS and conversion factor as affected by the SGR); and (3) opportunities to share in Medicare savings. Participating practices will be accountable for achieving substantial milestones and performance metrics.

Physicians and practices that transition to the PCMH model should be measured by distinct measures that are focused on delivery of patient-centered care, such as the core measures recommended by the PCMH Evaluators' Collaborative established by the Commonwealth Fund, which includes measures in the following domains: clinical quality (process and outcome), utilization, cost, and patient experience of care. In addition, the Agency for Healthcare Research and Quality (AHRQ) has available an atlas of care coordination measures.[viii] And the National Quality Forum (NQF) has established a platform for the development of care coordination measures consisting of a set of domains, principles and preferred practices.[ix]

ACP believes that the advancement of the PCMH model also is being facilitated through several recognition and accreditation programs including the National Committee for Quality Assurance's (NCQA) Patient-Centered Medical Home Recognition Program (2011)[x], URAC's Patient-Centered Health Care Home's Accreditation Program[xi], and The Joint Commission's Primary Care Medical Home Option.[xii] ACP supports the idea of CMS basing its determination of accreditation as a PCMH through a national accreditation organization (via a deeming approach for the purposes of Medicare payment, discussed further below). The standards included in each of these programs are already well known and widely used and, while not identical, do include very similar concepts.

Additionally, NCQA has recently released a Patient-Centered Specialty Practice Recognition Program[xiii], which now creates a pathway for non-primary care practices to be formally acknowledged and incorporated into a new, value-based health care payment and delivery system based on the PCMH-N concept. Several areas of the country are already involved in testing and implementing the PCMH neighborhood concept, including: the Vermont Blueprint for Health program, the Texas Medical Home Initiative, and programs in both the Denver and Grand Junction areas of Colorado. It is

likely other accreditation programs will follow suit and also start to develop programs that are relevant for non-primary care practices.

Also, ACO development is rapidly occurring throughout the country in both the public and private sector. The Medicare shared savings program has contracted with dozens of physician practices and hospitals, including ACO practices that involve ACP members. Although the financial model for each ACO varies depending on the type of ACO program in which it is participating, all are paid under the usual Medicare fee-for-service basis with the opportunity to share in savings to the program from more effective management of the Medicare patients attributed to them. Variations of the shared savings programs involve more or less financial risk and reward for the participating practices. Therefore, while not discussed in detail in this testimony, ACOs should also be considered part of a new value-based payment and delivery system.

Other 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 transitional quality improvement/value-based payment model. ACP's High Value Care Initiative, 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.[xiv] 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.

Another alternative, largely physician-led quality improvement approach that could be considered by Medicare for higher updates over time would be the development and implementation of patient registries. Patient registries involve a systematized method for collecting patient-based data that are often used to help clinicians understand and improve their practice—some physician societies have already implemented extensive and robust registry programs while others are still in the development phase.

The bottom line is that ACP recognizes that a one-size-fits-all approach is not ideal and therefore believes that moving toward alternative delivery system and payment models can be done in parallel with reforming a post-SGR FFS system to incentivize improved care coordination and better reflect the quality of care provided, particularly because FFS still remains an underlying tenet for most of the alternative delivery and payment models. Physicians should not be limited to only one payment model—the focus should be on the right mix of incentives that support the ability of physicians and patients to spend more appropriate clinical time together.

Deeming of VBP programs and Validation of Performance Measures

The Department of Health and Human Services has a long history and tradition of deeming non-profit private sector accreditation organizations to satisfy compliance with federal regulations in a way that relies on the accreditation organization's expertise, while still ensuring that the process meets federal standards relating to transparency. We believe that CMS can learn from those relationships and work with the accreditation organizations and national specialty societies, including ACP, to design a deeming program for PCMH and PCMH-N recognition that appropriately balances the interests of the non-profit, private sector accreditation organizations and CMS' responsibility to establish and maintain transparency in its decision-making processes. CMS could deem a program as meeting the standards to qualify for a graduated VBP update allowance as long it can demonstrate that it includes one or more of the core elements associated with effective programs, as described previously in our testimony. Such deemed programs could include:

- PCMH and PCMH-N practices as recognized or accredited by a nationally recognized accreditation organization.
- PCMH and PCMH-N practices as recognized and offered to enrollees of one or more private health insurance programs, and/or as recognized by state government programs including Medicaid.
- Programs developed by national specialty societies, state medical societies, county medical societies, community-based physician groups, or other entities that would apply directly to CMS to be deemed as an approved initiative.

Robust and aligned performance measurement approaches and a stable infrastructure to develop, test, validate, and integrate performance measures into practice are essential. Although ACP agrees with the goal of encouraging the development of performance measures applicable to all specialties, it is essential that this not result in specialty specific "siloed" efforts, but one that is part of a national strategy for quality improvement. The development, validation, selection, refinement, and integration of performance measures should be a multilevel process that takes advantage of the most recent scientific evidence on quality measurement and have broad inclusiveness and consensus among stakeholders and in the medical and professional communities. This entire process should be transparent to the medical community. Measures should be field-tested to the extent possible prior to adoption. All measures, whether developed by a specialty society or other experts, accordingly should go through a multi-stakeholder evaluation process, a role that is performed by the National Quality Forum as a trusted evaluator of measures. ACP encourages the committees to ensure that there is stable and sustainable financing for the NQF as the trusted validator for quality measures. Deeming of private sector specialty programs, such as patient registry programs, might be considered as another way of qualifying specialty society quality improvement programs, although the clinical performance measures used by such programs should go through the NQF validation program.

In addition, in order to maximize physician engagement and promote quality, the SGR repeal and Medicare physician payment reform proposal should explicitly acknowledge the role of the physician specialty certification community. The American Board of Medical Specialties (ABMS) maintenance of certification (MOC) is a multi-source assessment program that addresses competencies for good medical practice and provides a program of continuous professional development and a platform for quality improvement. In this regard, the SGR proposal should include participation in

ABMS MOC as a quality metric, include ABMS MOC as a reporting pathway, and allow physicians choice in reporting so that they can align their quality improvement activities in ways that are relevant to their practices.

CONCLUSION

In conclusion, ACP strongly supports a phased approach to repealing the SGR and progressing to better, value-based payment and delivery models. As outlined above, this approach should establish *positive* baseline updates, with a higher baseline for evaluation and management services, by statute, for a period of five years; allow physicians in the Camp-Upton draft proposal's phase 1 to qualify for additional VBP allowances for participating in an approved or deemed transitional VBP program, starting as early as January 1, 2014; establish a *graduated* VBP allowance structure (or Update Incentive Program) for physicians to qualify for higher FFS payment updates, above their baseline; and develop standards and criteria to be used by the Secretary for selecting and deeming programs that would be eligible for each level of graduated VBPs. Such standards should define the core elements associated with effective programs. ACP strongly believes that the PCMH and PCMH-N models are ready to be a part of this new, value-based health care payment and delivery system—as early as phase 1 for those practices that have made or are ready to make the transition to these models. It is also critical that robust and aligned performance measurement approaches and a stable infrastructure to develop, test, validate, and integrate performance measures into practice be incorporated into all of the VBP programs. Additionally, all measures, whether developed by a specialty society or other experts, accordingly should go through a multi-stakeholder evaluation process, a role that is performed by the National Quality Forum as a trusted evaluator of measures. The College looks forward to working with the Subcommittee on developing a viable Medicare physician payment system consistent with the Camp-Upton draft approach and the ideas presented in today's testimony and would be pleased to answer any questions.

[i] The full testimony from this hearing can be accessed at: http://www.acponline.org/acp_policy/testimony/medicare_value_based_payment_2012.pdf.
[ii] These letters, responding to the House Ways & Means and Energy & Commerce Committees' staff proposals to repeal the SGR can be accessed at: http://www.acponline.org/acp_policy/letters/gop_sgr_framework_proposal_as_released_by_the_ways_means_energy_commerce_committees_2013.pdf and http://www.acponline.org/advocacy/where_we_stand/assets/eliminating_sgr.pdf.
[iii] Additional information on ACP's High Value Care Initiative can be accessed at: http://hvc.acponline.org/.
[iv] Additional information on the Choosing Wisely effort can be accessed at: http://www.choosingwisely.org/.
[v] Additional information on the Chronic Care Model can be accessed at: http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2.
[vi] Katie Coleman, Brian T. Austin, Cindy Brach and Edward H. Wagner. Jan/Feb 2009. "Evidence On The Chronic Care Model In The New Millennium" Accessed at: http://content.healthaffairs.org/content/28/1/75.short.
[vii] A sampling of recent data on the effectiveness of PCMH programs can be accessed at: http://www.pcpcc.net/guide/benefits-implementing-primary-care-medical-home, http://content.healthaffairs.org/content/29/5/819.full, http://www.bcbsm.com/content/dam/public/Providers/Documents/help/R007532_2012PartnersReport_01WEB.pdf, http://content.healthaffairs.org/content/31/9/2002.full.html, and http://content.healthaffairs.org/content/31/9/2010.full.html.
[viii] Agency for Healthcare Research and Quality. Care Coordination and Measures Atlas. Accessed at http://www.ahrq.gov/qual/careatlas/.
[ix] NQF. Preferred practices and performance measures for measuring and reporting care coordination. 2010. Accessed at http://www.qualityforum.org/Publications/2010/10/Preferred_Practices_and_Performance_Measures_for_Measuring_and_Reporting_Care_Coordination.asp
[x] More information on NCQA's PCMH Recognition program is available at: http://www.ncqa.org/tabid/631/Default.aspx.
[xi] More information on URAC's PCHCH Accreditation program is available at: https://www.urac.org/healthcare/prog_accred_pchch_toolkit.aspx.
[xii] More information on the Joint Commission's Primary Care Medical Home Option is available at: http://www.jointcommission.org/accreditation/pchi.aspx.
[xiii] Additional information on the NCQA Patient-Centered Specialty Practice Recognition Program can be found at: http://www.ncqa.org/Programs/Recognition/PatientCenteredSpecialtyPracticeRecognition.aspx.
[xiv] Additional information on ACP's High Value Care Initiative can be accessed at: http://hvc.acponline.org/.

Appendix: Excerpts from ACP's Responses to Questions on the Second Version of the Camp-Upton Draft Framework (ACP's letter can be found at http://www.acponline.org/advocacy/where_we_stand/assets/eliminating_sgr.pdf)

Questions for Phase II:

How should the Secretary address specialties that have not established sufficient quality measures?

ACP believes that all specialties need to be engaged in programs that will result in measurable improvements in quality. To ensure a level playing field, no specialty should be exempted from having its performance measured or held to a higher or lower standard than any other. Dozens of externally validated measures already are applicable to and are widely in use for internal medicine specialists. Specialties that have not developed or incorporated such clinical measures and/or obtained external validation for them should be given reasonable but not open ended time to incorporate or create such measures; in the interim, the Secretary should ensure that in order to qualify for higher updates, such specialties be able to participate in robust programs to achieve measurable gains in patient safety, quality, and effectiveness, such as by participating in patient registry programs that meet certain standards to ensure that they meaningfully "raise the bar" on quality, programs to reduce medical errors, programs to encourage high value care and cost conscious care, or programs aligned with their own specialty board's Maintenance of Certification performance and practice improvement efforts.

Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?

Yes, we believe that it is appropriate to reward improvement in quality over time in addition to quality compared to peers, although we also believe that those physicians who have shown that they are able and willing to achieve an even higher level of performance, earlier than some of their peers, should be able to qualify for appropriately higher updates. Any comparison of performance compared to peers must be carefully adjusted to reflect differences in the complexity of the patient population being treated and especially, to ensure that it does not disadvantage physicians who are taking care of underserved patient populations who may be at greater risk of poor health and outcomes.

Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?

As noted above, there are many dozens of externally validated measures that apply to internal medicine and its subspecialties. While ACP does not independently develop performance measures, the College is deeply involved in the critical review of 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.

Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliably measure performance? If so, how?

Yes, ACP is supportive of small practices having the ability to aggregate their data in order to ensure the validity of their data. The committees should take advantage of the experience being gained in how to reliably measure performance in small practices through both public and private patient-centered medical home programs. The CMS Innovation Center is heading up the Comprehensive Primary Care Initiative (CPCi) which is a collaboration between private and public payers and primary care practices to support patient centered primary care. The CPCi currently involves nearly 500 practices in 7 regions across the country. The application for payer participation in the CPCi suggests an approach to data sharing between practices and CMS and other participating payers that could be more made more broadly applicable by extension to other efforts of smaller practices to reliably measure and report on performance.

Questions for Phase III:

How much time is needed to refine the methodology for determining and attributing efficient use of health care resources?

Is it preferable to only have a payment implication based on efficiency for providers that meet a minimum quality threshold?

With regard to the specific measurement of efficiency by clinicians, the College recommends that measure sets must primarily focus on improving patient outcomes, gauging the patient-centeredness of a practice, and improving the coordination of care across all providers. The College maintains that efficiency —or "value of care" measures must be based on an objective assessment of evidence on the effectiveness of particular treatments, with both cost and quality taken into consideration. Value of care measures must appreciate the nuances of physician care and must not compromise the patient physician relationship. Stakeholders must also work to develop population health measures designed for specific populations.

STATEMENT OF DR. FRANK G. OPELKA, VICE CHAIR CONSENSUS STANDARDS APPROVAL COMMITTEE MEASURE APPLICATIONS PARTNERSHIP NATIONAL QUALITY FORUM

Chairman BRADY. Dr. Opelka.

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

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

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

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

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

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

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

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

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

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

Chairman BRADY. Thank you.

[The prepared statement of Dr. Opelka follows:]

NATIONAL
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TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING TUESDAY, MAY 7, 2013 AT 10:00 AM

"Developing a Viable Physician Payment Policy"

Statement of:

Frank G. Opelka, MD, FACS
Vice Chair, Consensus Standards Approval Committee
Measure Applications Partnership
National Quality Forum

Executive Vice President for Health Care and Medical Education Redesign, Louisiana State University

Prepared for the Committee on Ways and Means
Subcommittee on Health

May 7, 2013

Written Testimony for House Ways & Means

Health Subcommittee Hearing

May 7, 2013

Thank you Chairman Brady and Ranking Minority Member McDermott for inviting me to participate in today's hearing and provide testimony on behalf of NQF.

My name is Dr. Frank Opelka. I am a member of the NQF-convened Measure Applications Partnership and the Vice Chair of NQF's Consensus Standards Approval Committee (CSAC); I will become Chair of CSAC in July. CSAC oversees measure evaluation and endorsement at NQF. I am a surgeon and in my day job, the Executive Vice President for Health Care and Medical Education Redesign at Louisiana State University as well as the Associate Medical Director for the American College of Surgeons.

Background on NQF

Founded in 1999, NQF is a non-profit, non-partisan organization with over 440 organizational members. NQF members span the health care spectrum, including physicians, hospitals, businesses, consumer and patient representatives, health plans, certifying bodies and other healthcare stakeholders.

NQF has two distinct but complementary roles focused on enhancing the quality and value of the U.S. health care system:

- **NQF reviews and endorses quality performance measures.** These measures are used by public and private payers to assess how well doctors, hospitals and other providers are doing in offering high-quality care, and are also used by providers to benchmark their performance against peers and national standards. About two-thirds of the measures that the federal government uses in its healthcare programs are NQF endorsed. There is also widespread use of NQF-endorsed measures by hospitals and health plans at the state, regional and local levels.
- **In addition to endorsing measures, NQF also convenes diverse, private sector healthcare stakeholders to provide input to the Department of Health and Human Services (HHS) quality improvement efforts.** More specifically, the NQF-convened National Priorities Partnership (NPP) has served as a forum for a diverse group of stakeholders to provide initial and ongoing input to the HHS developed National Quality Strategy (NQS), which is focused on improving care, increasing affordability and building healthier communities. The NQF-convened Measures Application Partnership (MAP) is another diverse stakeholder group that works together to make recommendations on which measures should be used in Federal payment and

public reporting programs, including Hospital Value Based Purchasing and the Physician Quality Reporting System (PQRS), among others.

NQF's Board of Directors is composed of 31 voting members—key public- and private-sector leaders who represent major stakeholders in America's healthcare system (see Appendix A). A distinguishing characteristic of NQF is that our by-laws stipulate that a majority of the Board must be representatives of patients/consumers and purchasers, which assures a strong voice for those who receive care and those who pay for care. By practice, patient representatives are prominent in all NQF committees and workgroups.

NQF is recognized as a voluntary consensus standard-setting organization under the National Technology Transfer and Advancement Act of 1995. Its process for reaching consensus adheres to the Office of Management and Budget's formal definition of consensus.[i] NQF is supported by membership dues, foundation grants, and Federal funding.

Why We Are Here Today

Mr. Chairman, we commend you and your entire committee for undertaking the critical task of reforming physician payment and for placing health care quality at the center of your efforts. Concentrating on health care quality is the right medicine for making our system more patient-focused, along with improving outcomes and reducing costs.

It may sound simple but it is true that focusing on quality will only work if the tools we use to measure are themselves "high quality". For quality measurement to have an impact, the measures must be rigorous and held to high medical and scientific standards. Also, it is critical that a range of stakeholders be involved in choosing which measures will drive the biggest improvements.

At Louisiana State University, I see the power of using standardized measures to compare and contrast different hospitals and provider groups within our system, and to gauge our institution's performance against other hospital systems both regionally and nationally. This kind of feedback and transparency motivates improvement.

It is why I and over 400 other physicians take time away from our practices to serve on NQF committees. Along with experts from other stakeholder groups – totaling about 850 volunteers strong in 2012 and logging about 55,000 hours, translating into approximately a $4 million contribution – we collectively embody NQF's public service mission to improve the health of the nation.

Why High Quality Measures Matter

Mr. Chairman, all of the "measures" work my professional colleagues do is predicated on a precious few goals – to improve care, get optimal use of affordable resources, and to engage patients and make care more patient centered.

There is no one size fits all for measures, rather there are different types of measures for different purposes. There are many measures that physicians use that help them improve the way they practice such as many measures contained in registries or maintenance of certification programs, but which are not necessarily appropriate for public reporting or payment purposes.

NQF's current focus is on measures that are linked to high stakes reporting or payment, which need to be standardized and vetted through a rigorous multi-stakeholder process. Examples of these measures and the difference they make include:

- **NQF-endorsed measures on infections are driving care improvements:** Many have contributed to patient safety gains in hospitals, including a CDC-reported 58 percent reduction in central line associated blood stream infections (CLABSIs) between 2001 and 2009, which is the window of when a new NQF measure in this area came into use. This represents up to 6,000 lives saved and approximately $1.8 billion saved in cumulative excess health-care costs.[ii]
- **Publicly reported NQF-endorsed measures improved physician group performance:** Physician groups in Wisconsin that publicly reported quality measures between 2004-2009 improved their performance on key indicators, e.g., cholesterol control and breast cancer screening, outperforming peers in the rest of Wisconsin, nearby states of Iowa and South Dakota, and the U.S. as a whole. [iii]
- **Hospitals that use NQF-endorsed measures have better outcomes:** A peer reviewed study of more than 650 hospitals showed a decline in mortality in those hospitals that have fully implemented NQF endorsed Safe Practices.[iv]
- **NQF's focus on endorsing measures related to prenatal care is making a difference:** The Joint Commission requires hospitals to report on elective delivery prior to 39 weeks. A recent study found that the rate of neonatal intensive care unit (NICU) admissions dropped by 16 percent in 27 hospitals focused on reducing elective deliveries – and that if widely implemented across the country this could result in a dramatic drop off of admissions and hundreds of millions of savings per year.[v]

Measure Development and Endorsement

Let me now talk about where measures come from and where NQF fits in.

Measures are brought to NQF by over 65 different developers including physician specialty societies, the American Medical Association, The National Committee for Quality Assurance (NCQA), academic and community organizations and others. More than half of NQF's chairs of committees are physicians, and about 30 percent of all measures in NQF's portfolio are developed by medical specialty societies. These measures are largely derived from clinical guidelines. As part of the measure development process, NQF requires developers to test the measures and submit the test results that demonstrate their measures are valid and reliable. NQF does not itself develop measures; we think that would be a conflict of interest. Rather, our job is to assure that measures meet rigorous standards. Let me explain how.

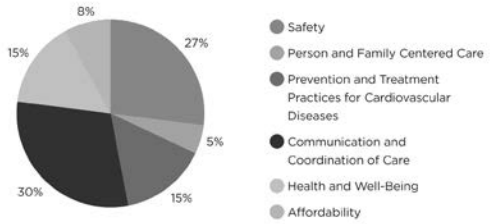
NQF assembles committees with the right specialty expertise on the topic at hand, whether that is related to appropriateness for cardiac imaging or best surgical care. Forty-eight percent of the experts on these committees are physicians who bring their deep clinical expertise to the table; the other half represent patients, payers, hospitals, and others with a stake in healthcare. Overall, these diverse perspectives are helping to move measures from being provider centric to be more patient centered and are reflective of where we collectively want to drive the healthcare system.
When these multi-stakeholder committees are convened, their task is to evaluate sets of measures against agreed upon standards. About 70 percent of measures reviewed are endorsed and receive the NQF good housekeeping seal of approval. In order to receive NQF endorsement, measures must meet key endorsement criteria:

- **Importance to measure and report** – This criteria evaluates whether the measure has potential to drive improvements, including care improvements, and includes a careful evaluation of the clinical evidence
- **Scientific acceptability of measure properties** –This criteria evaluates whether the measure will generate valid conclusions about quality; if measures are not reliable (consistent) and valid (correct), they may be improperly interpreted
- **Usability and use**– This criteria evaluates whether the measure can be appropriately used in accountability and improvement efforts
- **Feasibility** – This criteria requires evaluators to review the administrative burden involved with collecting information on the measure. If a measure is deemed too burdensome, alternative approaches need to be considered
- **Assess related and competing measures** – This criteria requires evaluators to determine whether the measure is duplicative of other measures in the field. NQF endorses best-in-class measures and where appropriate combines (harmonizes) similar measures to reduce burden associated with requests to report near-identical measures.

NQF strategically manages its portfolio of about 700 endorsed measures to simultaneously increase impact and decrease burden on providers, growing the measure portfolio in some

areas and shrinking it in others. NQF replaces existing measures with those that are better, reflect new medical evidence, or are more relevant; removes measures that are no longer effective or evidence-based; and expands the portfolio to bring in measures necessary to achieve the National Quality Strategy.

How NQF-Endorsed Measures Stack-Up Against National Quality Strategy Priorities



NQF plays an important role in the harmonization and alignment of performance measures. In the surgical world, NQF served as a key facilitator of a harmonization process between the American College of Surgeons and the CDC to achieve a single national standard for surgical site infections. For something as important as infections after surgery, there needs to be one and only one national standard to drive improvement. NQF has also worked to ensure that measures are aligned across populations and payers. NQF pressed CMS to expand key outcome measures like 30-day mortality beyond the Medicare population so that providers can be judged on their whole patient population. To move performance measurement into the future, NQF can play a critical role in ensuring that the building blocks of measures, like data elements and value sets used to define diabetes or heart failure, are harmonized, reliable and valid.

Rigorous standards are imperative to physician and purchaser confidence in and use of measures. The Committee is right to link rigorous measures to payments, just as you would be right to reject using poor quality measures that will fail to drive the system to be more patient centered and higher performing. Pursuit of the latter will add to cost and burden with no improvement in care.

Retaining a Single Measure Review and Endorsement Process

As policymakers consider payment reforms that focus on quality performance, I strongly believe that ensuring there is one central hub of measure review and endorsement – such

as has been created at NQF – allows for the most efficient, rapid, inclusive and effective process for bringing new quality measures into the system.

I know that there are proposals under consideration that would set up an additional process for approving measures. NQF and its wide range of stakeholders – including businesses, consumer groups, health professionals and plans -- are concerned that establishing a separate process will simply result in more cost and redundancy and will do little to move the ball forward in bringing effective, consensus-based quality measures into the health system.

Having an additional process for measure review would likely result in more "look alike" measures and lack of alignment in use of the same measures – both would add to data collection and reporting burden. And when the measure results were publicly reported, it would lead to confusion about whether they were comparable. Having said that, and to be absolutely clear, we welcome and are committed to finding ways to enhance and evolve the measure development, endorsement, and selection process and commend you for opening up the conversation on the critically important issue of getting better measures to market more rapidly.

Our stakeholders also believe it's important that they have a constructive seat at the table. Having HHS review and approve submitted measures instead of the existing consensus-based entity would mean that private sector stakeholders may have less opportunity for ongoing input into the measure review and approval process. Ensuring all stakeholders have a substantive role in this process ensures that the highest quality measures are approved that can drive real change in moving toward a lower cost, patient-centric healthcare system.

Additional Background on NQF's Portfolio of Endorsed Measures: 2012 at a Glance

By way of further background on the role NQF has played in bringing quality metrics to market, let me provide further details on NQF's recent work.

In 2012, NQF completed 16 endorsement projects -- reviewing 430 submitted measures and endorsing 301 measures, or 70 percent. This included 81 new measures and 220 measures that maintained their endorsement after being considered in light of any new evidence and/or against new competing measures submitted to NQF for consideration.

More specifically in 2012, NQF endorsed:

- **Patient safety measures.** Americans are exposed to more preventable medical errors than patients in other industrialized nations, costing the United States close to $29

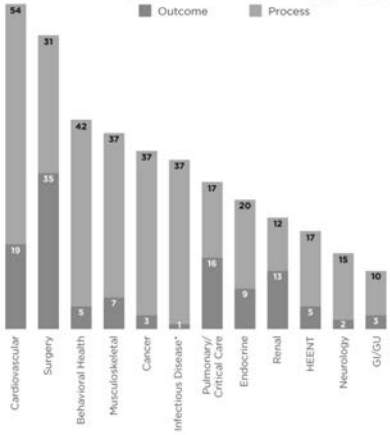
billion per year in additional healthcare expenses, lost worker productivity, and disability.[vi] NQF endorsed 32 patient safety measures in 2012, focusing on complications such as healthcare-associated infections, falls, medication safety, and pressure ulcers. ,

- **Resource use measures.** The full spectrum of healthcare stakeholders is increasingly attuned to affordability and focused on how we can measure and reduce healthcare expenditures without harming patients and improving care. NQF endorsed its first set of resource use measures—designed to understand how healthcare resources are being used—in January 2012, and it endorsed an additional set in April 2012. These measures are primed to offer a more complete picture of what drives healthcare costs. Used in concert with quality measures, they will enable stakeholders to identify opportunities for creating a higher-value healthcare system.
- **Patient experience measures.** Measures endorsed include a measure evaluating patient satisfaction during hospitalization for surgical procedures; measures focused on effective provider communication with patients regarding disease management, medication adherence, and test results; seven related measures that address health literacy, availability of language services, and patient engagement with providers; and measures that evaluate how bereaved family members perceive care provided to loved ones in long term care facilities and hospitals.
- **Harmonized behavioral health measures.** In 2012, NQF endorsed 10 measures related to mental health and substance abuse, including measures of treatment for individuals experiencing alcohol or drug dependent episodes; diabetes and cardiovascular health screening for people with schizophrenia or bipolar disorder; and post-care follow-up rates for hospitalized individuals with mental illness. As a part of this process, NQF also brought together CMS and the National Committee for Quality Assurance (NCQA) to integrate two related measures into one measure, addressing antipsychotic medication adherence in patients with schizophrenia.
- **A measurement framework for those with multiple chronic conditions.** People with multiple chronic conditions (MCCs) now comprise more than 25 percent of the U.S. population[vii,viii] and are more likely to receive care that is fragmented, incomplete, inefficient, and ineffective.[ix,x,xi,xii,xiii] Yet despite the growing prevalence of people with MCCs, existing quality measures typically do not address issues associated with their care, largely because of data-sharing challenges and because measures are typically limited to addressing a singular disease and/or specific setting. As a response to these challenges, NQF endorsed a measurement framework that establishes a shared vision for effectively measuring the quality of care for individuals with MCCs that developers can use to more expeditiously create measures for this population.
- **Healthcare disparities measures.** Research from the Institute of Medicine shows that racial and ethnic minorities often receive lower quality care than their white counterparts, even after controlling for insurance coverage, socioeconomic status, and comorbidities.[xiv] NQF commissioned a paper outlining methodological issues and an approach to identify measures that are more sensitive to disparities and as such should be stratified. From there, NQF endorsed 12 performance measures, focused on patient-provider communication, cultural competence, language services, and others.

In addition to the endorsement activities highlighted above, NQF is consistently working to ensure resources are devoted to the highest priority work. These initiatives include:

- ***Periodic review of measures to ensure NQF-endorsed measures are up-to-date:*** The size of NQF's portfolio declined in 2012 through retiring competing measures, or removing measures where performance was already topped out at very high levels. Specifically, 93 new measures were added and 103 were removed from the NQF portfolio.
- ***An ever-increasing focus on endorsing outcome measures, which have the greatest promise for improving care and reducing costs:*** At the end of 2012, 27 percent of the measures in NQF's overall portfolio were outcome measures, compared to 24 and 18 percent in 2011 and 2010, respectively. See the chart below for more specificity about NQF-endorsed condition-specific measures, which provide some insight as to the degree a given physician specialty is likely to have outcome measures. Overall the proportion of outcome measures differs across conditions, with proportionally higher percentages of outcome measures for surgery and cardiac care.

Measures Receiving NQF Endorsement in 2012, by Category



*Additional outcome measures captured in safety areas (not shown).

Why Measures Fail Endorsement

While roughly 70 percent of measures submitted to NQF in 2012 received endorsement, other measures did not because they did not adequately meet NQF's rigorous scientific, clinical and other criteria detailed above.

Of the measures that were not endorsed by NQF last year, the vast majority failed to meet the "importance to measure" requirement. The criterion of importance to measure and report is intended to ensure that performance measurement and reporting are focused in areas that have the greatest leverage for driving improvements in quality of healthcare and patient outcomes.

Many things that *can* be measured require additional actions before they can have any meaningful effect for patients. For example, ordering a lab test will not improve care and outcomes unless the results are reviewed in a timely manner, interpreted correctly, and followed with the appropriate treatment. For most measures that failed the importance criterion, there was limited evidence to suggest that a measured "process" had any relation to desired outcomes. Some measures had very high levels of performance with limited opportunity for further improvement. Other measures, especially at the hospital level, did not have fulsome enough risk adjustment to adequately distinguish between quality and unmeasured patient risk (e.g., severity of illness).

Illustrative examples of measures that failed to pass endorsement follow:

- ***No evidence of relation between a measured process and desired patient outcomes***: An NQF expert committee failed to recommend a measure regarding seizures because the measure focused simply on whether the "type of seizure" was documented, rather than how this documentation could be used by clinicians to determine the appropriate care and/or improve outcomes.
- ***Process measure too distal from effect on outcomes***: A measure of whether a physician considered using thrombolytic therapy was rejected in favor of a measure of actually administering life-saving thrombolysis to patients. A measure that included only whether a pain assessment was completed, without assessing whether an intervention reduced pain failed importance.
- ***Lack of a performance gap in care***: Measures that focus on areas where performance is already high are frequently rejected in favor of measures that focus on areas where there are clear deficits in performance. For example, the compliance rate for assessing neonates' initial temperature in the NICU is already at 98 percent. Given this, a recent measure in this area was rejected because the

expert committee determined that such a measure did not meet the "importance" threshold.

- ***Lack of adequate risk adjustment***: For outcome measures, it is critically important that the measures be risk adjusted to ensure that measurement reflects true outcomes of care, rather than unmeasured severity of illness. In the last year, NQF rejected measures related to stroke mortality and readmissions due to concerns related to adequate risk adjustment. A composite measure of adverse perinatal events was also not approved due to the absence of risk adjustment.

For measures that do not meet rigorous standards, there is an inherent risk in using them. The variation reported may not be true differences in quality across providers but rather measurement "noise." Further, linking payment to poor quality measures will not drive the system to be more patient centered or higher performing and instead will add cost and burden. Linking payment to poor quality measures is not a responsible expenditure of Federal dollars.

Evolving Endorsement as the Science of Measurement Changes

As the healthcare system continues to evolve and demand greater focus on healthcare quality and improvement, I thought I should also spend a minute providing information on how NQF is evolving its processes to meet increasing demand for endorsed measures. For example, over the last year, NQF has solicited feedback on ways to more rapidly bring critical quality measures into the health system. As part of this effort, the organization is moving forward with redesign efforts to reduce the wait for developers to submit measures to NQF and to decrease the amount of time it takes for measures to get through the NQF review process. This plan builds upon the success NQF has already had in reducing the measure review cycle time from 12 to 7 months.

- To provide a few more specifics, some of NQF's re-design efforts include setting up standing committees to expedite the review process, implementing a new approach for technical review of measures, and changing NQF's process for public comment:
  - ***Standing Committees***: NQF will move to Standing Committees, away from committees appointed for each project that receive submissions after a Call for Measures. Standing committees would reduce project start-up time; reduce time between measure submission and measure review; and move to single flow processing of measures, i.e., review measures one at a time. With training and facilitation, standing Committees also will provide greater consistency and a more global view of measures in a topical area.
  - ***Technical Review***: As a way to provide more consistency and objective input to the Standing Committees, NQF will incorporate peer reviews on the technical aspects of the NQF evaluation, including evidence, reliability and validity. These multiple peer reviews should provide consistent and unbiased input to the Standing Committees.

- ***Open Comment***: NQF will move to a more continuous, open commenting model on all measures, newly submitted and endorsed. This will enhance the information from the field on measures under consideration and provide NQF member and public input prior to committee recommendations.

All of these efforts are helping ensure NQF is ready and capable to meet the growing demand for quality improvement and quality measurement as our healthcare system continues to evolve.

Thank you for this opportunity to provide the Ways and Means Health Subcommittee testimony on behalf of the National Quality Forum. I am happy to answer your questions or elaborate further on any points made in my testimony.

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Appendix A - National Quality Forum Board of Directors

William L. Roper, MD, MPH, *Chair* Dean, School of Medicine Vice Chancellor for Medical Affairs and Chief Executive Officer, UNC Health Care System, University of North Carolina at Chapel Hill	**Helen Darling, MA, *Vice Chair*** President, National Business Group on Health
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William Kramer Executive Director for National Health Policy Pacific Business Group on Health	**Harold D. Miller** President and CEO Network for Regional Healthcare Improvement
Elizabeth Mitchell CEO, Maine Health Management Coalition	**Dolores L. Mitchell** Executive Director Commonwealth of Massachusetts Group Insurance Commission
Mary D. Naylor, PhD, RN, FAAN Director, New Courtland Center for Transitions & Health and Marian S. Ware Professor in Gerontology University of Pennsylvania School of Nursing	**Debra L. Ness** President National Partnership for Women & Families

Samuel R. Nussbaum, MD Executive VP and Chief Medical Officer WellPoint, Inc.	**J. Marc Overhage, MD, PhD** Chief Medical Informatics Officer Siemens Medical Solutions, Inc.
John C. Rother, JD President and CEO National Coalition on Health Care	**Bernard M. Rosof, MD** Chair, Board of Directors Huntington Hospital, and Chair, Physician Consortium for Performance Improvement (PCPI)
Bruce Siegel, MD, MPH President and Chief Executive Officer National Association of Public Hospitals and Health Systems (NAPH)	**John Tooker, MD, MBA, FACP** Associate Executive Vice President American College of Physicians
Richard J. Umbdenstock, FACHE President and CEO American Hospital Association	
DHHS REPRESENTATIVES	
CMS Centers for Medicare & Medicaid Services **Designee: Patrick Conway, MD** Chief Medical Officer	**AHRQ** **Carolyn M. Clancy, MD** Director, AHRQ **Designee: Nancy Wilson, MD, MPH** Senior Advisor to the Director
HRSA **Mary Wakefield, PhD, RN** Administrator, Health Resources and Services Administration **Designee: Terry Adirim, MD** Director, Office of Special Health Affairs	**CDC** **Thomas R. Frieden, MD, MPH** Director, Centers for Disease Control and Prevention **Designee: Peter A. Briss, MD, MPH** Captain, U.S. Public Health Service Medical Director
EX OFFICIO (NON-VOTING)	
Ann Monroe Chair, Consensus Standards Approval Committee President, Health Foundation for Western and Central New York	**Paul C. Tang, MD, MS** Chair, Health Information Technology Advisory Committee Vice President and Chief Medical Information Officer Palo Alto Medical Foundation

STATEMENT OF DR. PATRICK T. COURNEYA, HEALTH PLAN MEDICAL DIRECTOR HEALTHPARTNERS, INC.

Chairman BRADY. Dr. Courneya.

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

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

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

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

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

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

I would like to illustrate with a brief example from my own personal experience. I am a health plan medical director, but I am also a board-certified family physician with 25 years of clinical experience. By instinct I see performance-based payment through the lens of a 13-physician family practice clinic in Minneapolis that I once helped to run. Our small practice served a broad range of patients, from affluent middle class to first-generation Hmong, Somali, Eritrean, and Korean immigrants. We accepted a broad range of insurance coverage, including Medicare and Medicaid.

In the 1990s, as we sought to prove our value against larger systems, we responded to the early cost and quality transparency initiatives emerging in Minnesota. At that time, using a paper-based system, and supported by bonus payments from health plans and a local health-plan-sponsored quality collaborative, our small clinic

was able to perform as well as or better than the largest groups in our market on clinically-important quality measures. We learned just how much improvement is possible if the market signals are right and support is present.

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

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

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

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

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

Thank you again for the opportunity to appear here today.

[The prepared statement of Dr. Courneya follows:]

TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING TUESDAY, MAY 7, 2013 AT 10:00 AM

Hearing on Developing a Viable Medicare Physician Payment Policy
Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

Tuesday, May 7, 2013

Statement of Patrick T. Courneya, M.D.
Health Plan Medical Director
HealthPartners, Inc.
Minneapolis, Minn.

I. Overview

Chairman Brady, Ranking Member McDermott, and Members of the House Ways and Means Health Subcommittee, on behalf of HealthPartners, I am grateful for the invitation to submit the following testimony to the Subcommittee. My organization shares the belief that the replacement of the SGR with a viable Medicare physician payment policy is a critical element of the comprehensive approach to health care reform in the United States. Moreover, we believe that a broad-scale shift from fee-for-service payment to value-based payment is important throughout our health care system. We applaud all efforts to find thoughtful and workable solutions and we are very pleased to be part of the discussion here today.

The reform and repeal proposals released so far have included a phased approach that we think is wise and sequenced properly.

These phases essentially describe the same path we have taken as we have advanced meaningful physician payment reform in Minnesota. HealthPartners has played an integral role in the gradual strengthening of the alignment between physician payment and patient value in Minnesota over the past 20 years.

I will offer some of the details in this testimony. In doing so I hope to support our firm belief that the elements of payment reform in Minnesota are replicable, scalable and can contribute to a model for the rest of the country, including Medicare. And because much of the piloting of this work is complete and tools are established, we suggest that the implementation of these steps could happen much faster than they have in our state.

I speak as a board-certified family physician with 25 years of clinical experience. In my current role as Medical Director for the HealthPartners health plan, I direct a team of medical directors in the development of policy and strategy. For much of my career, I was a partner in an independent clinic practice in the suburban Twin Cities, which became part of the HealthPartners system in 2002.

As both a practicing physician and medical director, with a view of both care delivery and health plan operations, I have been involved in integrated efforts to improve cost and quality of both care and coverage throughout my professional career. I understand the wariness and skepticism that some physicians have about value-based payment because I once shared it. I have come to understand, however, that value-based payment systems – if built thoughtfully and properly – can be not only workable but desirable for physicians and an accelerant of improved health, better experiences and improved affordability for patients.

We assert that the national implementation of such as system is now possible and badly needed. Using our total cost of care and resource use measures (described below) as a foundation for measuring relative performance between groups and for measuring year-over-year trend for a

given group, we have structured a shared-savings payment model that has worked in real-world circumstances. We believe CMS can do the same, and that doing so would provide enormous benefit to Medicare and our nation's health care system.

I wish to thank the Alliance of Community Health Plans for helping to bring our work in this regard to your attention. While my testimony will focus on the HealthPartners organization, the members of the Alliance, spread across the nation, could each tell a story of innovations they support that fit well with the proposals for SGR Repeal and Reform.

II. About HealthPartners

Founded in 1957, HealthPartners is the largest consumer-governed, non-profit health care organization in the nation. We are dedicated to improving the health of our members, patients and the community.

We provide a full-range of health plan services including insurance, administration and health and well-being programs. We serve more than 1.4 million medical and dental health plan members nationwide, and are the top-ranked commercial plan in Minnesota. Our care system includes serves more than a million patients with more than 1,700 physicians; five hospitals; 50 primary care clinics; 21 urgent care locations; and numerous specialty practices in Minnesota and western Wisconsin. Our Dental Group has more than 60 dentists and 21 dental clinics. We also provide medical education and conduct research through our Institute of Education and Research.

Sixty percent of HealthPartners members receive care through our contracted network representing the vast majority of providers in our market.

Our Medicare plan has the highest rating (five stars), achieved by only 11 plans in the nation in 2013. We serve nearly 50,000 Medicare members through our health plan.

III. Aspects of the Minnesota market and diversity of physician practices

As a leading market for value-based payment reform, Minnesota is known for having large, well-known multispecialty groups and non-profit health plans such as our own at HealthPartners. This leads some to the conclusion that meaningful progress in payment reform can only be achieved in markets with similarly structured health care systems.

The Minnesota care market is actually quite diverse, however, with many mid-sized and smaller clinic systems throughout the state's urban and rural areas. Our experience has shown that system size is no barrier to effective participation in a value-based payment system, so long as the system is structured with the needs of these kinds of clinics in mind.

As I consider the idea of value-based physician payment systems, I instinctively view them through the lens of my previous experience as a member of a 13-physician, single-specialty,

private physician practice. Our group operated three clinics in the northern Twin Cities suburbs, accepting insurance coverage from a broad mix of payers including Medicare and Medicaid. Each clinic served a different demographic mix. Our first clinic served a largely white, middle-class population, the second served an exurban and rural population, and the third served a diverse community with a burgeoning population of first-generation Hmong, Somali, Eritrean and Korean immigrants (the Twin Cities has long been a center of refugee resettlement, and Minnesota's foreign-born population growth rate outpaces that of the nation).

In the late 1980s and early 1990s, my group was surrounded by the first-wave of practices being acquired by larger groups. We recognized that it was critical to our business to be able to demonstrate that our quality was equal or better than others in the area, regardless of our size, our diverse patient demographics and the differing issues we managed in serving our communities. Our first work was centered on improvement in diabetes quality and outcomes. Using paper-based tools, and with our small size lending some agility, we began to make meaningful progress.

This work was accelerated when we became a member of the Institute for Clinical Systems Improvement, or ICSI. It was founded as a collaborative of 20 different medical groups in our area, established by HealthPartners, the Mayo Clinic and Park Nicollet Health Services, and remains active today on an even larger scale with its membership having comprised most Minnesota physicians for the past decade. HealthPartners has invested approximately $30 million into the founding and expansion of the group, and other organizations have invested an additional $25 million. This does not include the investment of time and expertise from the provider community. The goal of the group was to develop shared protocols and best practices, but also to foster the skills necessary within clinic systems to perform the work of quality improvement.

The vital enabling work of ICSI is not unique to Minnesota. Many other regions in the nation have similar collaborative organizations with likeminded missions. ICSI is aligned with the Network for Regional Healthcare Improvement, a national membership organization for regional health improvement collaboratives, whose members support improved healthcare for 40 percent of the U.S. population.

My independent practice joined ICSI as small, primary care practice group, knowing that our results would ultimately be reported publically, and we consistently performed at a higher level than much-larger systems on quality measures. We continue to see smaller practices achieve excellent results with this kind of support. In 2012, for example, a 15-physician practice in suburban Minneapolis, Northwest Family Physicians (also an ICSI member), achieved the overall highest cost and quality rating of the 18 Twin Cities-area primary care physician groups participating in our health plan network.

IV. Building blocks: Support the shift from volume to value

Over the past 20 years, HealthPartners has implemented a series of initiatives, independently or in partnership with other organizations, to encourage the steady evolution to performance- and

value-based payment. Early on, we used the tools we had available to us at the time, and we have since adopted new tools and methods as our approach has matured. Fee-for-service payment still accounts for the majority of our payment to providers, but its proportion is shrinking as a share of payment thanks to the adoption of these measures and the introduction of shared savings contracts based on the total cost of care methodology. In the early phases of these changes, providers have an inherent downside risk as they make investments to improve their ability to manage based on these new objectives. If they have made changes to staffing to manage patients more closely and do not earn the shared savings, that investment could be seen as lost revenue. Even so, as the payment model evolves, direct downside risk has become a part of our agreements.

We provide several examples of tools we have used to support this transition below.

a. Bonus payments for practice improvement

Since 1997, the HealthPartners Partners in Excellence program has provided financial bonuses and public recognition for medical or specialty groups achieving stretch targets for performance on clinical quality, patient experience, and affordability. Financial rewards are based on medical or specialty group performance as measured by Minnesota Community Measurement, the HealthPartners Clinical Indicator measurement set, and the HealthPartners Consumer Choice satisfaction survey.

b. Grants

In addition to bonuses, we also have provided direct grants to provider groups to encourage operational changes and development of necessary infrastructure to make value-based incentives possible. We have found, in general, that providing grant money upfront is more successful than withholds or fees after the fact in this transitional period. It also allows us to direct revenues to providers without creating a new category of fee-for-service payment at a time when we are working to move steadily away from that model. We do not see this as a long-term strategy.

c. Withholds

Beginning in 2001, HealthPartners introduced payment withholds with incentives for meeting cost, quality and total cost of care targets. As our approach was originally structured, providers earned this withhold back based on negotiated focus areas and reasonable but meaningful targets for performance on quality or focus on the development of quality improvement building blocks.

Some of the topics over time have included:

- Payment for progress on quality measures with the greatest room for improvement
- Paying for chronic illness management and coordination; rather than for sickness only
- Encouraging use of and paying for use of online technology and supportive care; rather than only in-person, exam-room care.
- Gathering patient-reported race and ethnicity data to give clinics a way to judge their own performance on health care disparities

In recent years, this withhold has become a mechanism for adding downside risk to shared savings agreements. While withholds are still in place, they have become a less prominent part of our approach as other, more powerful tools have become available to us, including more aggressive shared savings targets.

d. Investments in community collaborations

As noted in the above example of ICSI, we are strong supporters of community partnerships that lead to sharing of data, best practices and common systems of measurement.

e. Establishment and shared use of publicly reported cost measures

For more than a decade, HealthPartners has used the Total Cost Index (TCI) to assess cost and efficiency differences among primary care groups, specialty groups and hospitals. A provider's TCI is a measure of efficiency, intensity and price of care delivered compared to the average for similar providers. 'Total cost" includes all care, such as lab tests, x-rays and care from specialist physicians and hospitals. Ratings are calculated using claims data submitted by medical groups and hospitals that show diagnosis and treatment for HealthPartners members. Ratings are then displayed on a scale of 1 to 4 dollar signs, with one dollar sign indicating lowest total cost of care. Compared to their peers, lower-cost providers are more efficient in diagnosing and treating conditions, charge a lower fee for delivering care, or both.

f. Establishment and shared use of quality and patient experience measures

HealthPartners quality assessment ratings are based on clinical quality as well as patient experience surveys, in which members rate quality of care and service. HealthPartners collects clinical quality measures across our regional network and also draws upon reputable third-party sources, such as Minnesota Community Measurement (described below), that collect, analyze, and publicly report measures of clinical quality. These measures are based on standards established by organizations such as the National Quality Forum and the Institute for Clinical Systems Improvement, as well as measures developed by Minnesota Community Measurement.

g. Supporting region-wide uniformity in reporting

HealthPartners works closely with Minnesota Community Measurement (MNCM.org), which is a nonprofit organization established in 2000 and dedicated to improving the quality of health care in Minnesota by publicly reporting quality results. Founded by Minnesota's health plans and the Minnesota Medical Association, it has helped to pioneer collaborative heath care reporting in the state. It involves a multi-stakeholder process and an extensive set of measures, some of which are nationally endorsed by the National Quality Forum. Medicare has also adopted some MNCM-developed measures for national reporting initiatives. By submitting data to a secure, direct data submission portal, local medical groups are able to participate in pay-for-performance programs based on their full population of patients. All health plans in Minnesota rely on MNCM as the foundation of quality-based incentives.

Minnesota Community Measurement measures include clinical quality measures reported at the clinic and medical group level as well as at hospitals. There is also a cost of care comparison page for over 100 common procedures. In December 2012, Minnesota Community Measurement selected the HealthPartners Total Cost of Care measure (described below) as the standard it will use to represent relative cost performance across all reported groups.

Minnesota Community Measurement issues clinical quality reports in 15 different clinical areas including a five-component diabetes measure, four-component vascular disease measure, asthma, depression, colorectal cancer and other preventive screens, among others. There are also patient satisfaction and health information technology measures. Where appropriate, as with asthma, specialty clinics are included in the measures. New specialty measures are under development to expand the scope beyond the primary care-dominated portfolio of measures now in use.

As a part of the process for selecting the Total Cost of Care Measure, Minnesota Community Measurement came to agreement on a patient attribution model it will use. It is important to note that all of this work results from a collaborative involving providers and payers.

An expectation of the members of the collaborative is that, wherever possible, health plans will use these measures as the source of performance results when crafting quality improvement or incentive programs. HealthPartners and the other plans in our market have done well in meeting that expectation.

One example of aligned and transparent reporting of clinical quality supported by incentives is the comprehensive diabetes measure. To get credit for this measure, a patient needs to be at target for Hemoglobin A1c (blood sugar control), high blood pressure, LDL cholesterol, being tobacco free, and taking aspirin when appropriate. When first reported a little over a decade ago, the community average for this measure was 7-8 percent. In the most recent reporting year, that average is now 40 percent with one of the top performers at 60 percent (a family medicine clinic). In fact, a solo family physician scored 59 percent, and a rural community clinic scored 58 percent. All of the health plans in this market have used improvement on this measure as apart of their quality incentive programs.

V. Associated benefits

In addition to enabling value-based payment systems, the incorporation of the systems and initiatives listed above has enabled a wide range of desirable, associated benefits within our community including reductions in preventable hospital admissions/readmissions, reduced non-urgent emergency room visits, reduced unnecessary lab testing, reduced use of higher-cost drugs when generics are available, avoidance of care in higher-cost settings when another venue is available, and price increases.

At the same time they have helped us track and improve preventive care, provide coordinated care for patients with chronic/complex conditions, practice evidence-based care, reduce healthcare disparities in our community, and reduce waste.

I will cite one specific example. About 10 years ago, our data indicated that our health plan members were showing increased utilization of hi-tech diagnostic imaging, which can be costly, sometimes unsafe, and can lead to further unnecessary care. Faced with the implementation of radiology benefit management programs by all health plans in our market, providers worked to create a decision support tool in our EHR supporting evidence-based use of MRI and CT scans.

Then, called to do so by providers and in collaboration through ICSI, we shared this decision tool with other groups in our market that use the same EHR, and all major health plans in our market agreed to accept use of it in place of prior authorization.

Through this, we estimate that our community has avoided 75,000 unnecessary scans with the associated savings of tens of millions of dollars, seen the saving of an estimated 20 lives from reduced exposure to medical radiation, and reduced prior authorization times from 10 minutes to seconds – all while providing a better patient experience.

VI. A breakthrough enabling step: Nationally endorsed, freely-available standardized measures for total cost of care and resource use

Total Cost of Care, or TCOC, is a name for a method of measuring health care affordability. TCOC measures are powerful analytical tools for health plans, providers, medical groups, government agencies, employers and others with a stake in reducing health care cost trends. They can help pinpoint ways to make health care more affordable without sacrificing quality or experience. Over eighty percent of HealthPartners health plan claims originate from care systems with which we have total cost of care agreements in place.

Many organizations have experimented with TCOC models in recent years. HealthPartners has developed a TCOC model that is unique in a significant way. In addition to consideration of cost of care provided to a patient (or "Total Cost Index"), it also incorporates an innovative approach to measuring resources used in providing that care (or "Total Resource Use Index"). When used in combination, these measures yield more comprehensive, revealing and actionable results than cost measures alone.

Until recently, there was no been nationally accepted, standardized TCOC measure endorsed by a major standards-setting body. This was the impetus, in January 2011, for the inaugural call for national voluntary consensus standards for TCOC measures by The National Quality Forum (NQF), which represents health care stakeholders including consumer organizations, health plans, health professionals, providers, public and community health agencies, public and private purchasers, health care research and improvement organizations supporting industry.
NQF's unique structure enables private- and public-sector stakeholders to work together to craft and implement solutions to drive continuous quality improvement in the American healthcare system.

The NQF review measured four key factors: 1) evidence of the importance and relevance of the measures, 2) whether the measures deliver consistent and credible results, 3) usability and 4)

feasibility of implementation. Following review by a dedicated 21-person steering committee, member and public comment, and a member vote, the NQF Board of Directors on Jan. 31, 2012, announced the organization's first-ever endorsement of a full-population TCOC measurement approach.

As NQF-endorsed standards, the HealthPartners Total Cost of Care and Resource Use measures complement existing quality measures to provide a much-needed, common reference point supporting the development of accountable care organizations (ACOs) and payment reform models. Providers, insurers, government agencies, employers, consumers and other organizations can use the measures to manage costs, drive affordability and improve delivery of healthcare.

For example, the measures allow employers and consumers to compare healthcare providers based on value and cost over time. Providers can use the measures to better understand and manage cost drivers within their systems. Health plans can use them to drive development of new payment approaches and benefit designs while improving transparency of provider performance reporting. Using the measures, HealthPartners has outperformed Minnesota, regional and national risk-adjusted cost of care benchmarks for three straight years.

HealthPartners has publicly released a depth of information about the Total Cost of Care and Total Resource Use measurement approach into the public domain at no charge, such that others can use the same measurement approach within their own organizations. This release includes guidance on using the measures, technical guidelines, detailed scientific background, reference guides and sample applications.

Multiple organizations around the country, such as Priority Health in Michigan, have taken advantage of the free license to use the TCOC measure to begin to introduce the tool in their market. In addition, Dartmouth, working with us, is using the measure on a national commercial claims database in an effort to produce a Dartmouth Atlas of health care cost and resource use similar to the one they have produced using Medicare claims data.

VII. Total Cost of Care as a foundation for value based payment and cost transparency

As noted above, the Total Cost of Care measure is the foundation of payment reform HealthPartners began four years ago. Using Total Cost of Care as the measure of cost performance, we negotiated agreements with providers that included shared savings evenly divided for groups that had costs better than projected trend targets. To ensure continued quality, groups are not eligible for the shared savings payments if quality performance measures slip. As of this year, over 80 percent of our health plan members go to clinics operating under a shared savings agreement. The newest of these contracts have introduced downside risk from the chance of losing withhold dollars if groups fail to meet target performance levels on cost.

Our partnership with providers in these shared savings contracts means it is in our mutual interest for them to perform well in these agreements. Using the Total Cost of Care measures as the foundation, we bring timely information on cost performance in a series of reports highlighting areas of opportunity for reduced resource use. We can also highlight where

providers are using high-cost referral partners that are hurting their performance, which has led some to change referral patterns and others to discuss problems of high cost with their referral partners. These reports come to the providers showing data no more than five months old. Combining this broad view of cost and resource use by patients within and outside their system with the more timely information available in their EHR, provider groups have begun to make targeted changes that have impact.

We also use the Total Cost of Care measures as the source for our reporting of cost to our members. That is the best way to ensure that the results we show them are based on results providers use to make management decisions. Employer reporting, as well, is based on Total Cost of Care data, driving a consistent source for consistent views across all the stakeholders we serve.

It is important to recognize that shared savings agreements are inherently transitional. As the best performers begin to come up against the limits of effective and efficient care for their patients, they will have less shared savings opportunity. We are in the early stages of developing newer models that continue to make the most effective and efficient care the most successful model for the financial performance of care systems.

There is another important point in this discussion. We have made these reforms on a foundation of fee for service payment, which still accounts for the majority of revenue that flows to providers. This has served as a way to use a familiar-though-flawed transactional framework while beginning to build the skills necessary to perform in newer models.

VIII. Summary

HealthPartners supports the goals of the Proposal and we applaud the bi-partisan congressional efforts to shift Medicare physician payment policies away from fee-for-service and toward payment that rewards performance, quality and value. In summary:

1) The Minnesota payment reform example is strong, but the solution is not Minnesota-specific.

Although the above list of tools available in our market will not necessarily be the same as those available in other markets, we do believe these and others are available, or can develop, in any market. We know other markets have unique challenges and unique strengths, but no market is incapable of making progress on this type of reform. It took us twenty years to get to this point, and we believe lessons learned here and elsewhere can significantly compress the timeline for making progress across the country.

2) The building blocks are available and present the chance to move ahead on a reasonable (3-5 year) timeline.

There are now ample, real-world examples that performance-based physician payment systems can work and work well. Of particular and timely import are the total cost of care and resources

measures newly endorsed by the National Quality Forum and available in the public domain, free of charge.

3) The potential opportunity is enormous.

The adoption of value-based payment policies by CMS would leverage one of the nation's most significant opportunities for assuring continued attention to high-quality care in measureable terms while grappling with the clear national concern about the cost of care. Because of Medicare's prominence as the single largest payer in the nation, fixing the SGR could become a powerful force in aligning incentives in a way that is consistent with the work already underway in the commercial market.

On behalf of HealthPartners, I again thank the Members of the Subcommittee for the opportunity to present this perspective. We look forward to continuing to support and assist in this important work in the months and years ahead.

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

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

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

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

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

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

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

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

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

Dr. COURNEYA. That is correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. OPELKA. Well, so——

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

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

As we are moving in the NQF and we look at what is happening with clinical data, rather than claims data, with clinical registries, rather than non-registry-based data, we move the performance

measurement system into a much more robust system. And so, moving from a claims-based system for performance measurement in the real clinical data drives much higher fidelity in the performance measurement world. And then, if that maps to a payment system, we push those together.

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

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

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

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

Chairman BRADY. Great. Thank you. Mr. Johnson.

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

Dr. COURNEYA. Yes, they are.

Mr. JOHNSON. Are they really? All the time?

Dr. COURNEYA. Well, as far as my business office tells me.

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

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

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

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

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

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

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

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

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

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

Dr. COURNEYA. Well——

Mr. JOHNSON. Because you said you weren't satisfied with it.

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

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

to make a big difference in the quality outcomes. And we did so with very simple approaches.

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

Mr. JOHNSON. Great. Thank you, sir. Yield back.

Chairman BRADY. Thank you. Mr. Kind.

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

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

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

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

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

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

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

So, it has been a rigorous process, it has been an evolution. We have been getting faster at how we do it, which is making the standard more usable, friendlier. But it is really that dedication to the science and the rigor, so that we avoid misclassification. And

we have seen it from measures that have not gone through the process where they end up with creating a misguided end result.

Mr. KIND. Sure.

Dr. OPELKA. So we are wedded to that as a standard.

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

[No response.]

Mr. KIND. The physician-based value modifier. Dr. Cutler, do you know what——

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

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

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

Mr. KIND. Right.

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

Mr. KIND. Right.

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

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

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

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

Dr. COURNEYA. You know, actually not.

Mr. KIND. Oh, no?

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

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

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

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

Dr. COURNEYA. Yes.

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

Chairman BRADY. Thank you. Mr. Roskam.

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

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

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

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

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

Dr. COURNEYA. Sure. A couple of thoughts. First of all, just on the best and brightest, I have the great pleasure of actually meet-

ing a lot of the new folks coming in. Still attracting them, and that is really exciting.

Mr. ROSKAM. That is good.

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

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

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

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

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

Mr. ROSKAM. Dr. Williams.

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

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

Mr. ROSKAM. Thank you. I yield back.

Chairman BRADY. Great. Thank you. Mr. Blumenauer.

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

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

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

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

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

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

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

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

Dr. HOYT. Yes, I would like to comment, because I think to really accelerate the pace of what you are asking for, we really need

to invest in information systems. And I don't mean the electronic medical record, per se. I mean data registries, data to physicians. And we need to then incentivize, in addition to individual physician behavior, we need to incentivize collaboration, or physicians working together to common solutions, that come out of the data that they examine. Those two elements are really the two major features that lead to change.

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

Mr. BLUMENAUER. Doctor——

Dr. HOYT. And the biggest inhibition is the finances behind that.

Mr. BLUMENAUER. Dr. Cutler, did you want to comment?

Dr. CUTLER. I would just add it is the position of the ACP that—the American College of Physicians—there are hundreds of practices, thousands of doctors, that have now incorporated team-based care, the patient-centered medical home, into their practices. Those practices, because of the team-based nature, can provide the services that you speak about. The physicians have the time to talk to the patients about the complex nature of their illnesses. And other members of the team can also supply medical information to them. So, there are enough practices, in the view of the ACP, that we could begin implementing these programs and incentives right now.

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

Mr. BLUMENAUER. Thank you. Thank you, Mr. Chairman.

Chairman BRADY. Thank you. Dr. Price.

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

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

I want to just touch on a different topic, but Dr. Williams mentioned utilizing especially society guidelines as an affirmative defense in a court of law to end the practice of defensive medicine.

We have been working on this for a number of years. And thank you for that note, and look forward to continuing to work with each of you on getting us to a system where we can end the practice of defensive medicine, which I believe—and others—wastes hundreds of billions of dollars.

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

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

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

Mr. PRICE. More flexibility——

Dr. HOYT [continuing]. I think to talk about it broadly, rather than looking—and study it in context that would be the appropriate way to do it.

Mr. PRICE. Dr. Cutler.

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

Mr. PRICE. Understand the——

Dr. CUTLER [continuing]. In a way——

Mr. PRICE. Yes, you know, I appreciate. And we look forward——

Dr. CUTLER [continuing]. That patient care wouldn't be compromised.

Mr. PRICE [continuing]. To working with you on that, yes.

Dr. CUTLER. But thank you.

Mr. PRICE. Let me talk about—Dr. Williams.

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

Mr. PRICE. Thank you, thank you. Now let me switch to the transition, because we—most folks have talked about a period of

time of transition. I think five years, as many of you have stated, is an important period of time. During that transition, though, I hope that it is not just a period of time to then impose another formula that again doesn't work. Shouldn't we get the quality measures, and all of those things, correct? Shouldn't that be our goal during that time of transition? Dr. Courneya, maybe?

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

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

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

Mr. PRICE. Dr. Cutler? Cart before horse?

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

And if you also look at the results of practices that are patient-centered medical homes, we are seeing that hospital admissions are down huge percentages, readmissions are down, costs are down. So the patient-centered medical home, I think, has built in some of the quality measures successfully that you are referring to. And the result is that costs are down. Patient satisfaction and professional satisfaction among those physicians is also quite high.

Mr. PRICE. Thank you.

Chairman BRADY. All right, thank you. Mr. Pascrell.

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

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

As you know, Mr. Chairman, in 2009 the Democrats passed a permanent fix for Medicare physician payment, H.R. 3961. So I think our position is pretty clear. But I must commend you, I must commend Ms. Schwartz, and those people who have put some pro-

posals on the table, because there is a lot of common factors when you look at all these recommendations. I hope that we can, with your help, get to the resolution. Because this cannot be hanging over our heads for the rest of the year or in years to come.

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

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

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

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

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

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

Mr. PASCRELL. Thank you. Dr. Courneya.

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

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

centile as a consequence of changing the way physicians work in that practice.

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

Mr. PASCRELL. Thank you. In conclusion, Mr. Chairman——

Chairman BRADY. Thank you.

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

Chairman BRADY. Thank you, Mr. Pascrell. Mr. Buchanan.

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

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

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

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

So, I guess I would ask the docs to start off—just my first—my own observation—I think it is very applicable here—is the fact that this idea—we have got to make sure we take the time, the thoughtfulness, as much idea as we can get from yourselves and others to get this right. And, Dr. Hoyt, do you agree with that?

Dr. HOYT. Let me give you an example. The way you can take data that is developed by registries and use it to effect behavior is as follows. If you graph it and put each provider, each physician on that graph, there is some on the right that are performing not as well as those on the left that are performing better. Those people on the right, when they see that and you make that data avail-

able to them, by the virtue of their commitment to their patients and improving as physicians, they want to move in the direction of improving. And so that is why data is such an important and powerful tool to get behavior aligned with, ultimately, quality.

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

Mr. BUCHANAN. Thank you. Dr. Courneya.

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

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

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

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

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

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

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

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

But I do want to go—come back to a practice that is patient-centered that is a high-level functioning, patient-centered medical home, by very definition has many of the quality metrics built in to that certification. And those homes are doing quite well in terms

of, as I said earlier, hospital readmissions, hospital admissions, cost of care. So I think the essence of the answer lies in team-based care and certified medical homes.

Dr. COURNEYA. Right——

Mr. BUCHANAN. Thank you, Mr. Chairman, and I yield back.

Chairman BRADY. Thank you. Representative Schwartz.

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

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

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

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

So, I wanted to ask two questions, if I may. And that is if you could talk a little bit more—I will start with Dr. Cutler, but think Dr. Courneya might want to mention—talk about this, as well—the focus on primary care and how important that is to helping enable all specialists and all physicians and all primary care physicians to actually provide the right kind of care to patients, and the degree

to which we have to or should be making sure that we focus on both increasing reimbursements and then also just making sure that the models that we move forward on actually include primary care. That is my first question.

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

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

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

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

Ms. SCHWARTZ. Right.

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

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

Ms. SCHWARTZ. Okay.

Chairman BRADY. Thank you. Mr. Smith.

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

[Laughter.]

Mr. SMITH. But I only mention that because I think it is a reflection of some well-intending efforts of those associated with government to try to create a better situation. And yet, SGR, although well-intended, has not been impacting the situation as we would prefer. And it is very compelling when I hear that patients themselves—for which there is no acronym description—are seeing reduced access because of the obvious fiscal realities that exist. And

that is without the next wave of health care reform efforts that I already sense are seeing some resistance.

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

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

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

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

Mr. SMITH. Dr. Williams.

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

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

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

Mr. SMITH. Dr. Hoyt.

Dr. HOYT. You know, I think, you know, in specialty care, particularly in surgery, we are seeing a trend toward employment as one form of this. And when you add to that, then, bundling of payments to entities or systems as a potential reimbursement model, you know, you create a—on the one hand, some real advantages so that somebody that is part of a bigger system doesn't have the in-

vestment costs in electronic medical records, they may feel less burdened by liability in a more protected environment.

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

Mr. SMITH. Very briefly, Dr. Courneya?

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

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

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

Thank you, Mr. Chairman.

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

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

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

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

Chairman BRADY. Very quickly, Dr. Hoyt.

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

Chairman BRADY. So it can be done.

Dr. HOYT. Yes.

Chairman BRADY. Your answer.

Dr. HOYT. Yes.

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

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

With that, the meeting is adjourned.

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

[Member Submissions for the Record follows:]

May 21, 2013

The Honorable Kevin Brady
Chairman
Subcommittee on Health
Committee on Ways & Means
1135 Longworth
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
Subcommittee on Health
Committee on Ways & Means
1135 Longworth
Washington, DC 20515

Dear Chairman Brady and Mr. McDermott:

Thank you for the opportunity to add to the record of the House Ways and Means Health Subcommittee hearing of May 7, 2013 regarding reform of the Sustained Growth Rate (SGR). We support and appreciate the committee's efforts to bring changes to the manner in which physicians are paid in the Medicare system, especially as it relates to making the fee schedule more accurate, more transparent and more flexible to the dynamics of health care costs.

As part of the Committees' SGR examination we respectfully request changes to the California Geographic Practice Cost Index (GPCI) localities be included to further accuracy in payments to Medicare doctors.

The GPCI is applied at county-level jurisdictions – localities – that are designated as "urban" or "rural" based on local physician charging patterns in 1966. Rural localities are generally paid less because traditionally the cost of doing business there is less. Though the law calls for regular updates in locality payments, CMS has only once, in 1997, changed locality boundaries and then only modestly.

The failure of CMS (Centers for Medicare and Medicaid Services) and its predecessor agency HCFA (Health Care Financing Administration) to regularly update the localities has resulted in massive discrepancies in payment patterns in many states. In California the problem is particularly egregious with CMS officially considering San Diego County – a robust community of 3,177,063 (2012 estimate) – to be a rural county. Because of this outdated designation under the current payment formula Medicare doctors in San Diego County are collectively underpaid by approximately $24 million.

This low reimbursement rate has created doctor access problems for senior citizens and denies the Medicare program the skills and services of talented physicians. It also creates financial

problems for hospitals that must accommodate low reimbursements from CMS for Medicare doctor services in their facilities.

California is not the only state with this problem. Florida, Texas, Illinois and Washington State also have similarly inappropriate payment applications to their localities. For example, in Texas doctors in Collin and Rockwall counties are underpaid by 8.72% and 8.03%, respectively. CMS pays Medicare doctors in Snohomish County in Washington 6.95% less than the formula requires due to the rural locality label applied to that county. Overall there is a $29.1 million discrepancy in doctor payments in Texas, a $12.6 million discrepancy in doctor payments in Washington and a whopping $60.7 million discrepancy in doctor payments in Florida.

California has worked for a number of years to correct the locality designation problem. Language to correct the California locality problem was a part of the CHAMP Act (HR 3162) passed by the House in the 110th Congress. It was also part of the Affordable Health Care Act (HR 3962) as passed by the House in the 111th Congress. It has been the subject of a GAO report (2007, GAO-07-466), an Urban Institute study (2008), a CMS-commissioned study by Acumen LLC (2008) and an Institute of Medicine (IOM) report as mandated by PPACA (Pub. Law 111-148, Sec. 1157) that was issued in 2011 and further updated in 2012 (http://www.nap.edu/catalog.php?record_id=13138). All these reports documented the locality problem – especially its significant mismatch in California – and recommended fixing it with an approach that used metropolitan statistical areas (MSA) as the geographic locality instead of the current county-based locality.

Under CMS regulations any shift in locality designations must be budget-neutral in its result. In addition, the CMS regulations require "sign-off" by the state medical association to effect a change. In California we have come up with a solution that is budget neutral and has the official endorsement of the California Medical Association. It comports to the recommendations of the GAO, Acumen and IOM studies and has the further added benefit of instituting a locality payment system that parallels the system CMS uses to pay hospitals, ie., one based on a geography of MSA economic drivers.

In the outline of the SGR fix this subcommittee has put forward one of its guiding principles is payment accuracy and transparency. We agree that these are absolute necessities for any SGR reform legislation. By extension, we respectfully submit that a correction to the GPCI locality problem should be included in the SGR reform package for the same reasons: payment accuracy and transparency. It makes no sense to attempt partial payment reform; reform has to encompass all aspects of the payment formula. As your outline states: accuracy is fundamental to a new payment regimen.

Attached is draft legislative language to update localities in California from the current county-based designation to one determined by MSA. It acknowledges that in making this re-designation there will be doctors in some counties that see reimbursement levels inch downward (which is the result of the mandated zero-sum budget neutrality regulation) but we protect those doctors by instituting a "hold harmless" for four years. The hold harmless is paid for by accompanying legislation that creates a County Operated Health System (COHS) in Alameda County,

California. In short: we fix a California locality problem with a California MSA fix paid for by a California COHS. No other state is impacted.

While we suggest this solution, we stand ready to work with the Committee and our California colleagues to develop a solution that is satisfactory to all parties.

Sincerely,

DARRELL ISSA
Member of Congress

SAM FARR
Member of Congress

[Public Submissions for the Record follows:]

The Alliance For Quality Nursing Home Care

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Statement for the Record on Behalf of the Alliance for Quality Nursing Home Care

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

Hearing on "Developing a Viable Medicare Physician Payment Policy"

May 7, 2013

The Alliance for Quality Nursing Home Care (the "Alliance") appreciates the opportunity to provide this written statement for the record of the May 7, 2013, U.S. House of Representatives Committee on Ways and Means Subcommittee on Health hearing entitled "Developing a Viable Medicare Physician Payment Policy." The Alliance applauds the Subcommittee's Leadership and Members for holding this hearing to improve the Medicare physician payment system. Our members agree that the current sustainable growth rate (SGR) formula is unworkable. SGR reform matters to America's nursing homes because outpatient therapy services, including those provided in skilled nursing facilities (SNFs), are paid according to fees established in the physician fee schedule. Any change in the SGR formula directly impacts the payment rates for therapy services provided under Part B. Thus, we call on Congress as it seeks to reform the physician payment system also to enact meaningful reforms to address problems with the current therapy payment program.

The Alliance fully supports efforts to avoid a "one size fits all" approach. Consistent with this view, we also strongly believe that it is important to decouple Part B therapy from the physician payment system and further recognize the significant distinctions between therapy provided in SNFs and other institutional settings and therapy provided in outpatient settings.

Just as the SGR formula fails physicians, it also fails those professionals and institutions providing therapy services. The Alliance supports the repeal of SGR and with it repeal of the therapy caps so closely linked to the SGR and physician payments currently. We agree that there is an urgent need for payment reform. However, we increasingly are concerned that the reform proposals under consideration at this time do not acknowledge or differentiate between physicians and others paid under the fee schedule. Proposals to reform the payment system so that it becomes more sustainable and rewards high-quality, efficient care should also include reforms that would address the problems with the current methods Medicare uses to pay for Part B therapy services provided in institutional settings generally and more specifically SNFs.

Specifically, the Alliance recommends that the Congress authorize the creation of a therapy-specific episode-based payment system that permanently separates payment for these services from the physician fee schedule payment structure. An episodic payment model would focus on patient needs and the duration of care rather than on arbitrary therapy categories. It would create

incentives for providers to manage therapy more efficiently. Shifting toward an episodic payment model would be consistent with proposals to reward the efficient use of resources.

Part B therapy services provided in institutional or inpatient settings (where payment under Part B simply is an artifact of payment policy inconsistencies) justify separate consideration from outpatient therapy services. The Alliance believes that an episodic payment model could be implemented more quickly with regard to therapy services, particularly in institutional settings, than in the traditional physician context.

Once a stable payment system is in place, additional incentives to reward high quality care could be developed. There are gaps in quality measure development, especially for therapy services. While some metrics exist today, more work is needed to develop a meaningful set of measures that could be applied to services provided in institutional settings. The Alliance supports exploring different models to afford greater flexibility for providing and rewarding high quality care. Thus, we recommend that as part of therapy payment system reform, any reform proposal include the requirement to develop robust therapy measures and to test different structural model(s) necessary to reward high-quality providers.

Finally, a reformed payment model for Part B therapy services should eliminate current policies that impose undue burdens on the provision of care and that would become unnecessary in an episodic payment system. For example, both the therapy caps and the multiple procedure payment reduction (MPPR) policies – which also disproportionately and adversely impact SNFs and other institutional providers – no longer would be necessary. In addition, the Subcommittee should also take the opportunity to review the inconsistency in regulations that apply to therapy services provided in Part A and Part B. These should be aligned in a manner that reduces unnecessary burdens on providers.

In sum, we reiterate our support for the ongoing efforts to stabilize and reform the physician fee schedule. Specifically, we recommend that any reform proposal:

1. Include a section that specifically reforms the payment framework for therapy services provided in institutional settings to focus on patient need and incentivize the efficient use of resources;
2. Repeal the therapy cap and MPPR along with the SGR; and
3. Authorize the development of specific therapy metrics to be tested in alternative payment models that reward providers for high-quality outcomes.

* * * * *

The Alliance is a coalition of 10 leading post-acute and long term care organizations providing quality skilled nursing care and other post-acute services to as many as 300,000 patients each year in approximately 1,200 facilities nationwide. As the leading provider of Medicare post-acute services, America's SNFs provide quality post-acute services that allow more than 50 percent of patients to return home. This percentage increases annually to the benefit of Medicare beneficiaries and U.S. taxpayers.

STATEMENT SUBMITTED BY THE

AMERICAN SOCIETY OF TRANSPLANT SURGEONS

TO THE

HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

REGARDING THE MAY 7, 2013 HEARING ON

"DEVELOPING A VIABLE MEDICARE PHYSICIAN PAYMENT POLICY"

May 6, 2013

Dear Congressman Brady:

On behalf of the American Society of Transplant Surgeons (ASTS), we appreciate the opportunity to submit this statement for the Committee's consideration regarding options for repealing the Sustainable Growth Rate (SGR) formula and developing a viable Medicare physician payment system that rewards quality and value. The ASTS is a medical specialty society comprising more than 2,000 transplant surgeons, physicians, scientists, advanced transplant providers, and allied health professionals dedicated to excellence in transplant surgery through education and research with respect to all aspects of organ donation and transplantation so as to save lives and enhance the quality of lives of patients with end stage organ failure.

Please note that in this submission we focus on two aspects of our detailed feedback of April 15, 2013, to Congressmen Upton, Camp, Pitts and you on your Second Draft of the Sustainable Growth Rate Repeal and Reform Proposal. First, we believe that transplant surgery and transplant healthcare delivery can serve as an ideal model for healthcare and payment reform, based on quality and value. Second, current proposals for SGR repeal pose certain specific challenges for transplant surgery and we hope you will consider our suggested solutions and incorporate them into reform plans.

Transplant Surgery as a Model

ASTS respectfully submits that transplantation should serve as a model for healthcare and payment reform, based on quality and value. Some relevant characteristics of our specialty include:

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- Coordinated delivery of lifelong, complex, multi-disciplinary care;
- System of bundled payments to the hospital and physicians who provide care to the patient;
- Established healthcare improvement initiatives that focus on the entire episode of care, incorporating data driven quality assessment and performance improvement;
- Use of the scientific registry of transplant Recipients (SRTR), as described below. SRTR reporting mechanisms focus on what transplant patients focus on: patient and organ survival – what health economists call "ultimate" health outcomes, rather than a multiplicity of "process" and intermediate outcomes measures that are of little or no meaning to patients and that are incomplete measures of quality.

The SRTR is a comprehensive national database of transplantation statistics. The SRTR operates under contract with the Health Resources and Services Administration (HRSA), a sister agency to CMS within HHS. Participation in the SRTR is mandatory. The SRTR is an electronic, secure registry. SRTR reporting is audited by the Organ Procurement and Transplantation Network (OPTN), which operates under a separate HRSA contract. Accuracy is audited and missing data is flagged. Non-compliance can lead to a transplant center being classified as not in good standing by OPTN. Additionally, CMS can decertify a program that is non-compliant with SRTR reporting. Third party payers utilize SRTR data to make contracting decisions such as selection of transplant programs into Center of Excellence networks. The SRTR provides:

- A well-established and publicly available website;
- Reliable transplant information for patients, families and medical professionals;
- A complete list of U.S. transplant centers;
- Waiting time and organ availability data;
- Survival statistics and other relevant outcomes data for waitlisted and for transplanted patients, lifelong;
- Risk adjusted outcomes data; and
- Publicly available, Program Specific Reports (PSRs).

The SRTR provides comprehensive outcomes data on patient and organ survival, broken down by transplant center and specific to the type of organ involved. It shares detailed patient and organ survival and other outcome information for every transplant for each transplant center and each type of organ transplant (i.e., kidney, liver, heart, heart-lung, pancreas, intestine, kidney-pancreas). This is precisely the type of specific, accessible outcome information that patients and prospective patients want and need. Each center's performance is risk adjusted and reported against applicable benchmarks: Actual performance is compared to "expected" performance on key measures, taking into account sophisticated (albeit as-yet-imperfect) risk adjustment methodologies. Hospitals can compare their results to hospitals of all types, in all regions of the country. The data is fed back to sites through a variety of reports, and guidelines, case studies and collaborative meetings help hospitals learn from their data and implement steps to improve care. CMS CoPs related to transplant program quality improvement mandate programs to continually review center specific data to identify opportunities for

process and outcome improvements. The SRTR has enabled health outcomes and transplantation research leading to publications in peer-reviewed journals covering such topics as renal patient mortality, morbidity, and quality of life, organ allocation, organ transplant wait lists, organ procurement, and outcomes after transplantation. We invite you to explore the SRTR website at greater length at www.srtr.org/local_stats.aspx.

RECOMMENDATION: Use the SRTR as a viable, tested, and effective model to create or support existing mechanisms to measure health care outcomes and quality.

Specific Concerns and Solutions

Your joint letter with the Energy and Commerce committee on SGR reform send to the Provider community on April 3, 2013, conveyed details about the three phase plan for payment reform. ASTS applauds the Committee's intention to provide a multi-year period of time to develop meaningful quality measures with adequate risk adjustment, and to decrease the administrative burdens of reporting on performance.

ASTS' key concerns and solutions regarding current proposals for SGR repeal include:

1) Although transplant healthcare providers already must comply with extensive process regulations and attain robust outcome standards, ASTS remains concerned about the time, expertise and expense needed to develop and implement additional meaningful measures of quality and efficiency. The process of quality measure development is complex and ongoing. In order to complement quality outcome measures, ASTS currently seeks to develop additional transplant-specific, evidence based, performance measures. We have engaged with the AMA's Physician Consortium for Performance Improvement (PCPI) and with ACS's NSQIP to investigate possibilities to facilitate this complex process. Such measure development requires great resource of expertise, time, and expense. While the SRTR focuses on what patients focus on – patient and organ survival – transplantation as a specialty would need time and require assistance to develop clinical practice improvement activities.

   ASTS is pleased that you plan for a period of stable payments allowing providers enough time to prepare for change, to develop appropriate quality and efficiency measures, and to implement clinical practice improvement activities.

   RECOMMENDATION: We request that Congress also make increased funding and assistance readily available from agencies such as AHRQ, HRSA, PCPI, and NSQIP, to bolster current systems or assist in the development of any new measurement systems.

2) As you have proposed, quality and performance measures must contain appropriate risk adjustment so that incentives are fair and mitigate against risk aversion. Providers who treat sicker, more complicated patients should not be penalized. Appropriate risk adjustment will require significant

time and expertise. For example, the SRTR publishes observed and expected outcomes for transplant centers every six months using a thirty month rolling national cohort and Cox proportional hazards models to adjust for risk. These program specific reports (PSRs) are used by OPTN and CMS to scrutinize transplant center performance. Despite having a long-standing registry, transplantation continues to struggle with appropriate risk adjustment. Even after many years, the current model does not appear to take into account many risk factors that may have an adverse effect on transplant center outcomes, but provides the best model going forward to achieve this important result.

RECOMMENDATION: We propose that the Committee use the SRTR as an example of the complexities of appropriate risk adjustment, and again ask that you provide for ample time and resources required to develop meaningful risk adjustment.

3) The quality of healthcare is increasingly viewed as a collaborative endeavor and ASTS is concerned about problems that would result from attribution of transplant results to individual surgeons, including the potential untoward effect of risk aversion instead of necessary teamwork. Transplantation is dependent not only on individual surgeon performance but also on a myriad of other factors, including the quality of the infrastructure and services provided by the transplant center, the efficacy of the organ procurement organization, and the contributions of the other members of the transplant team, such as non-surgeon transplant physicians, medical consultants, nurses, nutritionists, pharmacists, transplant coordinators, and administrators. To attribute patient or organ outcomes solely to the lead transplant surgeon is to ignore the significant and often critical roles of the rest of the team. Such an approach would be inimical to the focus on care coordination that is the hallmark of quality assurance programs and that is increasingly recognized as critical by healthcare policymakers.

   We urge the Committees to facilitate considerable flexibility in determining the reporting entity for which quality performance is assessed for the purpose of variable payments. Transplantation is a "team endeavor," and it is most appropriate for performance data to be attributed to the transplant center as an entity.

   RECOMMENDATION: We suggest that the proposal require institutions that organize transplant teams to be responsible for the individual quality measures. This approach would allow for the "ultimate" health outcomes to be viewed from the team perspective and other, less than "ultimate" measures, viewed from the individual standpoint. We believe this model has application across other specialties – especially certain surgical specialties.

4) ASTS is concerned about the huge administrative burdens on transplant centers created by dual federal agency oversight. Transplant Centers are currently regulated by both the Centers for Medicare and Medicaid Services (CMS) through its certification requirements and by the Health

Resources and Services Administration (HRSA) through the Organ Procurement and Transplantation Network (OPTN).

RECOMMENDATION: We strongly believe that CMS and OPTN requirements pertaining to transplant center safety and quality should be consolidated to the extent practicable; that on-site surveys should be conducted only when substandard outcomes are detected and documented; that surveys should be conducted at the same time by both agencies to reduce the administrative burden on affected centers; that survey personnel should be coordinated to ensure that clinical review is conducted by those with substantive expertise in transplantation; and that reports of deficiencies by the two agencies should be consistent.

Thank you for this opportunity to provide ASTS's perspective on the SGR issue. We applaud you for efforts to repeal the SGR and to develop a new Medicare payment policy. Transplant surgery's quality measurements an ideal model for your efforts to develop a viable Medicare physician payment system.

In summary, we strongly urge you to allow adequate time, funding, and assistance to develop specialty-specific quality performance measures and improved risk adjustment methods, and that transplant quality be measured from the perspective of a team endeavor, so that incentives are fair and to mitigate against risk aversion. We also call for increased harmonization of transplant regulatory measures (CMS CoPs, UNOS policies and SRTR mandates) and substantially decreased reporting burdens.

ASTS looks forward to continued partnership with you in this important effort and we would be delighted to engage in further discussion as you move forward.

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SGR REFORM AND THERAPY CAP REPEAL

Legislative Principles of the American Physical Therapy Association, the American Occupational Therapy Association and the American Speech-Language-Hearing Association

Outpatient Therapy Services and SGR/MPFS Reform
Physical therapists, occupational therapists, and speech-language pathologists provide critical outpatient health care services to beneficiaries that enable individuals to remain in their homes and communities and function at their highest possible level. The Medicare Physician Fee Schedule (MPFS) is used in Medicare Part B claims to report outpatient therapy services, and we are therefore acutely aware of the threat of annual fee schedule reductions, the cost to repeal the flawed sustainable growth rate (SGR) formula, and its impact on beneficiaries' access to health care services. We support reform but firmly believe that efforts to repeal or reform the SGR should reflect the role of both physicians and non-physicians in outpatient Medicare services.

Our Associations collectively recommend that the following principles be considered for inclusion in SGR legislation:

Repeal of the Medicare Therapy Cap on January 1, 2014
Since the inception of the SGR and the therapy cap in 1997, annual extensions to fix both policies have moved together in the SGR/Medicare extenders package (for CY 2013, the therapy cap is $1,900 for occupational therapy and $1,900 for physical therapy and speech-language pathology, combined). The Associations believe it is imperative to provide a long-term solution to the therapy cap in any legislative effort to reform the SGR. Including therapy cap reform in the larger SGR package will ensure that Medicare beneficiaries will continue to have access to medically necessary therapy services. The therapy cap is uniquely problematic in that it is a statutory provision directly preventing Medicare beneficiaries from receiving covered services after an arbitrary, artificial dollar limit.

Alternative Payment and Coding System for Outpatient Therapy
Our Associations support movement to a per-session payment system no later than January 1, 2016. Physical therapy, occupational therapy, and speech-language pathology should be treated as separate and distinct services under any payment system or systems.

When the therapy cap was created in 1997, Congress charged the Centers for Medicare & Medicaid Services (CMS) to develop an alternative payment system for outpatient therapy. The therapy community is proposing to reform payment for outpatient physical therapy and occupational therapy services by transitioning from the current timed codes system to a per-session system. This type of coding and payment methodology better describes services furnished in a session, reflects the professional clinical reasoning and judgment of the therapist, and provides policymakers and payers with a more accurate payment system that ensures the integrity of medically necessary services. The therapy community is working through the American Medical Association's Current Procedural Terminology (CPT) and Relative Value Update Committee (RUC) process to recommend a new payment and coding system to CMS for Physical Medicine and Rehabilitation Codes (97000 series). Under the reform, payment for outpatient therapy would remain under the MPFS. CPT codes associated with the evaluation and treatment of speech-language pathology related conditions have been billed at per-session rates since the development of those codes. As such, the new payment and coding system under development would apply to physical therapy and occupational therapy.

Cost Saving Recommendations
Medical Review: A system of medical review for claims over a threshold amount of $3,700 ($3,700 for occupational therapy and $3,700 for physical therapy and speech-language pathology, combined) was first instituted in 2012. Claims above this figure represent the top 5% of all outpatient therapy claims; this is the figure that the Associations proposed and that CMS implemented. Our Associations support a permanent policy of medical reviews of high utilization therapy claims once the therapy cap is repealed.

We recommend that this policy continue for claims exceeding $3,700 for services in 2014, and be thereafter adjusted annually using the Medicare Economic Index (MEI). We are monitoring the medical reviews process but based on problems identified with the current iteration of the process, we would also recommend refinements to the current medical review process to ensure timely submission and review of claims, such as streamlining and simplifying forms, electronic submission and proof of receipt, the use of peer reviewers, and enforcement of the Congressionally-mandated 10 business day turnaround time for decisions. Making this policy permanent–as opposed to just a one-year policy–will provide CMS with added incentives to make the process more effective and efficient.

We view this medical review process as a cost saving alternative to the therapy cap that will ensure beneficiary access to medically necessary therapy services without requiring yearly extensions of the therapy cap exceptions process. While the current therapy cap exceptions process ensures access to therapy services, we believe a refined medical review process will better assure appropriate utilization in a manner that is effective and appropriate.

Focus on Outliers: We recommend that CMS focus medical and/or other discretionary reviews of therapy claims on outlier claims. Reviews should be targeted; focusing on certain high-cost geographic areas (as identified by MedPAC), particular providers, diagnoses, number of episodes per year, and other factors, rather than consist of blanket reviews that are burdensome to both CMS and to providers.

Quality Outcomes for Medicare Patients
Consistent with ongoing efforts to link payment to quality, therapists have worked with CMS and others to develop, implement, and report on quality measures, and the Associations continue to work internally to develop measures specific to each therapy discipline. In 2013, the therapy community began a new system of functional data collection coordinated by CMS that will provide us with additional information. We support continuation of this program with evidence-based refinements in order to collect more accurate information on patients and on the services they received.

Moratorium on the Multiple Procedure Payment Reduction
As part of the American Taxpayer Relief Act of 2012, Congress increased the multiple procedure payment reduction (MPPR) policy applied to outpatient therapy from 20% in private practice and 25% in facilities to 50% in all outpatient settings as of April 1, 2013. We remain concerned that this flawed policy will have a significant impact on therapy payment and patient care, even as the therapy community is actively working to move away from multiple procedure services in an alternative payment system. The increased MPPR of 50% will result in a 7% cut for outpatient therapy reimbursement. Coupled with the previous 7% reduction in payment from the original MPPR in 2011 and the 2% sequestration cut, the cumulative reductions of over 15% in two years equate to a considerable impact for therapy services which will ultimately impact patient access and care. We urge Congress to place a moratorium on the increase from 20/25% to 50% MPPR until implementation of a new coding and payment system.

In addition, the way in which the MPPR is applied across disciplines on a given treatment day is inappropriate. We request that Congress work to ensure that the MPPR is applied separately to the disciplines, as they are separate Medicare benefits and distinct services.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

May 10, 2013

The Honorable Dave Camp
Chairman
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Henry Waxman
Ranking Member
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

RE: SGR Repeal and Reform Proposal: Medicare Payment Locality Update Needed in California

Dear Chairman Camp and Upton and Ranking Members Levin and Waxman:

The California Hospital Association (CHA), representing more than 400 hospitals and health systems across the state, applauds your efforts to resolve the problems plaguing the Medicare payment program for physicians and urge your careful attention to a specific problem in 14 counties in California.

The long outdated geographic locality designations used in the current payment formula for physicians designates 14 counties, including some as large as San Diego, Monterey and Sacramento, as "rural", thereby reducing payments and ignoring demographic and practice cost increases. The geographic regions used by Medicare for hospitals are updated regularly so that hospital reimbursement accurately reflects local costs to deliver care. Unfortunately, the physician regions have not been updated in 15 years. As hospitals and physicians work together to provide care in their local communities, it is only fair that they receive accurate payment for the services they provide.

Physicians practicing in these misclassified regions are paid as much as 14% below what Medicare would pay if they were in a correctly classified region. About a third to one half of the physician groups and hospitals in these regions report difficulty recruiting physicians because the cost of living and the cost to practice are high but the Medicare locality payments have not kept pace with these real costs. Most of these regions have lost substantial numbers of physicians. *Thus, patients in these regions report serious access to care challenges, including long waiting times to see physicians.* Exacerbating the problem is the fact that private payers track Medicare payments so the Medicare locality payments negatively impact access to care for all patients.

CHA supports the solution proposed by Representatives Darrel Issa and Sam Farr to redistribute physician payments within California in a way that would have no fiscal impact on the federal government. Their plan is a California financed solution to a California problem. We acknowledge that the outdated Medicare payment localities are a national problem that needs reform, but we urge you to start by addressing the most pressing concerns in California where the payment discrepancies are the largest.

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We urge your support for this important effort to address more equitable payments for physicians in California and preserving access to care for all Californians. Please contact Anne O'Rourke in CHA's Washington, DC office at 202.488.4494 or aorourke@calhospital.org if you have questions or need additional information.

Sincerely,

C. Duane Dauner
President and CEO

CAPG California Association of Physician Groups

Chairman Kevin Brady
Health Subcommittee
Committee on Ways and Means
Washington, DC 20515

Ranking Member Jim McDermott
Health Subcommittee
Committee on Ways and Means
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott,

We would like to submit the below comments for the record on the hearing on Developing a Viable Medicare Physician Payment Policy.

CAPG strongly supports a legislative change to the way Medicare pays certain physicians in California. Medicare's payment formula has created inaccurate payment to physicians in California by erroneously classifying certain payment localities as "rural" when their costs are equal to or greater than localities classified as "urban." The result of this error in the formula is that Medicare underpays physicians in some areas of the state. In the most severe instances, Medicare payments are as much as 14 percent lower than they would be under a more accurate formula.

We understand that the Committee is currently considering legislative language that would fix this inaccuracy for four years. The legislation would require a switch in locality designations under Medicare for a period of time. Such legislation would correct inaccurate payment in our counties for a period of four years and would make a significant positive difference for California doctors.

We encourage the Health Subcommittee to fix the California Medicare locality designation issue as part of any package to fix Medicare physician payments this year.

Please do not hesitate to contact us if you have any questions. We thank you for your consideration.

Sincerely,

Donald H. Crane
President & CEO
CAPG

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Community Hospital of the Monterey Peninsula®

May 10, 2013

The Honorable Dave Camp
Chairman
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The Honorable Fred Upton
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The Honorable Henry Waxman
Ranking Member
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

RE: SGR Repeal and Reform Proposal: Medicare Payment Locality Update Needed in California

Dear Chairman Camp and Upton and Ranking Members Levin and Waxman:

Community Hospital of Monterey Peninsula (CHOMP), a non-profit healthcare provider serving the Monterey Peninsula and surrounding communities, applauds your efforts to resolve the problems plaguing the Medicare payment program for physicians.

The long outdated California locality designations used in the current payment formula for physicians designates 14 counties, including some as large as San Diego, Monterey and Sacramento as "rural", thereby reducing payments and ignoring demographic and practice cost increases. The geographic regions used by Medicare for hospitals are updated regularly so that hospital reimbursement accurately reflects local costs to deliver care. Unfortunately, the physician regions have not been updated in 15 years. As hospitals and physicians work together to provide care in their local communities, it is only fair that they receive accurate payment for the services they provide.

Physicians practicing in these misclassified regions are paid as much as 14% below what Medicare would pay if they were in a correctly classified region. Community Hospital of Monterey County continues to encounter difficulty recruiting physicians because the cost of living and the cost to practice are high but the Medicare locality payments have not kept pace with these real costs. Most of these regions have lost substantial numbers of physicians. *Thus patients in Monterey County report serious access to care challenges, including long waiting times to see physicians.* Exacerbating the problem is the fact that private payers track Medicare payments so the Medicare locality payments negatively impact access to care for all patients.

CHOMP supports the solution proposed by Representatives Darrel Issa and Sam Farr to redistribute physician payments within California in a way that would have ***no fiscal impact on the federal government.*** Their plan is a California financed solution to a California problem. We acknowledge that the outdated Medicare payment localities are a national problem that needs reform, but we urge you to start by addressing the most pressing concerns in California where the payment discrepancies are the largest.

We urge your support for this important effort to address more equitable payments for physicians in California and preserving access to care for all Californians. Please contact Steven J. Packer at 831.625.4502 or Steven.Packer@chomp.org if you have questions or need additional information.

Sincerely,

Steven J. Packer, MD
President & CEO

GREENWAY®

May 21, 2013

Chairman Camp, Chairman Brady and committee members,

Greenway Medical supports almost 14,000 primary care and specialty providers nationwide through an integrated healthcare information technology and business services platform.

These provider-customers are currently embracing an array of care coordination programs based on quality and value over episodic or procedural care. As you have repeatedly heard in direct testimony, this approach toward a preventive, evidence-based and truly sustainable delivery system is the ultimate goal of the committee's initiative to repeal the Sustainable Growth Rate (SGR), enact payment stability away from Medicare Fee-For-Service and continue to improve value-based medicine initiatives.

Greenway's mission is to provide caregivers with data exchange, reporting and analysis solutions as the foundation for standardizing the metrics and measurements of reportable care coordination.

Providers utilizing these solutions - along with those of patient engagement, clinical decision support, revenue cycle management and more – are currently practicing within CMS Shared Savings (MSSP), patient-centered medical home (PCMH), meaningful use, PQRS, e-prescribing and various private payer accountable care programs.

Through our close collaborations with providers to fulfill their delivery needs through our platform, we have seen first-hand their uncertainty concerning current and future payment landscapes and how to reconcile changes with a long-term commitment to technology deployments that can deliver usable functions keeping pace with the future.

We applaud and urge Congress success in establishing a definable future within the Medicare structure that can continue to be a foundation for public and private care models within a system further stretched as approximately 10,000 Americans become Medicare-eligible on a daily basis.

Currently shouldering 21 percent of national healthcare expenditures, Medicare is the critical mass driver that can shape a smarter healthcare system and a behavioral change among our nation's providers. Of the many programmatic proposals in a post-SGR/FFS horizon, Greenway supports the spirit and the details put forth in the Bipartisan Policy Center's April, 2013 report, A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment.

Within it, for example, BPC outlines a Medicare Network approach that would strengthen MSSPs in part by allowing providers the freedom to adopt different care models within a given network and by sharing savings with beneficiaries to engage patients, both as tenets not currently available within MSSPs.

In line with a system-wide recipe for change, Greenway also supports continued investigations of how all metrics and programs underway within the umbrella of care coordination initiatives can be harmonized toward increasingly national standards.

Greater harmonization of clinical quality measures (CQMs), for example, and reporting requirements across care coordination and incentive programs would reduce the burden on care providers challenged with complying with multiple programs. That harmonization can merge with the introduction of the payment stability advances the committee is undertaking to align what is measured, how it is reported and how it is paid for.

Additionally, this harmonization of programs can also address the sources of newly aligned and measurable data metrics such as data from claims, patient charts or that being pulled from electronic health records, as another means to address any alignment within reporting or registry architecture.

The healthcare information technology industry itself is continuing to advance its own collaborative marketplace standards to further aid caregivers in the pursuit of a streamlined and community-based approach to patient care, aided by interoperable technology standards and secure, actionable data.

Collaborations such as the CommonWell Health Alliance, the Electronic Health Record Association (EHRA) and longstanding memberships within the Healthcare Information Management & Systems Society (HIMSS), are a few examples of technology provider organizations that regularly work with CMS and the Office of the National Coordinator for Health Information Technology (ONC) on standards and certifications directly in line with delivery and payment advances. Greenway's additional membership within the Bipartisan Policy Center referenced above is a further example of technology partners understanding the mutual benefits of the collaborative approach to policy.

Together, and with the continued unfettered ability to provide innovative health IT platforms, the greater movement toward national care coordination built from shared, risk-based or quality payment structures further harmonized through programmatic and measurable means, will benefit our nation's physical and economic health.

Thank you and Greenway stands ready to provide any assistance needed throughout this oversight process.

Sincerely,

Justin T. Barnes
Vice President, Industry & Government Affairs
Greenway Medical Technologies, Inc.

Testimony Submitted to the House Ways and Means Committee
Subcommittee on Health

Hearing on Developing a Viable Medicare Physician Payment Policy

John Noseworthy, M.D.
President & CEO
Mayo Clinic
Rochester, Minnesota

May 7, 2013

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Introduction

Chairman Brady, Ranking Member McDermott and members of the Subcommittee on Health. On behalf of the Mayo Clinic, I appreciate the opportunity to submit written testimony on the need to reform Medicare's physician payment system. As you know, the Sustainable Growth Rate (SGR) is anything but sustainable. It must be repealed. We have an opportunity to put in place a structure that helps providers offer higher quality care for Medicare patients. Mayo Clinic is widely viewed as one of the premiere providers of health care in the world. I want to share some of the learnings from our experience over more than one century of striving to provide high value health care. I also want to provide specific recommendations on how the Mayo Clinic proposes to reform the SGR.

Mayo Clinic Background

Mayo Clinic is a not-for-profit health care system dedicated to medical care, research, and education. With more than 3,600 physicians and 60,000 employees, Mayo Clinic demonstrates a relentless and unwavering commitment to excellence, which has spawned a rich history of health care innovation. Each year, more than one million people from all 50 states and 140 countries come to Mayo Clinic to receive the highest quality of care at sites in Minnesota, Arizona and Florida. In addition, we operate the Mayo Clinic Health System, a family of clinics, hospitals and health care facilities serving communities in Iowa, Georgia, Minnesota and Wisconsin. Most recently, we established the Mayo Clinic Care Network in 2011, which consists of health-care organizations across the U.S. that share a commitment to improving the delivery of health care in their communities through high quality, data-driven, evidence-based medical care. While retaining their autonomy, members of the Mayo Clinic Care Network have direct access to Mayo Clinic's expertise, as well as to Mayo Clinic's evidence-based disease management protocols, clinical care guidelines, treatment recommendations and reference materials for complex medical conditions.

Mayo's geographic footprint is illustrated in the map below.

Mayo Clinic's unique and distinguishing characteristic is the Mayo Clinic Model of Care, which is a trusted and collaborative approach to medicine that is complemented by a constant quest for knowledge and innovation and dates back to the Mayo brothers who founded Mayo Clinic 149 years ago.

In 2013, Mayo Clinic, Rochester, was ranked among the top three U.S. hospitals by *U.S. News & World Report*. Of the 16 specialty areas reviewed by *U.S. News*, Mayo Clinic, Rochester, was ranked in the top 10 in 15 specialties, in the top five in 11 specialties, and was the number one ranked hospital in four specialties.

When it comes to research and health care innovation, Mayo Clinic has been a steadfast leader. In 1907 Mayo adopted a unified medical record – a stunning advancement that is now embraced by almost two-thirds of practices in the United States. Mayo developed the first and largest multidisciplinary, academic medical group practice, created the first microscopic system for grading cancer, invented the heart-lung machine, and was awarded the Nobel Prize for the discovery of cortisone. Mayo Clinic will continue to pursue innovative care and services that will benefit patients worldwide.

Health Care Delivery in the U.S.

As Congress moves toward a permanent solution to the SGR, Mayo Clinic commends you for your efforts to tackle this challenge, and is committed to working with you to establish a plan that ensures quality, efficiency, and value for patients.

In America, we have come to expect the best of everything. However, when it comes to health care, we pay more in this country than anywhere else in the world. And yet the United States falls behind other countries on measures of health outcomes. Millions of Americans do not have or cannot afford the health care they need. We need to rethink how we pay for health care and develop differentiated payment models across the care delivery continuum –primary, intermediate, and complex care. At times, patients require primary care and preventive services. This makes up the largest portion of the continuum.

At other times, however, patients require elevated care—that may be delivered at hospitals with special expertise. Finally at the other end of the continuum, a small percentage, perhaps 1 in 1,000 each year across the U.S., of patients have conditions that are difficult to diagnose and treat and they need complex care. They are very sick and cannot get an accurate diagnosis, or require complicated care from a number of specialists or need cutting edge therapies.

Our health care system must be flexible and adaptable to the varying needs of patients.

Without it, providers will never be able to embrace the elusive goal of value: high quality care at lower costs. We propose the creation of a Medicare payment system that recognizes the different types of care along the continuum and rewards the quality and value of each, whether primary, intermediate or complex care.

Our health care payment system should include incentives and rewards for the proper management of primary care to complex cases. One irony of our current system is that the financial return from mismanagement – needlessly bouncing a patient from specialist to specialist and lab test to lab test and sometimes even giving the wrong or no answers – can be far greater than the financial return when patients are correctly and efficiently diagnosed and their treatment is managed properly.

Americans deserve a Medicare payment system that recognizes the continuum of care and rewards quality and value at each level. Medicare payment models should allow providers to choose the payment option that best fits their health care practices. The answers to the challenges we face will not be simple, but if we align how we pay for care with how we diagnose and treat patients, we can reach our goal of high-value health care for every patient.

The SGR and Payment Reform

The SGR is unsustainable. Medicare payments fall well below the cost of caring for America's seniors. At Mayo Clinic—where about half of our patients are Medicare recipients—current payments cover just 60 percent of the costs of the care we provide to our nation's Medicare beneficiaries.

The SGR has not been effective at controlling the volume of physician services. The SGR does not distinguish between those doctors who provide high quality care to beneficiaries and those who provide unnecessary services. In fact, as noted above, physicians providing the most efficient care are penalized under Medicare's current payment system while physicians who order more tests or perform more procedures than necessary receive greater reimbursement.

We must move beyond the traditional fee-for-service (FFS) system, which compensates volume of services regardless of overall patient outcomes, satisfaction, and safety. Furthermore, the FFS payment model alone does not reflect the diverse physician practice models across the U.S. The variety of business patterns employed by our nation's physicians require flexible models to accommodate these various structures.

Mayo Clinic SGR Reform Principles

After a decade of temporary fixes, Congress must act to implement a permanent solution to the SGR. We encourage Congress to adopt the following set of principles as the basis for any future reform.

- Repeal the Sustainable Growth Rate
- Establish a one to three year transitional update reimbursement schedule at no less than the Consumer Price Index (CPI).
- Put in place a menu of new payment models that recognize the diverse business models of our nation's physicians that ensures adequate provider reimbursement.
    - These payment models should offer opportunities for physicians to choose innovative models alongside FFS that work for their patients, practice, specialties and geographic region.
    - The new models of physician payment methodology must reward value-based outcomes, quality and efficient medical practices.

- New Medicare payment models such as bundled payments and accountable care models – tested in both ACA demonstration projects and private sector initiatives—are among the options that should be considered.

Accountable Care Organizations

The advent of Accountable Care Organizations (ACOs) under the Affordable Care Act (ACA) is designed to encourage coordination in a fragmented health care delivery system, with an emphasis on primary care providers. During the ACA debate, Mayo Clinic was often cited by bipartisan policy makers as a model for Medicare ACOs. We were looked to as an example because Mayo Clinic has been delivering care for more than a century in a coordinated and team based approach that produces the better outcomes and value espoused by the ACO concept.

We support greater integration of health care and strongly believe it will lower costs, increase quality and provide greater value. At the same time we recognize that the ACO model is not a panacea for the entire delivery system.

We must be careful that ACOs networks are not structured so narrowly as to preclude patients seeking answers to major health issues from having the option to come to Mayo Clinic and other top-of the-continuum centers. This is another example why it is essential to recognize the continuum of care delivery in our country. We must ensure that as we increase integration and efficiency we do not adversely impact systems, especially academic medical centers such as Mayo Clinic which are already designed to drive value in the health care system.

Patients with complex conditions often do not fit into neat categories, nor are two cases alike. For example, a cardiologist treating two patients with blackouts:

- In the first patient, the cardiologist found blackouts related to what is called neurocardiogenic syncope as well as signs of focal complex seizures.
- In the second patient with blackouts, the doctor recognized there was autonomic nervous system failure and Parkinson's disease with multiple system atrophy.

Both patients had blackouts, but the similarities ended there. The meticulous medical detective work that the cardiology team orchestrated succeeded in accurately diagnosing each patient's unique condition. Aligning how we pay for care with how we diagnose and treat patients must appropriately reflect the need for this type of complex care.

Within this part of the continuum of care, data and care outcomes must be used to create a sustainable continuum of care, and these outcomes and cost metrics must be readily available so patients, families and payers can make informed decisions about where to seek care.

Use of Data to Drive Cost Effectiveness

Public policy decision makers need to recognize, but more importantly reward, excellence across the continuum of care — primary, intermediate and complex — and do their part to create a competitive

marketplace where data drives innovation and better care at lower cost. Payment changes should include incentives and rewards for the proper management of complex cases. Patients, providers and taxpayers alike get into trouble when patients "churn" in the wrong part of the continuum of care, when health professionals fail to coordinate care or provide smooth transitions across the continuum.

Mayo Clinic's work with Optum, a subsidiary of UnitedHealth Group, is an important and promising step in aligning health care delivery and costs. By combining Mayo Clinic's robust clinical information with Optum's extensive claims data, we will better understand health care delivery over time, compare the effectiveness of care given by various health care providers and analyze the total cost of care for specific procedures or diseases. This will help Mayo Clinic provide better care to our patients, and help the industry define value through outcomes instead of volumes. This is the largest effort of this type (combining clinical and claims data) in the country. Stripped of all personal identifying information to protect patient privacy, we will be poised to assess some basic questions about what is successful, how much it costs and who is doing it best. As results are known and broadly shared, patients, providers and payers can seek and reward those who are providing the highest value.

The potential for this relationship will be even more remarkable when others join the alliance — academic medical centers, research universities, pharmaceutical and device companies, policymakers and other payers. The Optum Labs partnership is one aspect of Mayo Clinic's Center for the Science of Health Care Delivery, which was initiated in January 2011. Through collaborative work and partnerships, the center helps create and diffuse high value, lower cost care delivery models throughout the country.

By creating the center, Mayo Clinic is emphasizing the need to invest more resources into this discipline and to accelerate the pace of improvement. We constantly strive to perfect our own processes and procedures because we believe that health care providers have a responsibility to lead this effort.

Examples of high value Center for Science of Health Care Delivery initiatives:

- **Shared decision making** - Patients often get caught in the "machinery of health care" – appointments, tests, procedures – without an opportunity to participate in their own treatment decisions. Mayo Clinic is using decision aids with patients to help them define treatment goals and guide discussions on treatment or medication preferences
- **Blood transfusion program** - Mayo's patient blood management initiative seeks to reduce the number of unnecessary transfusions, ensuring that patients receive them only when medically necessary and there is a high likelihood of benefit. A transfusion program using standard protocols within Mayo Clinic's cardiovascular surgery practice resulted in a 50 percent reduction in red blood cell, platelets, and plasma transfusions. In addition, transfusion-related acute kidney injury diminished by 40 percent. Since the initiation of this program in late 2009, patient care has significantly improved and there has been a cumulative savings of $15 million.
- **Diamond depression/chronic disease project** - This new care model uses care managers and health care teams to assess the severity of the patient's condition, monitor care through a computerized registry, provide relapse prevention, intensify or change treatment as warranted, and transition patients to self-management.

In addition, Mayo Clinic is collaborating with several private sector and public sector organizations to improve coordination, and align incentives and reimbursement for outcomes that deliver high value, patient centered care. Examples of some of these efforts include patient-centered medical home partnerships with local employers and commercial market contracts with private plans.

Conclusion

It is our hope that for patients and providers and the long term sustainability of Medicare, all options will be examined with the goal of ensuring that this program is there for our grandchildren and beyond.

We applaud Congress for making SGR and payment reform a top priority this year and hope that a solution is found, agreed upon, and enacted before the end of the year. We encourage you to incorporate Mayo Clinic's SGR Reform Principles into the foundation of legislation to allow for the entire spectrum to deliver the best care, with the best outcomes, at the best value. Encouraging and incentivizing innovation and new technologies is the best way to deliver care. Please consider Mayo Clinic as a resource as you seek to find sustainable solutions for our country's health care future.

May 21, 2013

Kevin Brady, Chairman
House Ways and Means Health Subcommittee
Ways and Means Committee Office
1102 Longworth House Office Building
Washington D.C. 20515

Via email: waysandmeans.submissions@mail.house.gov

RE: ***Submission for Hearing on Developing a Viable Medicare Physician Payment Policy***
- Comments on Repeal and Replacement of Medicare's SGR with Payment Reform

Dear Chairman Brady:

The Medical Society of New Jersey (MSNJ) is a non-profit physician membership organization. We represent approximately 8,000 physicians and are the largest physician organization in the State of New Jersey.

MSNJ would like to thank the House Ways & Means Health Subcommittee for its work on the repeal and replacement of the sustainable growth rate (SGR) formula for Medicare fees. For the first time in a decade we believe that there is both the will and a way for Congress to repeal the SGR and replace it with a new payment model. We appreciate this subcommittee's work on a path forward to a sustainable Medicare program for our nation's seniors.

MSNJ supports the AMA's Principles on SGR Transition. We respectfully submit the following comments and information for your consideration.

Positive statutory payment updates for a number of years are necessary to stabilize the Medicare program. Without certainty on payment amounts for the foreseeable future many physicians will opt-out of Medicare or will reduce the number of patients they are willing to treat. We already see this trend. Our members are informing us that they have already begun to, or they will, stop accepting new Medicare patients if payment reform is not achieved. While this trend is not immediately apparent, it will inevitably result in an access to care issue. Physicians simply cannot continue to build their Medicare patient population if they face payment cuts or payment uncertainty.

Positive statutory payment updates for a number of years will ensure that physicians who are nearing retirement continue to treat Medicare patients. Our members who are nearing retirement wish to continue to treat Medicare patients. With the assurance of positive payment updates and payment reform that is phased-in over a reasonable amount of time, they are more likely to stay in the Medicare program. This is particularly important for a state like New Jersey where the physician population is more aged.

MEDICAL SOCIETY OF NEW JERSEY
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MSNJ is particularly concerned about the impact of payment reform on solo and small practices. While practice size is increasing, many of our members are still practicing in small groups. For these physicians, it is particularly important that CMS actively engage in outreach and training through phases II and III so that these practices can remain in the Medicare program. We recommend that resources be committed to outreach and training for small practices to ensure that they can continue to treat our seniors in the Medicare program.

Physicians must be involved in the development of quality measures. The development of quality measures should be physician-led and tested before the measures are fully implemented. Medical and specialty societies are eager to assist with the development of quality measures.

We strongly support choice in the types of quality reporting, including patient registries. Generally, physicians need more immediate and accurate feed-back on the quality measures that they undertake. We encourage this subcommittee to ensure that legislation requires better feed-back from CMS on quality initiatives.

MSNJ strongly supports the use of risk-adjusted ranking that takes geographic differences into account in phase III. We agree that physicians should be able to choose whether performance assessment on quality and efficiency is at the individual or group level.

MSNJ supports the concept that physicians be allowed to opt-out for alternate payment models at any time. In addition, physicians should be permitted to participate in more than one alternate payment model.

Finally, medical liability reform, repeal of the Independent Payment Advisory Board, and passage of the Patient Empowerment Act that would allow private contracting between physicians and patients are all important initiatives to our members. We urge the subcommittee to address each of these in legislation to repeal and replace the SGR.

Respectfully submitted,

Lawrence Downs, Esq.
Chief Executive Officer
Medical Society of New Jersey

Attachment: contact sheet

Cc: Congressman Bill Pascrell, Jr.

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Title of Hearing:
Developing a Viable Medicare Physician Payment Policy
Hearing Date: May 07, 2013

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Developing a Viable Medicare Physician Payment Policy
Before the Subcommittee on Health
Committee on Ways & Means
United States House of Representatives
May 7, 2013

Written statement submitted jointly by:

AARP
AFL-CIO
AFSCME
American Federation of Teachers (AFT)
American Society on Aging
Center for Medicare Advocacy, Inc.
Families USA
Medicare Rights Center
National Academy of Elder Law Attorneys
National Association for Home Care and Hospice
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Education Association (NEA)
OWL-The Voice of Midlife and Older Women
Services and Advocacy for GLBT Elders (SAGE)

Direct questions regarding this statement to:

Stacy Sanders
Federal Policy Director
Medicare Rights Center
1825 K Street NW, Suite 400
Washington, DC 20006
ssanders@medicarerights.org
202-637-0961

May 13, 2013

U.S. House of Representatives
Committee on Ways & Means, Subcommittee on Health
Washington, DC 20515

Re: Hearing on Developing a Viable Medicare Physician Payment Policy

Dear Mr. Chairman and Members of the Subcommittee:

The undersigned organizations welcome the opportunity to submit a written statement in response to the recent hearing conducted by the Subcommittee on Health of the U.S. House Committee on Ways & Means on developing a viable physician payment policy. Our organizations share a commitment to advancing the economic and health security of older adults, people with disabilities, and their families.

We agree the SGR formula is fundamentally flawed and permanent changes to the Medicare reimbursement system are long overdue. Under the current system, Congress must act on an annual basis to avert dramatic cuts to Medicare physicians and other providers. The threat of looming cuts creates uncertainty and needless stress for beneficiaries about their ability to see the physician of their choice.

We believe SGR reform must gradually replace the current volume-based payment system with a value-driven model. New payment models must reward quality, safety, value and coordination of care, as opposed to the number of services provided. At the same time, SGR replacement must strengthen primary care. Payment models which emphasize team-based care coordination, effective care transitions, and preventive care can lead to better care, better health and lower costs for Medicare beneficiaries.

On the whole, people with Medicare have multiple and significant health needs—40% of beneficiaries have three or more chronic health conditions, and more than one quarter of beneficiaries (27%) report being in fair or poor health. Nearly one in four people with Medicare live with a cognitive or mental impairment, requiring extensive, ongoing care. The health needs of the Medicare population demand a payment system that appropriately values primary care, care coordination and preventive services.[1]

We appreciate the Subcommittee's commitment to addressing the long-standing need to revisit the SGR. Yet, we believe any attempt to repeal and replace the SGR must adhere to the following principles:

1. Protect people with Medicare from cost shifting. A legislative proposal to repeal or replace the SGR must not be paid for by shifting costs to Medicare beneficiaries. Half of all Medicare beneficiaries—nearly 25 million—live on annual incomes of $22,500 or less. People with Medicare already contribute a significant amount towards health care. As a share of Social Security income, Medicare premiums and

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[1] Kaiser Family Foundation, An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Services Use (Statement by J. Cubanski before the Senate Special Committee on Aging, February 2013)

cost-sharing has risen steadily over time. In 1980, Medicare premiums accounted for 7% of the average monthly Social Security benefit compared to 26% in 2010.[2]

Given this economic reality, a permanent SGR solution must ensure beneficiaries are held harmless from payment adjustments that would increase Medicare premiums and cost sharing. To accomplish this, a new system must reduce overpayments and compensate for quality care, rather than the quantity of services provided. In short, a proposal to repeal and replace the SGR must not worsen the already tenuous economic circumstances facing many people with Medicare.

Proposals shifting costs to Medicare beneficiaries, such as by raising the Medicare age of eligibility, redistributing the burden of Medicare cost sharing through increased deductibles, coinsurances or copayments, and further income-relating Medicare Part B and D premiums, must be rejected as offsets to pay for a permanent SGR solution.

It is also important to note that current Medicare low-income protections are woefully insufficient. According to recent estimates from the Congressional Budget Office (CBO), only 33% of eligible beneficiaries were enrolled for Qualified Medicare Beneficiary (QMB) benefits and only 13% were enrolled for Specified Low-Income Medicare Beneficiary (SLMB) benefits. In addition, unreasonably low asset tests penalize beneficiaries by denying eligibility to those who set aside a modest nest egg of savings during their working years.

2. Extend the permanent fix to critical Medicare benefits. Averting steep cuts to physician payments is not the only Medicare policy revisited on an annual basis. Any permanent SGR solution must also account for these benefits, including the Qualified Individual (QI) program and therapy cap exceptions. We are very concerned that a permanent SGR fix could significantly diminish the prospects for continued bipartisan agreements on extenders packages, which always included extensions of these two critical provisions with expiration dates that correspond with the SGR.

We urge you to make permanent the QI program. The QI benefit pays Medicare Part B premiums for individuals with incomes that are 120% to 135% of the federal poverty level—about $13,800 to $15,500 per year. This benefit is essential to the financial stability of people with Medicare living on fixed incomes. Failure to make the QI program permanent alongside a permanent SGR solution raises the risk that vulnerable beneficiaries might be forced to drop Part B coverage outright, leaving them with significant, unaffordable out-of-pocket costs every time they need health care services.

Additionally, in the absence of full repeal of Medicare therapy caps, we request that you make the exceptions process permanent. Therapy cap exceptions ensure access to critical, medically necessary services that allow beneficiaries to live with independence and dignity each day.

3. Promote quality care. Payment policies must address the imbalance between primary and specialty reimbursement, as reflected in recommendations by MedPAC.[3] Medicare beneficiaries often have multiple chronic conditions, may have cognitive impairments, and need extra attention from their health care providers. Time spent explaining treatment options or following up with patients is not adequately

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[2] Kaiser Family Foundation, Policy Options to Sustain Medicare for the Future (January 2013)
[3] MedPAC, Re: Moving forward from the sustainable growth rate (SGR) system (Letter to Congress, October 2011)

valued by current reimbursement policies. These nonprocedural services provided by primary care physicians, including geriatricians, are undervalued because the current system does not take into account the needs of older adults with multiple illnesses or the cost of providing coordinated patient-centered care.

As such, the current payment system discourages providers from pursuing or continuing careers in primary care, including those with the training and skills needed to meet the unique care needs of our nation's growing population of older adults. Reimbursement rates which appropriately reflect the demand for primary care services will strengthen the primary care workforce. Replacement payment models must build a strong primary care foundation to meet the current and future needs of the beneficiary population.

In addition, new payment approaches must encourage promising delivery models, such as Patient Centered Medical Homes and Accountable Care Organizations, to coordinate and better manage care. In order to provide reliable, useful data to practitioners, quality measures must be consensus based, and endorsed by such organizations as the National Quality Forum. Allowing non-consensus-based measures undermines the current measure-selection process used by other programs and limits the ability to share quality data across programs. Moreover, a multi-stakeholder process ensures acceptance of and confidence in the measures which are ultimately selected for payment and other purposes.

In recent years, considerable energy has been focused on the development of quality measures. Yet, these efforts are largely specific to a single disease or condition, with little attention paid to developing measures for those with multiple chronic illnesses. Further, some measures specifically exclude those age 65 and over (and people with diabetes age 75 and over) from being measured precisely because of the complexity they present. Any new payment system must include quality measures constructed for vulnerable and frail older adults, so that multiple chronic illnesses are accounted for and providers are rewarded for treatment that improves quality of life.

Any process to enact a permanent SGR solution must involve the beneficiary community, including people with Medicare, family caregivers, and consumer advocates. Staying true to the principles outlined above is critical to designing a reformed payment system that provides economic stability and ensures access to high quality care for people with Medicare.

Thank you for the opportunity to provide comment.

Sincerely,

AARP
AFL-CIO
AFSCME
American Federation of Teachers (AFT)
American Society on Aging
Center for Medicare Advocacy, Inc.
Families USA
Medicare Rights Center
National Academy of Elder Law Attorneys
National Association for Home Care and Hospice

National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Education Association (NEA)
OWL-The Voice of Midlife and Older Women
Services and Advocacy for GLBT Elders (SAGE)

Monterey County Medical Society

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May 14, 2013

The Honorable Dave Camp
Chairman
Committee on Ways and Mean
United States House of Representatives
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

RE: SGR Repeal and Reform Proposal: Medicare Payment Locality Update

Dear Chairmen Camp and Chairman Upton:

Monterey County Medical Society is writing to urge you to include an update of the California Medicare payment localities in the Medicare SGR reform legislation. The outdated Medicare payment localities have created serious access to care problems in Monterey County. Because Medicare has failed to update the physician payment localities, physicians in our county are underpaid by 4% each year. Physicians have foregone $3,772,556 in Medicare payment over the years. In fact, Medicare still designates Monterey County as rural! Monterey County has a population of almost 500,00 people, with 126.5 persons per square mile (according to the U.S. Census Bureau's 2012 estimates). This payment policy has created significant access to care problems in our county.

We support the CALIFORNIA PILOT PROPOSAL being forwarded by Congressmen Darrell Issa (R-San Diego) and Sam Farr (D-Santa Cruz/Monterey) and supported by the California Medical Association. The proposal would update the payment regions to Metropolitan Statistical Areas (MSAs) as recommended by the IOM, GAO and MedPAC. Medicare pays and organizes hospitals according to MSAs. And the MSAs are updated annually. It would hold the rural counties harmless from cuts for five years. The hold is funded with California Medicaid savings in Alameda County so it does not impact the federal budget or any other state. After five years, the localities would revert back to the current locality configuration to avoid cuts to the rural physicians.
At that time, Congress can assess the California pilot and reform the geographic payment system as step two in the overall Medicare SGR payment reform effort.

Thank you for your interest in this important issue. This proposal will help to address the significant access to care problems that seniors are facing in California.

Sincerely,

William C, Parrish
CEO
Monterey County Medical Society

Cc: California Congressional Delegation
Senate Finance Committee
Marilyn Tavenner, CMS Acting Administrator

May 20, 2013

The Honorable Dave Camp
Chairman
Committee on Ways and Means
United State House of Representatives
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
Committee on Energy Commerce
United State House of Representatives
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
United State House of Representatives
Washington, D.C. 20515

The Honorable Henry Waxman
Ranking Member
Committee on Energy Commerce
United State House of Representatives
Washington, D.C. 20515

Subject: SGR Repeal and Reform Proposal: Medicare Payment Locality Update Needed in California

Dear Chairman Camp and Upton and Ranking Members Levin and Waxman:

Palomar Health, the largest public health district in California, appreciates your efforts to resolve the problems continually facing the Medicare payment program for physicians and requests your careful consideration and support of the solution proposed by Representatives Darrell Issa and Sam Farr.

The geographic locality designations used in the current payment formula for physicians designates 14 counties, including San Diego as "rural." San Diego County is home to more than 3.1 million people with an average of 735.8 people per square mile. That average is more than three times the state average of 239.1 per mile. This "rural" designation reduces payments and ignores demographic and practice cost increases, resulting in underpayments to San Diego physicians of nearly $24 million.

The geographic regions used by Medicare for hospitals are updated regularly so that hospital reimbursement accurately reflects local costs to deliver care. Unfortunately, the physician regions have not been updated in 15 years. As hospitals and physicians work together to provide care in their local communities, it is only fair that they receive accurate payment for the services they provide.

Physicians practicing in these misclassified regions are paid as much as 14% below what Medicare would pay if they were in a correctly classified region. About a third to one half of the physician groups and hospitals in these regions report difficulty recruiting physicians because the cost of living and the cost to practice are high but the Medicare locality payments have not kept pace with these real costs. Most of these regions have lost substantial numbers of physicians. *Thus, patients in these regions report serious access to care challenges, including long waiting times to see physicians.* Exacerbating the problem is the fact that private payers track Medicare payments so the Medicare locality payments negatively impact access to care for all patients.

At Palomar Health, our physician development team has experienced this issue first-hand during the recruitment process. In one instance, the physician development team had been working to recruit an experienced surgeon from the east coast. As he began to compare his income potential in San Diego County against his current practice, factoring in the Medicare reimbursement rate, the income levels didn't compare. At that point, the surgeon informed our team that while he was interested in working with Palomar Health, the dramatic decrease of income he would have to shoulder prevented him from

Administration
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continuing with the recruitment process. Unfortunately, this is just one of many such stories reflecting the struggle Palomar Health, and many other systems, deal with in recruiting physicians to San Diego County.

Palomar Health supports the solution proposed by Representatives Darrel Issa and Sam Farr to redistribute physician payments within California in a way that would have no fiscal impact on the federal government. Their plan is a California-financed solution to a California problem. We acknowledge that the outdated Medicare payment localities are a national problem that needs reform, but we urge you to start by addressing the most pressing concerns in California where the payment discrepancies are the largest.

We urge your support for this important effort to address more equitable payments for physicians in California and preserving access to care for all Californians. Please contact Elly Garner, Government Relations for Palomar Health at 858.675.5275 or elly.garner@palomarhealth.org if you have questions or need additional information.

Sincerely,

Michael H. Covert

Michael H. Covert
President & CEO
Palomar Health

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Riverside County Medical Association

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Narendrakumar S. Trivedi, M.D.

May 15, 2013

The Honorable Dave Camp, Chairman
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Fred Upton, Chairman
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

RE: SGR Repeal and Reform Proposal: Medicare Payment Locality Update

Dear Chairman Camp and Chairman Upton:

The Riverside County Medical Association is writing to urge you to include an update of the California Medicare payment localities in the Medicare SGR reform legislation. The outdated Medicare payment localities have created serious access to care problems in Riverside County. Our county suffers from the most acute shortage of doctors, having just one half the number of doctors needed for adequate healthcare services. The benchmark for primary care physician to population ration is 60-80 per 100,000 people. Riverside County currently sits at 34 primary care physicians to 100,000 people. Because of low Medicare and Medicaid reimbursement it is extremely difficult to recruit new physicians to our communities. These inequities have impacted access to healthcare for our citizens and as a result, our region consistently ranks among the least healthy.

Because Medicare has failed to update the physician payment localities, physicians in our county are underpaid by over $2,646,840 each year. Medicare still designates Riverside County as rural, when in fact we have a population of over 2.2 million people and Riverside County is the fastest growing county in the United States, expected to be the second largest County, only second to Los Angeles County, by the year 2040!

We support the **CALIFORNIA PILOT PROPOSAL** being forwarded by Congressmen Darrell Issa (R-San Diego) and Sam Farr (D-Santa Cruz/Monterey) and supported by the California Medical Association. The proposal would update the payment regions to Metropolitan Statistical Areas (MSAs) as recommended by the IOM, GAO and MedPAC. Medicare pays and organizes hospitals according to MSAs. And the MSAs are updated annually. It would hold the rural counties harmless from cuts for five years. The hold harmless is funded with California Medicaid savings in Alameda County so it does not impact the federal budget or any other state. After five years, the localities would revert back to the current locality configuration to avoid cuts to the rural physicians. At that time, Congress can assess the California pilot and reform the geographic payment system as step two in the overall Medicare SGR payment reform effort

Thank you for your interest in this important issue.

Sincerely yours,

Gerardo Hizon, M.D.
President

SAN BERNARDINO COUNTY MEDICAL SOCIETY

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Riverside, CA 92506-2229
(951) 787-7700
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May 20, 2013

The Honorable Dave Camp
Chairman
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

RE: SGR Repeal and Reform Proposal: Medicare Payment Locality Update

Dear Chairmen Camp and Upton:

On behalf of the San Bernardino County Medical Society (SBCMS), I am writing to urge you to include an update of the outdated Medicare physician payment localities in your Medicare payment reform legislation. Such an update would improve payment accuracy in the Medicare program and be consistent with your goal to reform the overall Medicare payment system. The last physician locality update was 16 years ago and physicians in San Bernardino County in California are underpaid by an annual sum of $1.8 million.

On April 15th, Paul Phinney, MD, President of the California Medical Association (CMA) submitted a letter to you highlighting in detail the many reasons why corrective action is needed and the possible solutions currently being considered at this time. The 2,500 physicians in San Bernardino County stand with CMA in calling for a long over-due adjustment of the Medicare payment amount.

Thank you in advance for your attention to this very important issue that affects healthcare access in San Bernardino County.

Sincerely,

Leroy Ounanian, MD
President

/jp

San Diego County Medical Society

"Physicians United for a Healthy San Diego"

May 15, 2013

Congressman Dave Camp, Chairman
Ways and Means Committee Office
1102 Longworth House Office Building
Washington D.C. 20515

Dear Chairman Camp:

The San Diego County Medical Society (SDCMS), which represents San Diego's more than 7,000 practicing physicians, urges you to include an update to California's Medicare payment localities in the Medicare Sustainable Growth Rate (SGR) reform legislation.

San Diego is the 8th largest city in the United States yet Medicare still designates our county as rural. Due to the fact that Medicare has failed to update the physician payment localities, physicians in San Diego are underpaid by 4% each year, and they have foregone over $313 million in Medicare payment over the years. This payment policy has created significant access to care problems in San Diego.

SDCMS strongly supports the California Pilot Proposal being forwarded by Congressmen Darrell Issa (R-San Diego) and Sam Farr (D-Santa Cruz/Monterey) and supported by the California Medical Association. The proposal would update the payment regions to Metropolitan Statistical Areas (MSAs) as recommended by the Institute of Medicine and MedPAC.

The proposal would hold California's rural counties harmless from cuts for a limited time at no cost to the government, using a California-only funding source. After five years, the localities would revert back to the current locality configuration to avoid cuts to the rural physicians. At that time, Congress can assess the California pilot and reform the geographic payment system as step two in the overall Medicare SGR payment reform effort.

Physicians are vital to the health and economic wellbeing of San Diego and are substantial contributors to the state and federal tax base. We urge you, in the name of San Diego's patients and doctors, to support the California Pilot Proposal as it will help to address the significant access to care problems that Medicare patients are facing in San Diego. Thank you for your interest in this important issue.

Sincerely,

Sherry L. Franklin, MD
President, San Diego County Medical Society

CC: Elizabeth McNeil, Federal Government Relations, CMA

5575 Ruffin Road, Ste. 250, San Diego, CA 92123
Tel: 858-565-8888 Fax: 858-569-1334 Web: www.SDCMS.org

SANTA BARBARA COUNTY MEDICAL SOCIETY

5350 Hollister Avenue, Suite A-4
Santa Barbara, California 93111
(805) 683-5333 FAX (805) 967-2871
sbcms@sbmed.org www.sbmed.org

15 May 2013 Sent by email

The Honorable Dave Camp, Chair
Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

The Honorable Fred Upton, Chair
Committee on Energy and Commerce
United States House of Representative
Washington, DC 20515

RE: SGR Repeal & Reform Proposal: Medicare Payment Locality Update

Dear Chairmen Camp and Upton:

On behalf of the Santa Barbara County Medical Association, I am writing to urge you to include an update of the California Medicare payment localities in the Medicare SGR reform legislation. The outdated Medicare payment localities have created serious access to care problems in our County. Because Medicare has failed to update the physician payment localities, physicians in our county are underpaid by 5% each year. In Santa Barbara County alone, physicians have foregone $74,496,063 in Medicare payments from 2001 to the present. In fact, Medicare still designates our County as rural!

This payment policy has created significant access to care problems in our County. The Medical Society office receives 10-15 calls every week from seniors who cannot find a physician who is accepting new Medicare patients.

We support the CALIFORNIA PILOT PROPOSAL forwarded by Congressmen Darrell Issa (R-San Diego) and Sam Farr (D-Santa Cruz/Monterey) and supported by the California Medical Association. The proposal would update the payment regions to Metropolitan Statistical Areas (MSAs) as recommended by the IOM, GAO and MedPAC. Medicare pays and organizes hospitals according to MSAs. And the MSAs are updated annually. It would hold the rural counties harmless from cuts for five years. The hold harmless is funded with California Medicaid savings in Alameda County so it does not impact the federal budget or any other state. After five years, the localities would revert back to the current locality configuration to avoid cuts to the rural physicians. At that time, Congress can assess the California pilot and reform the geographic payment system as step two in the overall Medicare SGR payment reform effort.

Thank you for your interest in this important issue. This proposal will help to address the significant access to care problems that seniors are facing throughout California.

Best Regards,

Ayesha Shaikh, M.D., President
Santa Barbara County Medical Society

May 14, 2013

The Honorable Dave Camp
Chairman
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Henry Waxman
Ranking Member
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

RE: SGR Repeal and Reform Proposal: Medicare Payment Locality Update Needed in California

Dear Chairmen Camp and Upton and Ranking Members Levin and Waxman:

Sharp HealthCare provides more healthcare services in the San Diego region than any other provider via four acute care hospitals, three specialty hospitals, two affiliated medical groups and Sharp Health Plan. Accordingly we applaud your efforts to resolve the problems plaguing the Medicare payment program for physicians and urge your careful attention to how the Geographic Practice Cost Index (GPCI) inappropriately classifies San Diego and 13 other counties in California as "rural" areas. The practical effect of this outdated designation is to under-reimburse San Diego physicians for Medicare services by almost $24 million annually.

The geographic regions used by Medicare for hospitals are updated regularly so that hospital reimbursement accurately reflects local costs to deliver care. Unfortunately, the physician regions have not been updated in 15 years. As hospitals and physicians work together to provide care in their local communities, it is only fair that they receive accurate payment for th services they provide.

Physicians practicing in San Diego are paid four percent below what Medicare would pay if they were in a correctly classified region. The 14 California counties currently inappropriately designated as "rural" face real difficulty in attracting physicians because cost of living and the cost to practice in these areas are high, but the Medicare locality payments have not kept pace with these real costs. As a result, Medicare beneficiaries in these 14 counties, including San Diego find it more difficult to access care. The problem is compounded by the fact that private payers base payments on Medicare reimbursement, so Medicare locality payments end up negatively impacting access to care for all patients.

Sharp HealthCare joins the California Hospital Association in supporting the solution proposed by Representatives Darrell Issa and Sam Farr to redistribute physician payments within California in a way that would have no fiscal impact on the federal government. Their plan is a California financed solution to a California problem. We acknowledge that the outdated Medicare payment localities are a national problem that needs reform, but we urge you to start by addressing the most pressing concerns in California where the payment discrepancies are the largest.

Thank you for your attention to this request and for your efforts to ensure proper reimbursement for America's healthcare providers.

Sincerely,

Michael W. Murphy
President and CEO
Sharp HealthCare
8695 Spectrum Center Blvd.
San Diego, CA 92123

Daniel L. Gross
Executive Vice President, Hospital Operations
Sharp HealthCare
8695 Spectrum Center Blvd.
San Diego, CA 92123

May 15, 2013

The Honorable Dave Camp
Chairman
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

RE: SGR Repeal and Reform Proposal: Medicare Payment Locality Update

Dear Chairmen Camp and Upton:

On behalf of the Sierra Sacramento Valley Medical Society (SSVMS), I am writing to urge you to include an update of the California Medicare payment localities in the Medicare SGR reform legislation. The outdated Medicare payment localities have created serious access to care problems in El Dorado, Sacramento, and Yolo counties.

Because Medicare has failed to update the physician payment localities, physicians in El Dorado, Sacramento and Yolo counties are underpaid by 1% each year, respectively. On a regional basis, this is equal to an annual underpayment of $3,388,669.

The Sacramento metropolitan area is the fourth largest in California after the Greater Los Angeles Area, San Francisco Bay Area, and the San Diego metropolitan area, as well as the 25th largest in the United States. Over the past decades our area has become urbanized with higher rents, staff wages and other local costs to practice medicine. Yet, Medicare still designates El Dorado, Sacramento and Yolo counties as rural!

Medicare payment inequities have created significant access to care problems in our area. We have a shortage of both primary care and specialist physicians and it is increasingly difficult to recruit new physicians to the area because of the low reimbursement from Medicare and other payors that base physician reimbursement at the Medicare level.

Our medical society supports the **California Pilot Proposal** being forwarded by Congressmen Darrell Issa (R-San Diego) and Sam Farr (D-Santa Cruz/Monterey) and supported by the California Medical Association. This proposal would update the payment regions to Metropolitan Statistical Areas (MSAs) as recommended by the Institute of Medicine (IOM), the General Accounting Office (GAO) and MedPAC.

On behalf of the thousands of physicians practicing medicine in our three-county area, I would like to thank you for your attention to this important issue.

Sincerely,

David Herbert, MD
President

Cc: Aileen Wetzel, Executive Director, Sierra Sacramento Valley Medical Society
Board of Directors, Sierra Sacramento Valley Medical Society
Elizabeth McNeil, Government Relations, California Medical Association

MMS
MARIN MEDICAL SOCIETY

May 16, 2013

The Honorable Dave Camp
Chairman
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

RE: SGR Repeal and Reform Proposal: Medicare Payment Locality Update

Dear Chairmen Camp and Upton:

The Marin Medical Society (MMS) is writing to urge you to include an update of the California Medicare payment localities in the Medicare SGR reform legislation. These Medicare payment localities are outdated and have created serious problems with access to care in Marin County.

Because Medicare has failed to update the physician payment localities, physicians in Marin County are underpaid by 6% each year, which translates to almost $2.9 million in underpayments annually. Our underpayment rate is the second highest in California.

Marin is one of the most expensive counties in California, with astronomic home prices and a high cost of living. The cost of providing medical services is also quite high, yet Medicare reimbursements lag far behind.

This disconnect between costs and reimbursements has greatly affected access to care for Medicare patients in Marin County. A recent survey conducted by MMS found that 27% of local physicians planned to limit or eliminate Medicare from their practices, and that more than one-fourth planned to move or retire over the next five years. More than half cited low reimbursements and high costs as the main impetus for moving or retiring. In addition, local practices have encountered chronic difficulties in recruiting new physicians. Again, the most oft-cited reasons are low reimbursements and high costs.

MMS supports the CALIFORNIA PILOT PROPOSAL being forwarded by Congressmen Darrell Issa (R-San Diego) and Sam Farr (D-Santa Cruz/Monterey) and supported by the California Medical Association. This proposal would update the Medicare payment regions to Metropolitan Statistical Areas (MSAs), as recommended by the IOM, GAO and MedPAC.

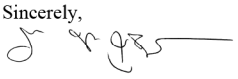
PO Box 246, Corte Madera, CA 94976 • 415-924-3891 • mms@marinmedicalsociety.org

Medicare pays and organizes hospitals according to MSAs, and the MSAs are updated annually. The pilot proposal would hold rural counties harmless from cuts for five years. The hold harmless is funded with California Medicaid savings in Alameda County, so it does not impact the federal budget or any other state.

After five years, the localities would revert back to the current locality configuration to avoid cuts to rural physicians. At that time, Congress can assess the California pilot and reform the geographic payment system as step two in the overall Medicare SGR payment reform effort.

Thank you for your interest in this important issue. This proposal will help to address the significant access to care problems that Medicare patients are facing in Marin County and throughout California.

Sincerely,



Irina deFischer, MD
MMS President

Sutter Health
Sutter Maternity & Surgery Center
of Santa Cruz

May 14, 2013

The Honorable Dave Camp
Chairman
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Henry Waxman
Ranking Member
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

RE: SGR Repeal and Reform Proposal: Medicare Payment Locality Update Needed in California

Dear Chairmen Camp and Upton and Ranking Members Levin and Waxman:

I join the California Hospital Association (CHA), representing more than 400 hospitals and health systems across the state, in applauding your efforts to resolve the problems plaguing the Medicare payment program for physicians and urge your careful attention to a specific problem in 14 counties in California.

The long outdated geographic locality designations used in the current payment formula for physicians designates 14 counties, including some as large as San Diego, Monterey and Sacramento, as well as my own Santa Cruz, as "rural," thereby reducing payments and ignoring demographic and practice cost increases. The geographic regions used by Medicare for hospitals are updated regularly so that hospital reimbursement accurately reflects local costs to deliver care. Unfortunately, the physician regions have not been updated in 15 years. As hospitals and physicians work together to provide care in their local communities, it is only fair that they receive accurate payment for the services they provide.

Physicians practicing in these misclassified regions are paid as much as 14% below what Medicare would pay if they were in a correctly classified region. We are made acutely aware of this here in Santa Cruz County on a regular basis, as a significant number of internists and family medicine practitioners have left the community – or choose to commute out of the community – for greater compensation in other counties. Access to primary care in Santa Cruz County and other similarly affected counties is disadvantaged as a result. Exacerbating the problem is the fact that private payers track Medicare payments so the Medicare locality payments negatively impact access to care for all patients.

I join CHA in supporting the solution proposed by Representatives Darrel Issa and Sam Farr to redistribute physician payments within California in a way that would have no fiscal impact on the federal government. Their plan is a California-financed solution to a California problem. We acknowledge that the outdated Medicare payment localities are a national problem that needs reform, but we urge you to start by addressing the most pressing concerns in California where the payment discrepancies are the largest.

Sincerely,

Stephen M. Gray
Chief Administrative Officer

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