MEDICARE PHYSICIAN PAYMENT: HOW TO BUILD A MORE EFFICIENT PAYMENT SYSTEM

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MEDICARE PHYSICIAN PAYMENT: HOW TO BUILD A MORE EFFICIENT PAYMENT SYSTEM

THURSDAY, NOVEMBER 17, 2005

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:41 a.m., in room 2123, Rayburn House Office Building, Hon. Nathan Deal (chairman) presiding.

Members present: Representatives Deal, Hall, Bilirakis, Upton, Gillmor, Norwood, Cubin, Shimkus, Shadegg, Pickering, Buyer, Pitts, Ferguson, Burgess, Barton (ex officio), Brown, Waxman, Towns, Pallone, Gordon, Eshoo, Green, Degette, Capps, Allen, Baldwin, and Dingell (ex officio).

Staff present: Chuck Clapton, Chief Counsel; Melissa Bartlett, majority counsel; Brandon Clark, policy coordinator; Chad Grant, legislative clerk; Jessica McNiece, minority research assistant; Jonathan Brater, minority staff assistant; Bridgett Taylor, minority professional staff; and Amy Hall, minority professional staff.

Mr. FERGUSON [presiding]. The hearing will come to order. Good morning. Chairman Deal will be here shortly.

I welcome you all to this necessary and timely hearing on Medicare's payment to those that act as a gateway into our health care system, our physicians. This morning we have two panels of distinguished doctors and observers of the medical profession to help us consider all our options in addressing this looming issue. Welcome all of you and look forward to your insights concerning some solutions to the physician payment problem at hand today.

The beginning of 2006, doctors will see a 4.4 percent cut in payment for their services to Medicare patients and will see cuts in several subsequent years thereafter. Medicare's current system of payment which applies a formula called the sustainable growth rate or SGT is part of a history of adjustment and reform that leads us to where we are today. When the SGR was applied last time in 2002, physician payments were cut 5.4 percent. After the Medicare Modernization Act passed 2 years ago in 2003, further decreases were averted and payment saw an increase of 1.5 percent in 2004 and 2005.

Today we are facing a similar problem, and it is my belief that Congress has to act to ensure that doctors do not see the cuts that are destined to happen if the SGR is allowed to be applied once again. There are many options for us to consider, and I look for-

ward to our panelists' help in deciphering what each means for our health care and for our system.

Many of the fixes are expensive, but they are more expensive than seeing our doctors struggle to justify carrying Medicare patients at their practices. Will Medicare patients stomach another large increase in premiums to offset the huge cost that a fix will bring?

Our doctors work long and hard to provide the care that they do. And our Medicare patients deserve the utmost quality of care and a wide and willing network of doctors to provide that care. I am currently on record as supporting a short-term fix to avert the looming cuts. I believe that is necessary so we can adequately compensate our doctors for their services and participation in Medicare. But I believe that if such a short-term fix is passed, it is necessary to work in the meantime toward finding a more efficient system for physician payment in the future.

Whatever the costs and however hard it is to find, we must work hard in order to find it. Again, I want to thank our distinguished panelists today for their insights and guidance as we hopefully move forward toward finding a fix. I now would like to recognize the ranking member, Mr. Brown from Ohio.

Mr. BROWN. Thank you, Mr. Chairman, thank you for filling in today.

Today's hearing is not about paying health care professionals more or paying them less. This hearing today is about paying them fairly. Medicare's physician payment system holds doctors and other healthcare professionals responsible for system-wide changes in health care needs, health care preferences. The payment adjustment mechanism, the sustainable growth rate, SGR, simply put, is not fair. The premise that individual providers should somehow pay for increases in Medicare utilization is not logical. It is simply expedient. Even if individual providers could significantly influence overall utilization trends, it is difficult to conceive of them looking for opportunities to pedal unnecessary health care any more than it is for Medicaid beneficiaries to want to seek unnecessary health care. Most of them, most of these doctors are too busy providing the necessary kind of care. Nor do I think it is in the Nation's best interest to reward physicians for reductions in Medicare utilization. Physician decisions should hinge on patient need, not on Medicare budget targets.

I join my colleague Nancy Johnson as a sponsor of the value-based purchasing of physicians' services act because it replaces the current physician payment system with an annual payment update. Taking that step would conform physician payment to that of most other Medicare providers. The Johnson-Brown bill also embraces the notion of value-based purchasing which is a promising strategy aimed at improving the quality, effectiveness and cost efficiency of health care services. Patients can only benefit from efforts to link services to outcomes and use those linkages to improve care.

Fixing the physician payment system is expensive; not fixing it is wrong. The Medicare program itself is expensive. Neglecting reimbursement flaws that jeopardize its future is wrong. To say we can't afford to pay physicians fairly but we can afford to cut physicians' taxes is a little disingenuous. There are legitimate concerns

about the impact of physician payment changes on the Medicare part B premium, but we shouldn't suffer one problem in order to keep another in check. The Medicare premium is derived from an arbitrary formula. If we don't like the annual premium increases that the formula generates, we should change the formula. In other words, rather than doing one thing wrong so we can get another thing right, we should do both things right. We should hold Medicare beneficiaries harmless unless it is all worked out.

But let's get back for a moment to the fairness issue. One of the most important insights I hope to gain from this hearing is why the Bush administration refuses to modify the physician payment formula to remove the effects of Medicare-covered prescription drugs. As far as I know, CMS has offered no policy rationale for their refusal to take this step. Removing drugs from the payment formula would prevent unjustifiable payment cuts next year. CMS could authorize the removal today even. I hope Dr. McClellan provides a compelling reason for intentionally perpetuating a bad policy. It is too expensive to fix. Remember, it was the President who initiated trillions of dollars worth of tax cuts, and I am confident the President has enough sway with his party even today to prevent the current round, which is worth $70 billion.

Congress and the Bush administration share responsibility for Medicare. It is within our power to treat health care professionals fairly. Let us do it right, let us do our part. Thank you.

Mr. FERGUSON. Now recognize the distinguished chairman of the full committee, Mr. Barton, for an opening statement.

Chairman BARTON. Thank you, Mr. Ferguson. It is good to see you there in the chair. You don't sound like Mr. Deal, but what you say is similar to what he says; you just say it differently. We are glad to have you chairing this subcommittee today.

Let me get my statement here. I appreciate the distinguished subcommittee holding today's hearing. It is important because, hopefully, it is going to provide members of this committee with a valuable perspective on the issue of Medicare physician payment and how to best ensure Medicare beneficiaries can continue to have access to quality health care. I want to particularly thank CMS Administer Dr. Mark McClellan and MedPAC Chairman Glenn Hackbarth for their appearances today. I applaud their leadership on building a more efficient and effective quality health care system.

I intend to ask some very difficult questions to try to find out what we need to do to fix the broken Medicare payment system for physicians. I am going to ask, how we are going to pay for it? For too long, Congress has tried to repair the problem by not structurally reforming the system. Instead, we just dump money into short-term fixes which have only exacerbated the problem. This has only increased the total cost of reform and delayed the inevitable day of reckoning. I will not support simply pouring more taxpayer dollars year after year into a system that is broken. I want to repeat that. I will not support simply pouring more taxpayer dollars year after year into a system that is broken.

I believe that we have an obligation to provide seniors with access to health care. We have an obligation to do it in a way that will not make taxpayers sick. We need to design a stable payment

system which provides doctors with the right incentives and adequate compensation to provide the right health care for their patients every time. The incentives in the current system are misaligned. Doctors have to make more money by increasing the number of office visits, performing more imaging scans, running more tests. I doubt that they really want to do these things; it is simply something they have to do in order to cover their costs.

Not only does this make our shrinking Medicare dollars more vulnerable, it hurts the beneficiaries stuck with copays for every visit and every test. We need to build a system instead that drives physicians to provide care for each patient because it is the best treatment, not because it is the best way to pay the bills.

In this regard, I want to specifically applaud Dr. McClellan for his dedication to this issue. Under his watch, the government has taken steps to become a better payer and providers are working toward a more efficient and effective health care system. Dr. McClellan started this mission with the hospitals, I am pleased to say, with some success. As a result, the groundbreaking hospital pay-for-performance demonstration, the Medicare program, is giving close to $9 million to hospitals that showed improvements in the quality of the care they provide. The success of this demonstration program is evidence that the model works to improve the quality of health care.

I look forward to working with CMS and others that share this vision on efforts to translate the physician reimbursement system or transform the physician reimbursement system. Again, I want to thank our subcommittee chairman for holding this hearing. I want to thank these two witnesses and the witnesses on the next panel. This is a very, very important hearing. We all know we need to do something before the beginning of the next calendar year, and it is possible that this hearing will lead to legislative action to fix the problem.

Thank you, Mr. Chairman.

Mr. FERGUSON. On the advice of Mr. Brown, I am going do recognize Mr. Gordon for on opening statement.

Mr. GORDON. Thank you, Mr. Chairman. While I am pleased the committee is holding a hearing on the Medicare physician payment system, in all due respect, this hearing is a day late and a dollar short. The committee so far has abrogated its responsibility to act on this issue on all fronts. Just a few weeks ago, this committee voted down a Democratic-supported amount to provide a temporary fix as part of the budget reconciliation package. It is long past due that this committee act decisively to reclaim its jurisdiction and to find a permanent solution to the SGR problem before physician payment cuts result in significant access problems to Medicare beneficiaries.

Mr. Chairman, I think I can speak with personal hand or firsthand, talking to physicians all across Tennessee, they really are limiting access now. This is a real problem. Many physicians are just simply not able to take additional Medicare patients. We are seeing it in community after community. So, in all due respect, I think it is time this committee stopped talk about wanting to do something and actually taking action. Yield back the balance of my time.

Mr. DEAL. The gentleman yields back.

Recognize Mr. Bilirakis for an opening statement.

Mr. BILIRAKIS. Thank you, Mr. Chairman, thank you for this hearing.

As we all know, Congress has specified a formula to provide an annual update to the physician fee schedule. This update is largely based on whether spending in the prior year has exceeded or fallen below the established spending target. That target, known as the sustainable growth rate or SGR, as we fondly refer to it, provides a spending benchmark for Medicare. If spending exceeds that target, the update for future years is reduced. If spending falls below that target, future updates are increased.

The problem is the SGR formula upon which the updates are based is flawed principally because it fails to link payments to what it actually costs doctors to provide services for Medicare beneficiaries. These and other shortcomings have precipitated cuts in reimbursement which threaten the access of Medicare beneficiaries to the critical care that physicians provide.

The Senate as we know has included a 1 percent payment update for next year in its recently approved budget reconciliation bill. While the version of the bill which this committee reported does not include a payment update, I am hopeful that conference deliberations or other alternatives will produce an appropriate remedy before payment cuts affect patient access to care.

We don't have, as we have already said, the luxury of not acting. Under the current schedule, physician payments are projected to be reduced by 26 percent over the next 6 years while the costs of running a practice are expected to increase during that same period. This is simply unacceptable.

Our colleague from Georgia, Mr. Norwood, has introduced legislation which would stop future reimbursement cuts and guarantee that physicians would receive at least level payments until we can address this issue in a comprehensive manner. Other members also have introduced payment reform bills which have served to further understanding this complicated issue. Many of us were involved in leading efforts in Congress in prior years to circumvent the application of the formula the past several years in order to avoid negative updates which would have resulted in substantial payment reductions. We helped to ensure that the Medicare prescription drug law provided a 1.5 percent update in each of these years instead of the scheduled cuts that would have taken effect had Congress not acted. The problem of course with providing at least temporary fixes, though they are much needed, is that doing so adjusts future updates downward to make up for added program spending.

It is clear, I think, to all of us, Mr. Chairman, that we have got to change that formula to something so that we won't have to have these temporary fixes year after year and year. Thank you.

Mr. DEAL. Thank you.

Mr. Pallone is recognized.

Mr. PALLONE. Thank you, Mr. Chairman.

In my home State of New Jersey, Medicare payments are scheduled to be cut by at least $107 million beginning January 1st and will total $5.26 billion from 2006 to 2014. Such actions would have

a considerable negative impact on physicians and beneficiaries alike.

Cuts in physician payments may result in diminished access to care for Medicare beneficiaries. Without financial relief, physicians and other health care providers may be forced to limit services, drop Medicare patients or leave the Medicare program altogether.

Mr. Chairman, we need to provide our doctors with the appropriate economic support in order to preserve access to quality care for Medicare beneficiaries. Doctors are already underpaid, in my opinion, under the Medicare program. Congress has averted scheduled payment cuts in previous years by enacting stop-gap legislation, but I believe Congress needs to enact permanent legislation that would fix the funding formula once and for all. Physicians should not have to fight each year to ward off future cuts.

There are several issues in particular that must be addressed when updating the fee schedule or the sustainable growth rate, SGR. First, the initial conclusion of drug spending as part of SGR must be adjusted. Drug spending has increased far more rapidly than any spending on physician services, and the cost of physician administered drugs as part of the SGR severely distorts the calculation of actual spending that should count toward the amount in Medicare reimbursement.

In addition, it is unfair for the SGR formula to be linked to the GDP. Physician fee updates should not be linked to the overall economy because physician services and fees do not parallel its ups and downs. Exercising fiscal discipline through the current SGR is not fair to doctors in my opinion, and again, I urge this committee to work on enacting a permanent fix to the formula that would accurately assess the appropriate reimbursement for their services. Thank you.

Mr. DEAL. Thank the gentleman. Mr. Upton is recognized.

Mr. UPTON. I thank you, Mr. Chairman and Chairman Barton, to make sure this was on today's calendar. As a co-sponsor of the legislation that was introduced by Mr. Norwood—Dr. Norwood—and Mr. Whitfield, I am absolutely committed to working with all of us, all of you to prevent the anticipated 4.4 percent cut from going into effect on January 1st that will replace the current badly flawed mechanism for calculating Medicare physician reimbursement. We need to put in place a system that accurately measures the true cost that physicians incur in providing high-quality medically necessary care to Medicare beneficiaries.

Permitting the 4.4 cut next year and similar cuts that will occur in each succeeding year under the current flawed Medicare physician payment system and putting into place a system that accurately reimburses for the cost of care is particularly urgent to preserving for access to care for Michigan's Medicare beneficiary. With only 13.2 physicians per thousand Medicare beneficiaries, Michigan is below the national average, and that ratio is only going to get worse. Further, about a third of today's Michigan physicians are over 55 and approaching retirement. According to a recently released study of Michigan workforce modeled after a national study from the Council on Graduate Medical Education, Michigan is going to see a shortage of specialists beginning in 2006 and a shortage of 900 physicians overall in 2010, rising to 2,400 in 2015 and

4,500 in 2020. Obviously, this Medicare reimbursement will only exacerbate the shortages and seriously undermine access to care. I look forward to working with you to make sure that we seek legislation that can correct the problem, and I yield back my time.

Mr. DEAL. Thank the gentleman.

Mr. Dingell is recognized for an opening statement.

Mr. DINGELL. Mr. Chairman, thank you, and I commend you for this hearing. To begin by mixing a few metaphors, however, unfortunately, we have the cart firmly in front of the horse, and we are seeking to lock the barn door after the horse has been gone. It is a very important matter, and it must be observed that the current system for paying doctors in Medicare and Medicaid in a fair way is not good. Doctors have already confronted several years of cuts in what Medicare will reimburse them for patient care. Further cuts are scheduled. None of these cuts and the inadequacy of payments to physicians and others as providers is grossly inadequate and threatens not only the morale of the providers but, very frankly, the sustainability of the program and the possibility of its success. While it is theoretically possible that something can be done about these problems within the framework of legislation, it appears to me to be quite difficult to accomplish anything during this year or perhaps even next year to correct what is a gross unfairness to providers in something which indeed was clearly to be anticipated as being a consequence of cuts already made.

When this committee considered reconciliation measures, as you will remember, Mr. Chairman, I offered an amendment to help the doctors and the elderly patients who rely on them. The amendment failed because the majority's budget priorities were elsewhere. The problem remains. A continued cut in payments to doctors in the Medicare fee-for-service program will only gladden those who wish to turn seniors over to private insurance companies. It is a most curious fact that doctors will see a 4.4 percent cut in payments to them while HMOs in Medicare will see a 4.8 percent payment increase. I wonder, is this a coincidence? Of course, changes to the physician payment system will increase Medicare spending, and we must recognize that we need to protect beneficiaries against further out-of-pocket cost increases.

Medicare beneficiaries have seen 2 years of premium increases because their premiums are based on Medicare spending. Even though covered under Medicare, the elderly are still paying a significant portion of their health care out-of-pocket.

Fixing the Medicare physician payment system is expensive, but there are steps that the administration could take and perhaps can focus on them that would lower the total price tag for a congressional fix of Medicare payment systems, and they could be done this year. I understand why the HMOs do not want the problem solved, but why is it that the administration does not wish to help?

We will also hear about pay-for-performance and other new health care buzzwords. Improving quality is the right goal, but we need to proceed in a measured fashion, and we should be starting first with the HMOs that promised they would improve performance but have only succeeded in increasing the payment to them and benefits to their stockholders and office holders.

As you will recall, during the last budget reconciliation, we made changes to Medicare to provide financial incentives to induce HMOs to participate. We were promised that they would improve care and lower costs. It is most doubtful that either has occurred. They may have lowered costs for themselves, but the Federal Government is seeing none of it, and in fact, the HMOs, according to MedPAC, who is testifying today, are being overpaid.

For those who championed the bill of rights and fought for the rights of doctors to make medical decisions in the best interests of their patients without corporate interference, there is peculiar, special and particular irony in what is happening to Medicare. If we do not act to address physician payments, we are going to see more seniors forced into managed care programs, not by choice but by grim necessity, over their reluctance.

These plans cost more, are not as efficient and are more responsive to shareholders than they are to patients. The committee should act. The administration should act to protect the ability of our seniors to see their doctors and see to it that the doctors are properly paid. But I fear that the tax cuts, which were programmed by the majority leadership, will leave the cupboard bare for doctors, forcing them out of fee-for-service and forcing seniors into HMOs. That could clearly be the end of Medicare as we know it.

I thank the witnesses here today for addressing these important issues. I am grateful, Mr. Chairman, that you are holding this hearing, and I look forward to the consequences. I yield back the balance of my time.

Mr. DEAL. I thank the gentleman.

Dr. Norwood is recognized for an opening statement.

Mr. NORWOOD. Thank you, Mr. Chairman, and thank you for having this hearing. It is very important, and I agree with Mr. Dingell and others that it is time for this committee to act. And I am pleased; this is a good first step. I want to do my part like all of you to make sure that Medicare beneficiaries maintain their access to their doctors. But you know what? That is just simply not going to happen if we continue down this path of using this misguided SGR formula. Just doesn't work. And repeal of it is extremely expensive, but we have to find a fair and better way.

We have big spending problems in Medicare. We are not paying, for example, for prevention, which is a cost saver. We are not utilizing the technology that is available, and frankly, fee-for-service has its problems simply because Medicare will not pay even the cost of doing business.

However, linking physician payments to the GDP just simply doesn't make sense. I know the government, when it did it, thought it did, but none of us today think it makes any sense, and including biologics in that formula even makes a great deal less sense.

Not having a payment system that reflects physicians' true costs is reducing Americans access to care. That is not difficult to understand. We have alternatives. The Medicare economic index is a good first place to start. Doctors in Medicare face a 4.4 percent cut. Next year, in my home State of Georgia, doctors are expected to lose $64 million in 2006 and $164 billion over the next 5 years if we just sit here and do nothing.

In light of this, along with my good friend, Mr. Whitfield, we have introduced a very simple bill, H.R. 4078, and this legislation, thankfully, is already supported by 12 members of our full committee. It has been endorsed by the Alliance of Medicine, a group of 13 specialties representing over 200,000 physicians, and I would very much love for my friends on the opposite side of the aisle to get on board with us with this so we make sure this 4.4 percent cut doesn't take place.

I know that it is inevitable that pay-for-performance is going to come up today since 600,000 thousand Medicare recipients are in some type of test program. I think it is extremely sad that we don't separate these two issues in terms of what we actually and how we actually pay our physicians versus what we can do to improve quality, but it doesn't seem it is easy to get them separated. I have not been able to get one person anywhere to define what this so-called pay-for-performance would look like or how it would work across Medicare or prove to me in any way that it is going to save money or improve quality or tell me how much this sucker is going to cost. I also know folks over in the Senate Finance believe that the only way the doctors should see any increase in their payments is by selling their soul to the so-called quality reporting.

Now the devil, I agree, is in the details, and I am ready to wait and learn. But I fear there is a lot of devil in the details we are going to learn. Mr. Chairman, any time that we start discussing changes that could possibly give our government bureaucrats more say-so over determining what is good treatment or a quality outcome instead of patients and doctors, it should get all of our attention. It does mine. Here is an idea, why don't we start by finding out how much it costs a doctor for a service and build in a reasonable profit for them participating in Medicare as we are discussing improving patient care all at the same time maybe by covering some prevention, things that would save money? Here is basically, what we are telling our physicians, you need to work harder to provide the almost weekly expansion of services and regulations by CMS, while taking more patients as the Baby Boomers retire. The bunch of non-physician, government clerks, or in the case of insurance companies as you know, tell you how to do your job and even will do so more in the future. We are going to cut your paycheck up to 30 percent over the next 10 years even though we pay no more than that costs today; all the while, your practice costs are going to be rising by 20 percent, so in the next 10 years, you will have twice the work at half the pay. Why in the world aren't you happy?

We say, you must be faster or do less tests or spend less on physical exams. What does that do for quality? Mr. Chairman, we won't have a Medicare program if we continue on this path because every physician in this program will quit, and they should, and they will have to. Doctors need to know for many reasons before the new year, not next year sometime, their payments are going to be updated. We called for a freeze. It ought to be an increase. I look forward to working with members on both sides of this aisle on this very important issue, and I yield back. Thank you, Mr. Chairman.

Mr. DEAL. Thank the gentleman.

Ms. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman. This is an important hearing today. For Medicare to work, for our seniors to get their health care, we have to have enough doctors. We cannot afford for beneficiaries, real people living in communities across American, to lose access to their doctors because of some arcane formula that does not match health care costs or needs.

Since 2001, we have known about this problem. At that time, I introduced legislation to stop the immediate cuts. This committee moved swiftly to pass this bill, to actually provide a small increase for the next year. Then the committee bought more time to make a long-term fix in the Medicare prescription drug bill. The time is about to run out. Nothing has been done.

Now doctors are facing a 4.4 cut next year and 26 percent in cuts over the next 6 years. In my district, Medicare physician payments are already artificially low. Santa Barbara, San Luis Obispo Counties are lumped in with more rural parts of California where costs are lower. Doctors receive a payment that absolutely does not meet their needs, and they are leaving. And so their patients, my constituents, are already facing access programs. I along with other members of the California delegation have asked CMS to fix this problem; they have refused. Now the doctors will have to deal with these absurd cuts on top of the too low payments. It is intolerable. It is time for us to get to work on this problem, and we have to work quickly.

I do applaud the efforts of Mr. Norwood and Mr. Whitfield to prevent these cuts but we also need to be providing a small increase so physicians can deal with medical inflation and make sure that beneficiaries who are already on a fixed income don't have to swallow the costs.

Now Congress, in a drive to control Medicare spending, created this problem when it passed this arbitrary system. Now we have to fix it. The amendment that Mr. Dingell offered of the Medicaid markup would have been just the thing, 2.7 increase for physicians next year, and would have prevented Medicare from passing this increase on to beneficiaries. It is a shame it was defeated on a party line vote.

I also want to raise my concerns along with Mr. Norwood about the efforts to pass pay-for-performance. We should be looking for ways to improve quality and eliminate unnecessary costs, and financial incentives can be a very good way to accomplish this. But we must be absolutely sure we are not creating incentives for doctors to deny needed care, and we must not prevent physicians from doing what they think is necessary to care for their patients because we have an arbitrary national policy. Health care, after all, is about a relationship between a patient and his or her doctor. It is an individual relationship. Unnecessary care for one patient may be life-saving for another. I look forward to hearing from the witnesses. I yield back.

Mr. DEAL. Thank the gentlelady.

Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman, and I want to thank both you and Chairman Barton for holding this hearing, and I do believe it is important this committee be very involved in this serious situation. I was at a breakfast yesterday with Chairman

Greenspan, and he talked about funded pension plans, whether they are private or government sponsored, and this would include Medicare. And he specifically mentioned Medicare, and he said they are eventually not worthwhile if there is no one there to provide the services for those who are to receive them. I think he is exactly right, and that is what the current pay reduction that we are looking at in the Medicare system is going to do for us. It is going to drive more doctors out of providing Medicare. I hear that every day in my district, and I hear from patients' comments at town hall meetings the question is about the cost of drugs, But how come I turn 65 and I have to change doctors?

Well, I don't think we are doing ourselves or our constituents any favors by driving doctors out of the practice of medicine. I don't think we are doing any favors by encouraging our best and brightest to avoid the field entirely, and I agree with Dr. Norwood's call for a freeze on the 4.4 percent reduction for this next 2-year time period. We need that amount of time to think of innovative solutions to think outside the box for a more serious effort and at a long-term fix. We need to ask for—we are going to ask our doctors for considerable investments in information technology in their offices. Well, I think we need to ensure that we keep the best lines and best clinicians involved in the practice of medicine as we make that move for greater investment to information technology. It makes no sense to spend a lot of dollars on computers if we don't have good doctors. Garbage in, garbage out.

Pay-for-performance, I have always had emotional trouble with pay-for-performance. As a physician, I never woke up in the morning and said, I hope I can be at least adequate for the better part of the day while I am seeing my patients. I always woke up and thought, I am going to do the best job possible, deliver top quality care. We need to keep excellent physicians involved in providing care for their patients, and we need to encourage bright, young physicians to participate. I hope MedPAC can shed some light on long-term solutions. I for one would like to see us consider some type of balanced billing. In the Medicare Modernization Act, we set the income guidelines when we implemented the part B premium. Maybe we should explore that exercise for bringing more money into the system, and I don't have a problem emotionally with loaning or borrowing from a part A premium that I pay every month whether I want to or not, no upper limit on that one, and as the economy improves there is more and more money in the Medicare trust fund, and I don't see why we don't look for that to a short-term solution to solve this problem. I yield back.

Mr. DEAL. Thank the gentleman.

Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman, for convening this hearing. I want to welcome Dr. Jacob Garretson who is the president of the Maine Medical Association who is in the audience today.

We cannot stand by and do nothing about the scheduled 4.4 percent Medicare set to begin in January. Unless Congress acts, physicians can expect a 26 percent decline in payments over the next 6 years. By 2013 Medicare payment rates would be less than half of what they were in 1991 after adjusting for practice cost inflation. If the goal were to undermine Medicare while professing to support

it, failing to act would be a giant step toward that goal. Physicians in Maine need relief because their Medicare payment rates are already lagging behind increases in practice costs. Rural States like Maine have two major problems: a disproportionate share of elderly citizens and problems in many places simply getting access to physicians, particularly specialists. Congress passed three updates to the physician payment schedule over the past several years but we need to do more. We need to change the underlying funding formula to accurately reflect practice costs. There are two ways to do that, two particular legislative fixes: H.R. 2356, Representative Shaw and Cardin, which would halt payment cuts in 2007 and beyond by replacing the SGR formula with a new formula that reflects changes in the Medicare economic index. That bill has 162 bipartisan cosponsors.

The second effort is H.R. 3617 introduced by Representative Nancy Johnson which would repeal the SGR formula and replace it with a stable and predictable annual update based on the costs of changes in providing in care. The bill would link payment updates to health care quality and deficiency. That also has support on both sides of the aisle with 46 cosponsors.

We should accept the Senate budget reconciliation package that has a 1 percent payment update for physicians. That also eliminates the slush fund for regional preferred provider organizations. CBO estimates that the elimination of this fund would reduce Medicare spending by $5.4 billion over 5 years and $10.2 billion over 10 years. MedPAC has explicitly called for the stabilization fund to be eliminated, sighting Medicare is already heavily overpaying HMO's.

I hope that Dr. McClellan and Mr. Hackbarth as well as our other panelists can help us understand the flaws of the current payment system and how to ensure Medicare patients across the country continue to have the access they need. Mr. Chairman, I yield back.

Mr. DEAL. I thank the gentleman. Mr. Hall is recognized.

Mr. HALL. Thank you, Mr. Chairman, and as others, I appreciate your organizing this meeting. Like so many members I am concerned as you are about the impending physician pay cuts and I am looking forward to a good solution like all of us are. The sustainable growth rate formula is clearly not workable. That has been said over and over again as evidenced by the fact Congress keeps providing temporary fixes to it year after year. The Centers for Medicare and Medicaid Services projects that physician practice costs are expected to rise 15 percent from 2006 to 2011, while payment rates continue to follow. So it is easy to see that this trend may cost physicians to decrease their Medicare patient mix and defer to the purchase of beneficial information technology resources, something we don't want to see happen. However, it is equally clear that repealing the SGR and replacing it with a new reimbursement mechanism is also not viable since it costs approximately $50 billion over 5 years. Medicare beneficiaries are already facing a 13 percent increase in part B premiums. A move to replace the SGR would result in further premium increases that have to be borne by our Nation's seniors.

At a time when gas prices and home heating bills are increasing, people living off of fixed incomes cannot shoulder the burden of steep increases in health care premiums. It seems the me that any solution also needs to address the usage of services and the flawed system of incentive. The current system encourages doctors to increase their volume of services, an incentive to reward those physicians who provide more procedures even if they are not necessary. I am interested in hearing what the panelists have to say about building better incentives into the system. And I appreciate the panelists taking their time. I look forward to hearing their testimony and proposed solutions to a challenging issue, and I yield back the balance of my time.

Mr. DEAL. Thank the gentleman.

Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman. Do I have 1 minute because the clock is clicking with less time than I thought.

Mr. DEAL. Living on borrowed time.

Mr. WAXMAN. Thank you for lending it to me. Woe is me. Every member of this committee is just shocked, absolutely shocked the physicians are going to get a cut. This is already the last week of the session until we break for Thanksgiving, and then we will come back and see what happens for a couple of weeks. How did this happen? Who is in charge? This is like the perils of Pauline, the doctors are Pauline strapped to a log about to go over the waterfall. We have got to save her.

Look, some of us who have been around a long time have some memory of how this happened. This was put in the 1997 Balance Budget Act where the Republicans in Congress negotiated with President Clinton to make deep cuts in Medicare. They made deep cuts in Medicare not to balance the budget, because the budget was going to be balanced anyway, they made deep cuts in Medicare to do what, cut some taxes. Does that sound familiar? That was 1997, and many of us voted against that balanced budget act; not too many but some voted against it because we didn't think those cuts in Medicare made any sense. Now it didn't hurt the doctors all that much when the GDP was going up. You may remember, when Democrats were in control, the economy was doing quite well. The GDP was increasing. Now the economy is not doing as well with doctors facing these cuts. Well, doctors, if you get your wish not to let this happen, you will get a short-term fix. That is about the best you are going to get. While members in the House on both sides of the aisle pontificate about how this would be terrible to let a cut go into effect, you have got to do something permanently and we have got to figure out what to do and wish we would do something but we can't let this happen, it is not fair to doctors, not fair to Medicare beneficiaries. They are right. But we had a chance to vote on this when we were doing the reconciliation bill. The reconciliation legislation is where we fix Medicare and Medicaid issues and Medicare is part of the jurisdiction of this committee and Mr. Dingell had a proposal, the republicans voted against to make sure that the 4 percent reduction didn't—4 percent fee payment decrease didn't take effect. Well, stay tuned.

I hope and I think the political reality is that there will be a short-term fix before the end of the year, no thanks to this com-

mittee. We didn't do anything about the problem, but I shouldn't say that, that would be unfair, what you have had today is a real expression on a bipartisan basis that none of us want this to happen, and we sure hope somebody takes charge and someone makes sure it doesn't happen. Well, they are the ones in charge and let's see what they do and let's hope, at the end of the year, we will have another short-term fix, and we can visit the issue again next year and tell the doctors how much we care about them.

Mr. DEAL. Mr. Shadegg.

Mr. SHADDEG. Thank you for holding this hearing. Everyone in the room does know we have a serious problem we have to deal with. The current system is not sustainable and it is not reasonable to expect physicians to take a 4.4 percent reduction in payments. I join my colleagues in urging that we look at this issue and not just enact a temporary fix but look at a permanent reform. I think today is in some ways historic. I am told that CMS and MedPAC now agree, and that perhaps that is the first time they have ever agreed that 20 years of various standards, volume performance standards, behavioral offsets and sustainable growth rates simply have not worked. We need, I believe everyone in this room, should agree that we need fundamental reform. The question is not how much we pay physicians this year, the question is how do we fairly compensate physicians for the work the government asks them to do. I think there is even a more fundamental question and that is can the Congress and the government go on promising a level of benefits and then when they discover, when the government discovers that the cost of that level of benefits is higher than anticipated, push that burden, shove that gap between cost and what they are willing to pay off on the providers.

I would suggest that, since the creation of this program, we have had that problem. Politicians have said well, we love to promise benefits to the public, tell them we will provide these services, outline vast expansive services and then when the bill comes home, they like to say, my gosh, I didn't realize it was going to cost that much, what can I do. I don't want to raise taxes so I will short change the providers. The effects of that in the short term and in the long term are extremely serious. I believe they demonstrate that government-run health care fundamentally doesn't work. I think they demonstrate that the market doesn't work. I think they demonstrate that government planners don't know the answer, and I think they demonstrate that politicians that promise benefits and refuse to pay for them don't belong in office. I believe we need to pay physicians for the services they provide. We looked at the quality of the service they provide and the value they added. But seems to me we are forever looking at one more government solution, one more government plan.

The latest word now is pay-for-performance. And I share my colleague's skepticism about pay-for-performance because, in this context, while you think pay-for-performance sounds wonderful, let's do that, let's pay doctors who perform; you have to ask one more question, who is going to decide what level of performance we are going to pay for? And guess what? In none of these plans is it the consumer that is going to decide what performance they pay for. No, no, no, it's a government bureaucrat who is going to layout a

set of practices and tell the doctor, perform to this standard, and then we will pay you. If I wanted to get my health care from a government bureaucrat, I would go to a government bureaucrat for my health care, but I don't. I go to physicians whom I trust and whom I believe in, and I would rather pay them based on the quality of the care I believe they deliver.

Mr. Chairman, I commend you for holding this hearing. I think we have to look at fundamental reform of the Medicare system and I simply want to conclude by at least recognizing them for their travel here from far away Arizona, both Chick Older the executive vice president of the Arizona Medical Association and Dr. Richard Perry, a member and my personal surgeon. I thank you. With that, Mr. Chairman, I yield back my time.

Mr. DEAL. Gentleman yields back.

Ms. DeGette.

Ms. DEGETTE. Thank you very much, Mr. Chairman, and I would like to join my colleagues in welcoming my folks from Colorado, Dr. Lynn Perry, who is our new president-elect of the Colorado Medical Society and my old friend, Suzanne Hamilton, who I have worked with over the years. And I would like to recognize everybody from all of the State medical societies and you folks here in the room for coming today. It is just too bad you all weren't here 3 weeks ago when we passed the budget reconciliation bill out of the Energy and Commerce Committee which did nothing to fix the physician reimbursement problem and in fact when, with one exception, every single person on the other side of the room here voted against Mr. Dingell's amendment that would have increased physician reimbursement by 2.6 percent in 2006 and then would have updated the rate using MedPAC's suggested formula, that would have been a 2.7 increase in 2007.

Dr. Perry, I know you have come today to see how sausage is made. Sometimes it is not a really happy experience for some of us. I think every single person in this room who cares about physician reimbursement and who cares about serving patients needs to look both at what your Members of Congress say and what they do because sometimes they are two different things. And I am sorry to say this because I love my friends on the other side of the aisle, but, you know, each of the last few years, physicians who serve Medicare beneficiaries have had cuts in reimbursement. Every year, we come in. We do a short-term fix, but the short-term fixes coupled with the broader problems inherent with the sustainable growth model right now have exacerbated the problem.

Now given how close we are to the end of the year, we probably will work in the first couple of weeks in December to do some kind of a short-term fix, but in the longer run, we don't want a scenario that will force physicians to see more—to see fewer Medicare beneficiaries because of the reimbursement and what is worse in the longer run, as the Baby Boomers start to retire, physicians who will close their practices altogether toward these patients.

The fundamental problem is there is no longer a stable basis for reimbursement for Medicare physicians, and the system is so susceptible to changes in the Medicaid and the Medicare population. And there are so few mechanisms to incentivize and support physi-

cian attention to improve quality that Congress really needs to take a broader long-term view, and that is what many of us think.

This problem is going to be exacerbated by the fact that Medicare beneficiaries are going to start using the new prescription drug plan on January 1st, 2006, if, of course, they can figure it out, which I am wondering, but these beneficiaries, if they have to pay higher copays for their drugs and they have to pay higher copays for their physicians, should give us all pause to see what is going to happen with patient care. I think there is a lot of other issues that we need to look at, but most importantly, I think we need to look at the long-term model of how we are going to do physician reimbursement so that all you good folks don't have to fly in every year right before the holidays to try to get Congress to give you a short-term fix. Thank you, Mr. Chairman.

Mr. DEAL. I will recognize myself since I was not here at the beginning of the meeting, and I thank Mr. Ferguson for opening the hearing today. First of all, we are pleased to have so many representatives of the medical associations across the country with us today. We welcome your presence, and we have two very distinguished panels that we will hopefully hear from in the very near future.

I would respond, though, to the last opening statement with regard to what was not done several weeks ago. The context of that hearing and that markup at least was Medicaid. It was not Medicare. And we restricted our actions as we appropriately did to the reforms that we proposed in Medicaid, and those were difficult votes that we had to take. Unfortunately, most of those votes were taken on a partisan line, but I think those of you in the audience recognize that in dealing with the issue of Medicaid reform, those were necessary reforms, things that had to be done to change that program to keep it viable.

We are here today to talk about the issue of physician reimbursements, a topic that is obviously very appropriate, and I will not take any further time but look forward to the testimony of the witnesses that I will introduce in just a few minutes.

Ms. Baldwin is next.

Ms. BALDWIN. Thank you, Mr. Chairman, and welcome to our witnesses and guests today. I want to associate myself with all of my colleagues who have voiced their support for enacting a long-term fix to the Medicare physician payment issue rather than continuing to engage in these yearly or biyearly fixes. The short-term solutions that are really Bandaids are unfair. They are unfair to the physicians who, at the end of each short-term fix, are once again faced with projected cuts. They are unfair to beneficiaries who may face access issues if cuts are enacted. They are unfair to taxpayers because of the cost of providing a fix gets more and more expensive with each passing year. And they are unfair to Medicare because Medicare is truly a successful and efficient program that provides comprehensive, affordable health care for over 40 million seniors.

I was happy to support the amendment offered by Ranking Member Dingell during our markup several weeks ago of the reconciliation bill that would have addressed the negative payment update. And while it is unfortunate that this amendment was voted down

on a largely party line vote, I am encouraged that we are here today discussing physician reimbursement.

That said, I do have concerns about some of the proposals that have been put forward. I believe that improved clinical quality should be rewarded, but I am concerned that some proposals set up a system of winners and losers in their effort to improve quality. I fear that lower-performing systems or practices would be deemed losers, would receive lower payments and then would be set up—set further back from reaching the quality level that we are trying to entice them to achieve, all the while affecting real people, real patients.

Also, it is important that we keep in mind that efficiency in improvement is not the same as better patient care, and when considering the options before us, high-quality patient care should always be in the forefront of our thoughts. I thank the witnesses for coming. I look forward to today's discussion.

Mr. Chairman, I yield back.

Mr. DEAL. Thank the gentlelady.

Mr. Towns.

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

I think it is important that we come up with a long-term fix. There are no ifs, ands or buts about it.

But I am troubled by two things this morning: No. 1 is how I am hearing statements, and then I look at the way people vote, and it is so different from what they say. That bothers me. And the second thing that bothers me is how we are using the term reform. Reform is not something that is always positive. And we use it like it is always positive. Reform is neither positive or negative, depends on what you do with it. Of course, around here, most of the time, what we do with it is cut the budget. That is what it really means. It is like what my father used to tell my brother and I about prayer, he said, son, if somebody says they are going to pray for you, you need to find out what they are going to say. They might pray that you break your neck. So as I look at this term reform here, that is what we are saying to the doctors, break your neck. That is exactly what we are doing.

We need a long-term fix. I think that what we are doing is not fair to the doctors, and it is not fair to the patients. And I am hoping that we really get serious here and not just make statements but begin to do the kind of things that we know need to be done to fix this problem. We are aware of what happened and what needs to happen. I am certain you are hearing from doctors the way I am hearing from them that they are leaving the profession. They are just walking away from it, no longer want to practice, and I think that becomes very serious because if we don't fix that, then a lot of good people are not going to be out there providing the kind of services that we need.

So I am saying to my colleagues on this committee this morning, let us listen very carefully, let us take this information in, and let us do something that we know that we need to do, and that is to fix it, and let us not loosely use that term reform because that is not a solution because you know as well as I do that everybody on this committee knows the word reform here in the U.S. House of Representatives means cut the budget. That is all it means. It

doesn't mean fix anything or make it better; it means cut the budget and lets use less money. That is the only thing it means here.

Mr. Chairman, I yield back the balance of my time. I have a statement that is prepared I would like to place in the record.

Mr. DEAL. Ms. Eshoo, You are recognized.

Ms. ESHOO. Thank you, Mr. Chairman.

This committee has held a series of hearings examining the Medicare payment system. I am just about the last one to speak, so I am not going to repeat the things that have been stated at this time. And I want to associate myself with what my colleagues on this side of the aisle have said. Really, today is the opportunity for members to get on record, everybody, and say, doctors, we are with you. But the fact of the matter is that when the vote came in order to implement what really needs to be done, it is not what happened. But I still welcome the opportunity because I think it is essential that if we are going to honor Medicare, that we are going to honor the people that are a part of it, the patients and the physicians. We are nowhere without the physicians, and we all know that. Try running a healthcare system without doctors.

So now we are going to lurch to what we have done over the last couple of years. You should get that, but it shouldn't look like this; it should be long term. We all know that there needs to be a fix.

Dr. McClellan, I am glad to see you here today. I am going to raise an issue with you that has been—that you know we have worked on. I am deeply, deeply disappointed in the CMS final rule, the failure to fix the payment localities in my home State of California.

You know, I have been an honest broker in this, and I think that, as I look over my shoulder, where I would fault myself is that I trusted what you all would do, and we are now back to square one; we are now back to square one. It is not good enough for the physicians that are in the system or the people that are so dependent upon that. And I am going to have some questions to ask you about this and where you are going to take it. I am deeply frustrated because I was given the assurances that this was going to be done. I have done everything on my part, everything that you asked me to do to get done with the medical society, with all the people on the ground, and now we are completely back to square one. I don't think this speaks well of CMS. I really don't, and the rest of it, as far as I am concerned, are excuses. But I hope you will be prepared to tell me what you really plan to do, if you are going to shove this over to the legislative arena. You didn't want that before. We went to Mr. Thomas; he said that you were going to take care of it. Now it is going to go back to the legislative arena. We have wasted over a year. And meanwhile, people are left holding the bag. That is not what we are supposed to do. We are supposed to solve things.

So you can tell that I am not only deeply disappointed, I am really, frankly, disgusted. I am disgusted. And that is pretty harsh, but for all of the work that is put into this, nothing, nothing has come—no fruit has been born as a result of it. And CMS weighs very heavily into this, very heavily.

So I am going to look forward to the answers to the questions that I am going to pose, that is just a taste of where I am.

Thank you, Mr. Chairman.

Mr. DEAL. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

I ask unanimous consent to place my full statement in the record, and again thank Dr. McClellan for coming today. This is such a major issue, and I think all of us on the committee understand that, whether you are Democrat or Republican.

The Congress has deferred from 2005 these physician cuts; the problem is our committee, we need to correct the problem. And whether—I know the issue is getting overutilization, but I have a district where if physicians see more, because of the Medicare case load, they have more patients. So 1 year they go up, and then they get cut the next year because they are actually seeing more patients. And we need to deal with whether it is over utilization or whether this actually is providing better healthcare for our Medicare recipients, and that is our fault. I think we need some structural changes so we can see if someone is gaming the system as compared to actually working with patients to get better healthcare.

And Mr. Chairman, again, I thank you, and I will yield back my time so we can get to questions.

Mr. DEAL. I thank the gentleman.

Ms. Cubin.

Mrs. CUBIN. Mr. Chairman, I would like time to yield to Dr. Norwood; can I do that?

Mr. DEAL. I suppose we can.

Mr. NORWOOD. I will be very brief, Mr. Chairman, I just want to try to see if we can get the record straight here just a little bit.

A few weeks ago, we marked up a Medicaid bill, at which time an amendment was brought which does away with the cuts for the physicians and has an increase. Well, everybody then at that time in that room knew that was the wrong time, the wrong place, the wrong amendment. It had absolutely no offsets for the $20-plus billion. Everybody in this room knows the same thing.

You ask what you can do to say to the doctors, we are with you? Well, I have a bill that is going to have a hearing, that is going to have a markup—it is going to the floor, it is going to pass—that stops that 4.4 percent increase. So I invite at least one of my Democrat colleagues to be a co-sponsor of that. If you do that, then you can actually say to your doctors, we are with you. And with that, Mr. Chairman——

Mr. WAXMAN. With the gentleman yield? Will there be offsets to pay for this? Is that what the gentleman is saying?

Mr. NORWOOD. Yes.

Mr. WAXMAN. We look forward to seeing the physician fees.

Mr. NORWOOD. Reclaiming my time, Henry. Why don't you just look at first considering being a co-sponsor on something that is good for our physicians, that would be a nice first step, and then hopefully maybe you will even vote for it on the floor.

Mr. WAXMAN. Well, I was for patients' rights——

Mr. DEAL. Regular order——

Mr. NORWOOD. Mr. Chairman, I yield back.

Mr. DEAL. The Chair would recognize Mr. Pitts for an opening statement.

Recognize Mr. Whitfield for a unanimous consent request.

Mr. WHITFIELD. Mr. Chairman, thank you for recognizing me.

This is the first time in my 11 years in Congress that I have not been a member of the health subcommittee, and I would ask unanimous consent that I be allowed to speak for maybe 90 seconds on this issue.

Mr. DEAL. Without objection.

Mr. WHITFIELD. Thank you. And first of all, I am delighted that you are having this hearing. This is the committee that has exclusive jurisdiction over Medicare Part B, and we should be addressing this problem.

My friend Charlie Norwood and I did introduce 4048, the Medicare Access Act which in effect would be a 1-year stop gap measure that would at the very least avert this reduction in Medicare for physicians for 1 year. We look forward to the testimony of the eight witnesses today who have great experience. And I know that Dr. McClellan is going to be addressing this issue in his testimony. And it is our hope that if the reconciliation bill passes the House—and I guess that is still a question mark—but if it does, then we will be able to go into conference with the Senate, that they will have a bill that addresses this issue of Medicare reimbursement for physicians, and that we can fix this for the next year, and then ultimately come forward with major reform so that this program can work in a more effective way. And with that, I appreciate the opportunity and yield back the balance of my time.

Mr. DEAL. I thank the gentleman.

Well, we are pleased to have our first panel, who have waited patiently. They are two of the most respected individuals in the area of healthcare policy.

First of all, Dr. Mark McClellan, who is the administrator of CMS; and Mr. Glen Hackbarth, who is the chairman of MedPAC.

And Dr. McClellan, you are recognized for 5 minutes.

STATEMENTS OF MARK B. MCCLELLAN, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES; AND GLENN M. HACKBARTH, CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. MCCLELLAN. Mr. Chairman, Representative Brown, distinguished committee members, thank you for the opportunity to testify on Medicare physician payments. Our current payment system for physicians is not sustainable, both from a standpoint of the very rapid growth we have seen in spending on physician-related services and from the standpoint of failing to support high-quality care. We are committed to continuing to work with physician groups and the Congress to move toward a payment system for physicians that provides stable reimbursement and also promotes higher quality and more efficient care without increasing the financial strain on the Medicare program.

As the budget reconciliation process moves forward, the administration will work with the Congress on a fully offset provision to address the negative physician updates for 2006 and 2007 with differential updates for physicians who report valid, consensus-based quality measures. These short-term reforms should provide a transition to a better payment system that spends Medicare dollars more effectively.

At a historic time when we are bringing Medicare's benefits up to date, when medical science gives us more opportunities than ever to help seniors and people with disabilities to live longer and better lives, it is time to change our payment systems to provide better support for physician efforts to improve quality and avoid unnecessary healthcare costs.

Healthcare providers are in the best position to know what can work most effectively to improve care of their patients. And their expertise, coupled with their strong professional commitment to quality, means that any solution to the problem of healthcare quality and affordability must involve their leadership.

But today, our current payment system does not support the best efforts of physicians to improve quality and lower costs. Instead, it reimburses providers on a per-service basis; the more services provided, the greater the reimbursement, and we are getting what we pay for. We have seen rapid increases in the Medicare spending on physician services in the past few years. This is not a sustainable course.

It is time to provide better support for the best efforts of physicians. Linking a portion of Medicare payments to clinically valid measures of quality and effective use of healthcare resources would provide more financial support for care that results in better quality and better value.

With support from the Medicare Modernization Act, we have already taken steps in this direction in other parts of the Medicare program. Thanks to payment updates tied to reporting on valid measures of quality, almost all hospitals are reporting on consistent measures of the quality of care they provide. And earlier this week, as Chairman Barton mentioned, I announced the first year results of the Premiere Hospital Quality Incentive Demonstration, which showed that pay for performance works in Medicare. Hospitals improved the quality of care they offer, avoiding costly complications when payments are structured to support a focus on quality.

CMS has been engaged with the physician community and other stakeholders in our healthcare system to work collaboratively on establishing quality measures that can be used for reporting and for a better payment system. Using these quality measures, including measures related to avoiding unnecessary healthcare costs, CMS is working with physician organizations and physician practices to conduct a number of demonstrations and pilots of payment reforms to pay more for better quality, better patient satisfaction and lower overall healthcare costs in the Medicare fee-for-service program.

Another step in this major collaborative effort to support better care is the Physician Voluntary Reporting Program that we announced on October 28th. Under this program, physicians can choose to work with CMS to voluntarily report on a number of widely accepted evidence-based quality measures that will help us implement the least burdensome approaches to quality reporting and will provide new information relevant to improving quality for the participating physicians.

On these efforts, we have worked with many physician organizations, including the Alliance of Specialty Medicine, the American

College of Physicians, the American College of Surgeons, the Society of Thoracic Surgeons, and many others. I would like to thank them for their continued collaboration and constructive imput as we keep working together to improve quality of care for patients.

Mr. Chairman, it has taken a lot of collaborative work to get to the point where we now have a path to a better payment system, to a better alternative, to rapid and costly increases in the volume of services on the one hand and to a failure to support quality care on the other.

We look forward to working with you and others in Congress and the medical community to use the opportunity we have right now to change Medicare's physician payment system to help provide appropriate payments while also promoting better care for patients without increasing overall Medicare costs. And I would be glad to answer your questions.

[The prepared statement of Mark B. McClellan follows:]

Testimony of

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Before the
House Committee on Energy and Commerce
Subcommittee on
Hearing on
Medicare Physician Payments

November 17, 2005

Chairman Deal, Representative Brown, distinguished members of the Subcommittee, thank you for inviting me here today to discuss Medicare physician issues. The current Medicare physician payment system will result in multi-year reductions in physician payments, raising real concerns about this system's ability to ensure access to care for Medicare beneficiaries. In addition, it does not create incentives for physicians to provide the highest quality care at the lowest overall cost. The existing system is designed to control spending in the aggregate, but in recent years it has not been successful in limiting spending growth by influencing the behavior of individual physicians. Fully addressing this situation will require legislative action by the Congress. The Administration looks forward to working with the Congress as it explores a legislative resolution to this challenge. The Centers for Medicare & Medicaid Services (CMS) has also taken a number of important first steps in developing the standards, information and systems needed to move us toward a payment system that encourages quality, supports physicians in their efforts to provide the most effective care, and avoids unnecessary costs. These steps will prepare us to quickly and efficiently implement a fully modified payment system should Congress make that possible. I will address many of the steps we are taking in collaboration with physician organizations and other private-sector groups to help implement this system later in my testimony.

On November 2, we released the final rule updating payments for physicians and several other types of non-physician practitioners who serve our Medicare beneficiaries. The update scheduled by law for 2006 and beyond is one of the biggest issues facing

physicians. The final rule indicated that the current statutorily mandated formula will result in a 4.4 percent reduction in physician payments in 2006. Under current law, this same statutory formula will result in cuts in several succeeding years as well. We recognize, as does this Subcommittee, that sustained cuts in physician reimbursement raise real concerns about this payment system in terms of access to quality care for Medicare beneficiaries. We also recognize that the very rapid growth in physician-related Part B services has contributed significantly to the extent of this payment problem. For example, in 2004 this system experienced a 13 percent increase in spending, driven largely by increases in the volume and intensity of services on a per-beneficiary basis. Double-digit spending growth has persisted in the first half of 2005, according to our most recent figures. Simply increasing spending under the current volume-based payment system would have an adverse effect from the standpoint of Medicare's finances and would drive up beneficiary premiums and cost-sharing. Furthermore, increasing spending under the current system would do nothing to promote better quality care.

Although CMS carefully examined the possibility of taking administrative action to address statutorily mandated cuts, we have concluded that we have no authority, under the existing statute, to make changes that will immediately or directly impact the physician update. Moreover, even if we took administrative actions suggested by the physician community, this step would add substantially to Medicare costs and beneficiary premiums, on top of the increased spending just described.

Physician Payments Based on Statutory Formula

Updates to Medicare physician payments are made each year based on a statutory formula established in section 1848(d) of the Social Security Act. The calculation of the Medicare physician fee schedule update utilizes a comparison between target spending for Medicare physicians' services and actual spending. The update is based on both cumulative comparisons of target and actual spending from 1996 to the current year, known as the Sustainable Growth Rate (SGR), as well as year-to-year changes in target and actual spending. The use of SGR targets is intended to control the growth in

aggregate Medicare expenditures for physicians' services. Target expenditures for each year are equal to target expenditures from the previous year increased by the SGR, a formula specified in the statute comprising the following four factors: (1) the estimated percentage change in fees for physicians' services, (2) the estimated change in the average number of Medicare fee-for-service beneficiaries, (3) the estimated 10-year average annual growth in real gross domestic product (GDP) per capita, and (4) the estimated change in expenditures due to changes in law or regulations.

When actual spending exceeds targeted spending, the following year's update is reduced to bring actual spending back in line with the targets. Unfortunately, actual spending has greatly exceeded targeted spending, and the formula results in negative updates to physician payments to correct this disparity. Recent rapid growth in the volume and intensity of physicians' services per beneficiary is helping to drive the growth in Medicare physician spending and is a significant factor in the negative 4.4 percent update for 2006. We anticipate that physicians will experience negative updates in each of the next six years as well.

Some have suggested that CMS could retrospectively remove drugs covered under Part B from the definition of physicians' services, and thus revise the SGR. However, as we have indicated in the past, retrospective removal of drugs from the SGR is statutorily difficult. For example, the statute requires the estimated SGR be refined twice based on actual data. We do not see a legal basis to re-estimate the SGR and allowed expenditures for a year after they have been estimated and revised twice. Further, our current estimate is that removing drugs retroactively from the SGR would not result in a positive update for several years. Consequently, CMS believes that statutory change is needed to improve the physician payments. Moreover, such changes should do more than simply add substantial taxpayer and beneficiary payments to the current payment system.

Increases in Utilization

For physicians' services, increases in utilization and intensity during 2004 were 6.3 percent, and are estimated to be 5.6 percent for 2005 and projected to be 6.4 percent for

2006. These figures are much higher than the average utilization and intensity increase of about 1 percent per year between 1992 and 1999. This continued growth in the volume and intensity of physicians' services has resulted in a high projected growth in spending for these services in 2006, which is a principal factor contributing to the increase in the 2006 Part B premium. As indicated in a letter from CMS to MedPAC on March 31, 2005, the rapid growth in services administered in physicians' offices has resulted from rapid growth in intensity and utilization for office visits, lab tests, minor procedures, and physician-administered drugs.

Some of these increases in use of services are unquestionably related to improvements in the quality of health care. However, as noted in the MedPAC letter and in subsequent analysis by CMS and other groups, much of the spending increase cannot easily be explained by changes in treatments based on new medical evidence and valuable new technologies.

CMS has taken collaborative steps to better understand these concerning trends, including what changes in utilization are likely to be associated with important health improvements and which have limited or questionable health benefits. We have been reviewing the technical aspects of this situation in detail with health policy experts as well as the AMA and various specialty societies. For example, the AMA has provided us with some potential reasons accounting for growth. While it was not possible with available data to precisely analyze the impacts of every factor identified, we were able to assess the impacts of most of them. Generally, our results indicate that while the factors the AMA identified have contributed to higher spending, our preliminary analysis suggests that these identifiable factors do not account for a substantial part of the $10 billion spending growth between 2003 and 2004.

We appreciate the efforts of the AMA and the many specialty societies that assisted CMS in identifying these medical trends. They have helped further our understanding of the reasons for the growth in spending. I am sure that all stakeholders involved in these critical payment issues will benefit from an ongoing, evidenced-based analysis regarding

these issues, particularly focusing on which changes in utilization are likely to be associated with important health improvements and which ones have health benefits that may be more questionable.

The fact is that the current payment system is simply not moving us toward the goal of supporting more efficient and better quality care while avoiding unnecessary costs and disease complications. We have seen rapid spending growth over the past few years, partially because our payments do not encourage and support physicians in their efforts to become more efficient or focused on innovative approaches to improving quality. The current system has not been entirely successful at focusing physicians on quality over increasing volume or intensity of services, regardless of quality. This outcome does not help physicians become more efficient and implement steps that improve quality and reduce overall costs, does not help our beneficiaries get the best care possible while keeping down out-of-pocket costs, and certainly does not help address Medicare's long-term financial needs. CMS does not have the administrative authority to fix payment updates so that physicians do not experience multiple, significant negative updates in their payments over the next few years. Even if the Agency did have such authority, revising the annual updates upward each year would be extremely costly and doing so would not help address the root cause of rapid spending growth.

Moving Toward a New Model

Compensation for physicians who provide for our Medicare beneficiaries should encourage and support their efforts to provide the highest quality care in the most cost effective manner. Measuring the quality of care provided, and providing better incentives and support for evidence-based care that improves quality and avoids complications and their associated costs, can give us data we need to help physicians to improve quality and avoid unnecessary costs.

There are many promising ideas for improving the predictability and effectiveness of physician payments that do not add so greatly to Medicare's expected spending growth. Pay-for-performance methods work. We have seen some encouraging results in our

Premier hospital demonstration project and it has been successfully utilized in the private sector as well. Medicare should move forward with new financial models that encourage quality and efficiency, not only for its own fiscal health, but for the well being of our beneficiaries and to support physicians in what they want to do in the first place. It is clear that there is much potential for physicians to assist in our efforts to improve the value of our health care spending. For example, under the current system, there are substantial variations in resource use and spending growth for the same medical condition in different practices and different parts of the country, without apparent difference in quality and outcomes, and without a clear basis in existing medical evidence. A study published in 2003 looked at regional variations in the number of services received by Medicare patients who were hospitalized for hip fractures, colorectal cancer, and acute myocardial infraction. The researchers found that patients in higher spending areas received approximately 60 percent more care, but that quality of care in those regions was no better on most measures and was worse for several preventive care measures.[1] Further, there are many examples of steps that physicians have taken to improve quality while helping to prevent complications and duplication of services and keeping overall costs down. Yet under our current payment system, physicians who take these quality focused steps get less reimbursement from Medicare.

The Administration supports legislative action to move toward a payment system for physicians that provides adequate reimbursement and promotes more efficient and higher quality care, without increasing the financial strain on the Medicare program. As the Budget Reconcilliation process moves forward, the Administration will work with the Congress on a fully-offset provision to address the negative physician update for 2006 and 2007, with differential updates for physicians who report valid, consensus-based quality measures. We also support the bipartisan Congressional interest in moving toward a performance-based payment system in Medicare that does not add to overall Medicare costs. We believe that this step would provide a transition to performance-

[1] Fisher, Elliott S., et. al., "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality and Accessibility of Care," in *Annals of Internal Medicine*, February 18, 2003, vol. 138, no. 4, pp. 273-287.

based payments. These reforms to improve the effectiveness of physician payment in 2006 cannot be undertaken administratively. The pending negative updates are a result of continuing rapid growth in volume and the cost of physician-related Part B services, and this change would provide a stronger foundation for determining the extent to which an increased emphasis on supporting quality care can help physicians provide better care without increasing overall Medicare costs.

Supporting physicians in providing clinically proven, evidence-based care can result in better health outcomes for beneficiaries. Healthier beneficiaries are less likely to experience complications and acute conditions and Medicare dollars could be spent more effectively as a result.

CMS has already undertaken many collaborative steps to work with physicians and other health professionals to make progress toward better quality and avoiding unnecessary health care costs. These include a number of demonstration projects; several required by Congress under statute, aimed at encouraging quality care and designed to lay the groundwork for pay-for-performance systems in the future. These include the Physician Group Practice demonstration, the Health Care Quality Demonstration and the Care Management Performance Demonstration. These projects are helping us to examine our current systems to better anticipate patient needs, especially for those with chronic diseases, and explore how incentives can be better aligned with the kind of care we want.

On October 28 of this year, as another element of our activities to make sure that we are supporting quality measurement, reporting, and improvement as effectively as possible, we announced the Physician Voluntary Reporting Program (PVRP). In this program, physicians who wish to collaborate with us on implementing quality measures and on improving quality can voluntarily report on a number of validated, evidence-based quality indicators beginning January 1, 2006. PVRP is a substantial first step in developing the kinds of reporting mechanisms and data needed to support the creation of a revised physician payment methodology founded on payment for performance. We anticipate that over the next few years, the results of this program will prove to be very

useful as we work with the Congress to move in that direction. I will discuss this program at greater length later in my testimony.

There is more evidence than ever before that these approaches can work, from the private sector and now in Medicare. Information we have gathered as a result of our Premier Hospital Quality Incentive demonstration has shown that financial incentives tied to improved quality may lead to measurable improvements. Furthermore, as shown by the MMA hospital update provision, small incentives to hospitals are sufficient to encourage provider interest in providing evidence-based, quality care. We will keep working together to provide more effective compensation for physicians, building on our demonstration programs and gaining insights from voluntary reporting effort to learn together how best to support physicians in their efforts to provide quality care at the lowest possible cost.

Developing Quality Measures

For several years, CMS has been collaborating with a variety of stakeholders to develop and implement uniform, standardized sets of performance measures for various health care settings. In recent months, thanks to the leadership of many physician organizations, these efforts have accelerated even further.

Our work on the quality measures has been guided by the following widely-accepted principles. Quality measures should be evidence-based. They should be valid and reliable. They should be relevant to a significant part of medical practice. And to assure these features, quality measures should be developed in conjunction with open and transparent processes that promote consensus from a broad range of health care stakeholders. It also is important that quality measures do not discourage physicians from treating high-risk or difficult cases, for example, by incorporating a risk adjustment mechanism. In addition, quality measures should be implemented in a realistic manner that is most relevant for quality improvement in all types of practices and patient populations, while being least burdensome for physicians and other stakeholders.

More than two years ago, CMS initiated a process with the National Committee for Quality Assurance (NCQA), the AMA's Physician Consortium for Performance Improvement, and other stakeholders to develop measures that would be appropriate for the ambulatory setting. As part of this endeavor, CMS took the lead in supporting the National Quality Forum (NQF) endorsement of ambulatory care measures developed by the NCQA and the Physician Consortium. The NCQA is a private, not-for-profit organization dedicated to improving health care quality by providing information about health care quality to help inform consumer and employer choice. The NQF is a private, not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. The result of this activity has been the recent endorsement by the NQF of a set of ambulatory quality measures.

Examples of three ambulatory quality measures are the results of the hemoglobin A1C and LDL and blood pressure tests for diabetic patients. The clinical evidence suggests that patients who have a hemoglobin A1C test below 9 percent, an LDL less than or equal to 100 mg/dl, and blood pressures less than or equal to 140/80 mmHg have better outcomes. These measures are evidence-based, reliable and valid, widely accepted and supported, and were developed in an open and transparent manner. Evidence indicates that reaching these goals can lead to fewer hospitalizations by avoiding complications from diabetes such as amputation, renal failure, and heart disease.

Two quality measures endorsed by NQF for heart failure patients include placing the patient on blood pressure medications and beta blocker therapy. Here too, these therapies have been shown to lead to better health outcomes and reduce preventable complications. Together, diabetes and heart failure account for a large share of potentially preventable complications.

In addition to primary care quality measures, other specialties are developing measures. For example, measures of effectiveness and safety of some surgical care at the hospital level have been developed through collaborative programs like the Surgical Care Improvement Program (SCIP), which includes the American College of Surgeons.

Preventing or decreasing surgical complications can result in a decrease in avoidable hospital expenditures and use of resources. For example, use of anti-biotic prophylaxis has been shown to have a significant effect in reducing post-operative complications at the hospital level. This measure is well developed and there is considerable evidence that its use could not only result in better health but also avoid unnecessary costs. These post-operative complication measures, which are in use in our Hospital Quality Initiative, are being adapted for use as physician quality measures. Application of this type of post-operative complication measure at the physician level has the potential to help avoid unnecessary costs as well as improve quality.

We also are collaborating with other specialty societies, such as the Society of Thoracic Surgeons (STS), to implement quality measures that reflect important aspects of the care of specialists and sub-specialists. The STS has already developed a set of 21 measures at the hospital level that are risk adjusted and track many common complications as outcome measures. STS is also conducting a national pilot program to measure cost and quality simultaneously, while communicating quality and efficiency methods across regional hubs with the objective of reducing unnecessary complications and their associated cost. The STS measures have been adapted to a set of five quality measures for physicians, such as for a patient who receives by-pass surgery with use of internal mammary artery.

Many other specialties have also taken steps to develop evidence-based quality measures. On July 14, 2005, I sent a letter to many specialty societies, summarizing some of the work to date and requesting an update on their efforts to develop quality and performance measures.

I want to thank the AMA and specialty societies for their very positive response to this effort to develop quality measures. Six months ago few specialties had quality measures. Today the majority of specialties have quality measures. Many specialties have created quality task forces and are participating in the quality measurement process. Activity is underway to prepare other measures for NQF endorsement.

CMS has had productive exchanges with most medical specialty organizations. I would encourage organizations that have not entered into discussions with us to initiate a dialogue as soon as possible so we can work together to develop clinically valid measures. In certain areas, compliance with evidence-based practice guidelines has the potential to be a quality measure.

The process we have used with the medical profession to develop quality measures beyond ambulatory care should greatly expedite and facilitate the development, acceptance and implementation of quality measures for additional specialties and services. By working in collaboration with the societies, there has been considerable progress in the measure development process. This preparation will facilitate the NQF endorsement process. However, measures that have not yet gone through the NQF endorsement process are still of great value. Physician reporting of these measures will help foster their acceptance in the medical community and help prepare physicians for their eventual adoption. Moreover, since there is likely to be reporting of the quality measures for a period of time before payment based on performance, NQF consensus is not required to begin reporting of such measures. The rapid progress to develop quality measures for the majority of specialties is a clear indication that quality measures are gaining acceptance as an important element in achieving better performance in our health care system.

Our experience with hospital quality measures is that after a measure is endorsed additional work with stakeholders is necessary to assure successful implementation. The Hospital Quality Alliance played an important role in implementation of the hospital quality measures by facilitating hospital adoption and understanding of technical concerns. The Ambulatory Care Quality Alliance (AQA) can serve a similar role to help with physician adoption of the ambulatory quality measures. The AQA is a consortium led by the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans and the Agency for Healthcare Research

and Quality, CMS and other stakeholders, including the AMA and other physician groups, as well as representatives of private sector purchasers and consumers.

Resource Use

CMS is taking steps toward implementing the MedPAC recommendation to use Medicare claims data to measure fee-for-service physicians' resource use and to share these results with physicians confidentially to educate them about how they compare with aggregated peer performance. We are using existing claims data to simulate and test the measurement and quantification of individual physician patterns of practice, incorporating both services they order (including facility services) as well as services they furnish. Resource use is often measured for episodes of care and periods of time (e.g., 3 months). The most widely used measure is total expenditures per episode of treatment or period of time. Other measures of resource use are possible, such as examining the percent of a physician's patients who have a particular service ordered. This can indicate potential variations in practice that may affect costs significantly without evidence-based benefits for patients. For example, MRI scans may be ordered for patients with non-specific lower back pain, a condition that studies of Medicare data have shown is often used in cases where there is not clear evidence of medical benefit. By comparing relative use of such a service among physicians, a data-driven foundation for identifying opportunities to avoid some medical costs without reducing patient health may be developed. As a next step, we are planning to begin pilot projects to share the results with physicians confidentially to educate them about how they compare to peers in an effort to decrease the use of inappropriate services. Sharing both quality and resource use data will help physicians understand how to provide the best care, at the best price.

CMS is also supporting the development of more evidence-based care. For example, CMS recently launched the "Fistula First" initiative, which is designed to give patients with end stage renal disease the ability to receive life-sustaining dialysis through a method that performs better than other procedures while requiring less maintenance. By

funding and overseeing this initiative, CMS is using its leadership position to partner with the medical community and improve the lives of patients.

Quality Improvement Demonstrations and Pilots Underway

In addition to our work on establishing quality measures, we have begun a number of demonstration and pilot projects to test pay-for-performance principles. Pay-for-performance initiatives are currently underway in a variety of health care settings where people with Medicare receive services, including physicians' offices and hospitals. Because patients with chronic conditions often require treatment across several settings of care, CMS is pursuing pay-for-performance initiatives to support improved coordination of care. CMS will seek input concerning actions we can take administratively to best implement a pay-for-performance system to achieve our goals of promoting better quality and reducing program costs. We want to provide the public with an opportunity to present ideas and suggestions about how pay-for-performance payment mechanisms should be structured, including a public dialogue on key technical and statutory issues.

The Physician Group Practice demonstration is assessing large physician groups' ability to improve care that could result in better patient outcomes and efficiencies. Ten large (200+ physicians), multi-specialty physician groups in various communities across the nation are participating in the demonstration. These physician groups will continue to be paid on a fee-for-service basis, but they may earn performance-based payments for implementing care management strategies that anticipate patients' needs, prevent chronic disease complications, avoid hospitalizations, and improve the quality of care. The performance payment will be derived from savings achieved by the physician group and paid out in part based on the quality results, which CMS will assess. Providing performance-based payments to physicians has great potential to improve beneficiary care and ensure fair and appropriate payment in the Medicare program.

In addition, CMS is preparing to implement the Medicare Health Care Quality Demonstration. This demonstration program, mandated by the MMA, is a five-year

program designed to reduce the variation in utilization of heath care services by encouraging the use of evidence-based care and best practice guidelines. Detailed proposals are due at the end of the year. CMS is also implementing the Medicare Care Management Performance Demonstration, a 3-year pay-for-performance pilot, mandated by the MMA, with small- and medium-sized physician practices that will promote the adoption and use of effective health information technology that achieves improvements in the quality of care and reductions in preventable costs for chronically ill people with Medicare. This demonstration will provide performance payments for physicians who meet or exceed performance standards in clinical delivery systems and patient outcomes, and will reflect the special circumstances of smaller practices. It also will give CMS the opportunity to provide technical assistance to small providers in adopting information technology that is effective in improving quality and avoiding costs, as CMS has already been working to do in limited pilots. This demonstration project is currently under development and will be implemented in Arkansas, California, Massachusetts, and Utah. We are supporting an evaluation of this demonstration with AHRQ and insights from health IT implementation that produces improvements in quality and efficiency will be shared broadly through AHRQ's National Resource Center.

Quality Improvement Organizations Assist Physicians' Offices

We recognize that taking advantage of performance-based payment reforms may be more difficult for small providers, rural providers, and providers in underserved areas. Consequently, CMS has enhanced its efforts to give such providers assistance with proven system advancements and quality improvement initiatives. Beginning August 1 of this year, under our new three-year contract with the quality improvement organizations (QIOs), the QIOs began offering assistance in clinical process redesign to physicians' offices who are seeking to achieve substantial improvements in care through the adoption of health information technology, patient-focused care processes, and clinical measures reporting. In each state, QIOs will use the tools and methods developed in the Doctors Office Quality - Information Technology (DOQ-IT) two-year pilot project to help primary care physicians make changes to clinical processes to improve quality. This initiative is part of CMS's overall commitment to supporting physicians and other

providers who are committing to success in our developing programs of public reporting and pay-for-performance.

Over the past year, the CMS California QIO, Lumetra, has been piloting CMS DOQ-IT assistance efforts for over 500 physicians and their offices in California. Many of these physicians' offices are small offices with one or two physicians and are located in rural or underserved areas of California. Lumetra staff and consultants provide consultation and assistance for these offices, supporting the clinical process changes and improvements resulting from the incorporation of health information technology in their offices, which in turn will allow them to utilize electronic health records, electronic prescribing, decision support and clinical practice guidelines relevant to their patient population, and electronic billing and communications. In addition, QIO staff will assist these offices in implementing office redesign to enhance patient management, and increase office efficiency. All of these efforts are designed to result in enhanced patient safety and better quality of care. Our goal is to help support effective physician office enhancements to become standard in all medical practices in the coming years and CMS QIO efforts will help ensure that physicians' offices can accomplish these enhancements.

The QIOs also have implemented quality improvement projects that lead to better care in rural and underserved areas. For example, Qualis Health, the CMS Alaska QIO, has worked with the almost exclusively rural Alaska providers to increase the rates of preventive services available to rural Alaska residents. Mountain Pacific QIO, the CMS QIO in Hawaii, is working to implement telehealth services to bring care not otherwise available to rural Hawaii beneficiaries.

Physician Voluntary Reporting Program

On October 28, 2005, CMS announced another step in these efforts to provide better support for quality care, the implementation of the Physician Voluntary Reporting Program (PVRP). This program builds on work being done under a number of current demonstrations, such as the Physician Group Practice demonstration, which involve many of the same kinds of quality measures to be reported under the PVRP.

Under the PVRP, beginning in January 2006, Medicare physicians who choose to participate will be able to voluntarily report information to CMS about the quality of care they provide to Medicare beneficiaries. There will be no penalty for those who choose not to participate, nor will claims be denied if they do not include this information. Physicians who wish to report will select those measures relevant to the services they actually provide. The measures they report will come from a group, selected by CMS, of 36 evidence-based clinically valid measures, widely recognized as being appropriate for indicating quality of care. The measurements were previously developed in a collaborative fashion by CMS and a number of stakeholders, including the AMA and other relevant specialty and quality groups. When CMS made the decision to implement the PVRP, we selected from this pre-existing, widely agreed upon body of measures. Twenty-nine of the measures have been endorsed, or submitted for National Quality Forum (NQF) endorsement and the remaining seven will be submitted for endorsement.

Our initial measures for this voluntary reporting program were intentionally selected to cover a broad range of medical practice where broadly-supported, evidence-based quality measures have been developed, including not just ambulatory care and preventive medicine but also physician care provided by specialists. The 36 measures cover diagnoses such as diabetes and heart failure that constitute significant amounts of Medicare spending. The 36 measures involve care by physicians in specialties that cover about 65 percent of Medicare physician spending.

The measures we are using also include NQF endorsed preventive measures such as whether the beneficiary received a flu shot, pneumococcal vaccination or mammography. In addition, NQF has endorsed a number of measures developed by the Society of Thoracic Surgeons (STS) for coronary artery bypass surgery such as pre-operative beta blocker. These STS measures were endorsed for hospitals to report and our PVRP allows physicians to report these measures. We are also allowing physicians to report three measures that were endorsed by the NQF for hospitals and are being reported by hospitals right now as part of their reporting of 10 measures under section 501(b) of the MMA.

These measures, important for services physician provide in emergent care, are: aspirin at arrival and beta blocker at arrival for heart attack patients, and the timing of antibiotic administration for hospitalized pneumonia beneficiaries. As part of the PVRP, we expect to identify the least burdensome ways to reliably report physician quality measures for hospital-based care.

We are also using three measures for end-stage renal disease (ESRD): the dialysis dose, the hematocrit level and receipt of an AV fistula. These are important measures for treating ESRD beneficiaries. They are already being used by ESRD facilities, and were developed with significant stakeholder support and consensus and have been submitted to NQF for endorsement.

We are also using four assessment measures developed by the Assessing Care of Vulnerable Elders (ACOVE) project (assessment for falls, hearing acuity and urinary incontinence in elderly patients and assessment of osteoperosis in elderly female patients), and three measures developed by the RAND QIT project. ACOVE measures were developed with significant input from the physician and research communities and submitted for peer review and then re-reviewed. We expect these ACOVE and RAND QIT measures to be submitted to NQF.

The PVRP relies on existing administrative systems for initial quality reporting. In the years ahead, it is expected that electronic record systems can be developed that would provide information that is needed to measure and report on quality while fully protecting patient confidentiality. As part of the Administration's quality improvement efforts, we expect to continue to make progress toward the widespread use of electronic health records that, among other things, would greatly facilitate the accurate and efficient use of information on quality measures and quality improvement. Progress on supporting measurement for quality improvement efforts can occur in conjunction with these steps toward more widespread availability of electronic health records. Indeed, increased emphasis on quality reporting and quality improvement would facilitate more the adoption of effective health IT systems.

In the short term, information on a broad range of quality measures can be obtained adequately using existing claims and the administrative claims system. In particular, with adequate guidance for appropriate coding practices by physicians' offices, HCPCS codes established by Medicare and reportable on existing claims forms, the so-called G-codes, can be the vehicle to report the information on claims. While HCPCS codes generally represent services furnished, the G-codes would report information on the quality measures, and could potentially be a basis for payment based on the report of such information. This reporting mechanism allows collection of information on the quality measures via an existing system familiar to the physician community. Furthermore, it allows collection of the quality measures to begin, on a voluntary basis, on January 1, 2006.

CMS uses G-codes when a new or revised service is introduced in such a way that there is insufficient time to establish a more permanent Current Procedural Terminology (CPT) code. CPT contains a set of supplemental codes, called Category II codes, that can be used for performance measurements. According to the CPT book, Category II codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support performance measures. Some organizations have expressed concern about our use of G-codes in the PVRP. We envision the time when G-codes used to report on quality measures under the PVRP are transitioned to Category II codes, as appropriate Category II codes are available.

We have converted the 36 quality measures into a series of G-codes that could then be reported by a physician on a claim in a way that is simple and does not burden physicians. Each code has a numerator (the appropriate G-code that would be reported) and a denominator (specifically defined by appropriate procedure and diagnosis codes). We have released instructions about the numerator and denominator for each measure in a recent Change Request (CR 4183). As an example, we have established four G-codes for the hemoglobin A1c measure. A physician would use G-8016 to report that the hemoglobin A1c was 9 or less, use G-8015 to report that the value was above 9, use G-

8017 to report that the beneficiary was not a candidate for the measure, and use G-8018 to report that the physician had not treated the beneficiary for a sufficient period of time. While there are four codes to select from for the reporting of this measure, only a single G-code would be reported on the claim form. The instructions specify the particular HCPCS procedure and ICD diagnosis codes for which the measure should be reported.

CMS is sensitive to the need to keep the reporting requirements for physicians simple and useful. Currently, additions and deletions to the body of procedures codes are made every year, often as the result of new services, revision of existing codes, and physician requests for code changes. CPT code changes are announced around October 1, and effective the following January 1. In the 2006 edition of CPT, there are approximately 450 code changes (221 additions, 129 revisions, and 97 deletions). CMS typically adds a few G-codes every year as well, announced in the annual physician fee schedule, released in early November and effective the following January 1. Physicians and vendors of the electronic billing systems they use are accustomed to making timely adjustments for these coding changes each year.

While there are a total of 104 G-codes for the 36 measures, physicians would report only a single G-code for a measure. The number of new codes is in line with the average number of new codes per year. Further, although there are 36 measures, the number of measures that would actually be reported by an individual physician will be a subset of those measures, based on their specialty and the range of conditions they treat. Moreover, many of the measures are likely to be reported only once per year, further minimizing the reporting burden. Finally, in this voluntary pilot program, physicians who decide to participate would only report the measures that they determine are relevant and practical for their practice

We expect that reporting of a G-code would be a reasonably straight forward matter. Item 24 of the universally familiar HCFA-1500 form will be used to report the new G-codes, precisely as physicians have been doing for years to report and bill for their other procedure codes. All a physician needs to do to report is put the appropriate G-code(s)

on one of the lines within Item 24, exactly as a physician would list a HCPCS code in order to bill any given service. While we encourage physicians to submit G codes when applicable, failure to provide a G-code will not result in denial of a claim that would otherwise be approved.

Electronic systems have the potential to make reporting a fairly simple and routine matter. However, we recognize that software vendors may need to make adjustments to their products in order to integrate reporting of the quality measures. We want to work with physicians and software vendors to identify the specific steps needed to facilitate quality reporting that is as simple and reliable as possible, and we expect the PVRP process will help make sure we achieve this goal.

We plan to provide feedback to physicians who submit the data in 2006 about their reporting rate. The goal is to begin to use this information to assist physicians in improving their reporting rate, reducing their reporting burden, and supporting better quality of care. During the pilot, the feedback will be provided directly to the reporting physician and will not be made available to the public. The other primary goal of the PVRP is for CMS to seek and obtain practically relevant input from participating physicians on ways to improve the ease and completeness of reporting and usefulness of the quality measures, such as by promoting reports and analysis through electronic medical record systems. Practical issues related to the least burdensome approach to collecting the kind of data that are needed to construct a system that rewards quality care and good outcomes, rather than volume, are important to address promptly as we work to establish a more effective payment system for physicians.

We look forward to working with the physician community to ensure the program's success in achieving both of these goals. We are gratified by expressions of support for the program that we have already received. Specifically, the Consumer Purchaser Disclosure Project, a coalition of the nation's leading consumer, employer and labor organizations, supported by the Robert Wood Johnson Foundation and the Leapfrog Group, and led by the Pacific Business Group on Health, has expressed strong support for

the PVRP. The Alliance of Specialty Medicine, a coalition of 13 medical specialty societies, has also recognized the PVRP as an important step in moving toward a pay-for-performance system for physicians. We look forward to working with them and many other members of the physician community as we move forward. We are already working on potential improvements in the program based on specific comments and suggestions we have received from interested parties. For example, it has been suggested that we consider allowing measures to be reported independent of the payable claim. We appreciate these constructive comments and are considering them as we work toward developing the easiest reporting system, while minimizing unnecessary costs to both physicians and CMS.

Medicare's Hospital Performance-Based Payments Have an Impact

The experience with MMA section 501(b) – under which hospitals that report on ten quality measures receive an update that is 0.4 percentage points higher – suggests that relatively small payment incentives can have a significant impact on provider behavior. Virtually all hospitals are submitting the required data. There is an increasing belief that linking a portion of Medicare payments to valid measures of quality would support better health care.

Evidence exists that some hospital admissions are preventable. Heart failure patients have a readmission rate of 21 percent over 30 days, yet research shows that about half of the readmissions are preventable. For example, providing angiotensin-converting enzyme inhibitor (ACEI) drugs to heart failure patients is an example of high quality care, yet ACEI prescriptions are found in only 66 percent of audited patient records. Giving beta-blocker drugs to patients with acute myocardial infarction (AMI) can reduce rehospitalizations by 22 percent, but only 21 percent of eligible AMI patients receive a prescription for a beta-blocker. Pneumonia is a very common cause of hospital admissions for people with Medicare, but many of these cases could be prevented through pneumococcal and influenza vaccinations. Studies have shown that proper adherence to vaccination protocols can reduce hospitalizations for pneumonia and for

influenza by about half, with reduced diseases, mortality, and potential savings for the Medicare Program.

If physicians are supported in their efforts to better manage patient care, preventable and costly hospitalizations, readmissions and admissions for complications may be avoided. Too often, costs of avoidable admissions are greater than the costs of services for physicians better managing beneficiaries on an ambulatory basis. As Congress considers modifying the payment system for physicians, we should work together to ensure that the physician payment system supports and encourages physicians to reduce unnecessary Medicare spending by avoiding unnecessary services such as preventable hospital admissions. This could result in more effective expenditure of Medicare dollars.

The Premier Hospital Quality Incentive Demonstration is a demonstration project that tests if providing financial incentives to hospitals that demonstrate high quality performance in a number of areas of acute inpatient care will improve patient outcomes and reduce overall costs for Medicare. Hospital participation is voluntary. We believe that creating incentives to promote the use of best practices and highest quality of care will stimulate quality improvement in clinical practice and may result in cost savings. Under the Premier demonstration, a hospital can receive bonuses in its Medicare payments based on how well it meets the quality measures. Poorly performing hospitals will face financial penalties in the third year.

I am pleased to report that evidence from the first year of the Premier Hospital Demonstration shows that performance-based payments may work to improve quality and help prevent complications in Medicare. The demonstration tracks hospital performance on a set of 34 widely-accepted measures of processes and outcomes of care for five common clinical conditions. The 20 measures now included in Medicare's national hospital quality reporting program are a subset of these measures.

Quality of care improved in all of the five clinical areas for which quality was measured. Composite quality scores improved between the first and last quarters of the first year of the demonstration:

- From 87 percent to 91 percent for patients with acute myocardial infarction (heart attack).
- From 65 to 74 percent for patients with heart failure.
- From 69 percent to 79 percent for patients with pneumonia.
- From 85 percent to 90 percent for patients with coronary artery bypass graft.
- From 85 percent to 90 percent for patients with hip and knee replacement.

In the Premier demonstration, top performing hospitals received bonuses based on their performance of evidence-based quality measures for inpatients with the five conditions. A hospital received a bonus in its Medicare payments based on how well it met the quality measures related to each condition.

Overall, these conditions account for a substantial portion of Medicare costs. If we achieve improvements in aspects of care that are proven to help patients avoid complications, patients are less likely to require more costly follow-up care for such conditions, and they are more likely to have a better quality of life.

Promoting Coordinated Care and Disease Management

CMS recognizes that many patients require care in a variety of settings. Therefore, CMS has projects in operation or in the planning stages that will use pay-for-performance systems to support physician efforts to coordinate care and execute an effective patient management plan for beneficiaries with chronic illnesses.

- *Medicare Health Support Program* – This program is testing a population-based model of disease management. Under the program, nine participating organizations are being paid a monthly per beneficiary fee for managing a population of beneficiaries with advanced congestive heart failure and/or complex

diabetes. These organizations must guarantee CMS a savings of at least 5 percent plus the cost of the monthly fees compared to a similar population of beneficiaries. Payment is contingent upon performance on quality measures and beneficiaries and provider satisfaction. The program will generate data on performance measures that will be useful in improving the Medicare program as a whole.

- *Disease Management Demonstration for Severely Chronically Ill People with Medicare* – This demonstration, which began enrollment in February 2004, is designed to test whether applying disease management and prescription drug coverage in a fee-for-service environment for beneficiaries with illnesses such as congestive heart failure, diabetes, or coronary artery disease can improve health outcomes and reduce costs. Participating disease management organizations receive a monthly payment for every beneficiary they enroll to provide disease management services and a comprehensive drug benefit, and must guarantee that there will be a net reduction in Medicare expenditures as a result of their services. To measure quality, the organizations must submit data on a number of relevant clinical measures.

- *Disease Management Demonstration for Chronically Ill Dual-Eligible Beneficiaries* – Under this demonstration, disease management services are being provided to full-benefit dual eligible beneficiaries in Florida who suffer from advanced-stage congestive heart failure, diabetes, or coronary heart disease. The demonstration provides the opportunity to combine the resources of the state's Medicaid pharmacy benefit with a disease management activity funded by Medicare to coordinate the services of both programs and achieve improved quality with lower total program costs. The demonstration organization is being paid a fixed monthly amount per beneficiary and is at risk for 100 percent of its fees if performance targets are not met. Savings above the targeted amount will be shared equally between CMS and the demonstration organization. Submission of data on a variety of relevant clinical measures is required to permit evaluation of the demonstration's impact on quality.

- *Care Management For High Cost Beneficiaries* – This demonstration program will test models of care management in a Medicare fee-for-service population. The project will target beneficiaries who are both high-cost and high-risk. The payment methodology will be similar to that implemented in the Chronic Care Improvement Program, with participating providers required to meet relevant clinical quality standards as well as guarantee savings to the Medicare program.

Private Sector Initiatives Pave the Way for Improved Quality and Efficiency

The private sector also has recognized opportunities to improve quality and efficiency of care through better measurement of the delivery of care in coordination with better reimbursement models. In fact, the Leapfrog Compendium on Pay-For-Performance

includes over 100 projects related to physicians. For example, the Bridges to Excellence (BTE) program, a not-for-profit organization of employers, providers, and plans has three programs to promote and reward improvements in the quality of patient care for physicians' offices, diabetes care, and cardiac care. To date participating employers have paid over $1.65 million in bonus payments to over 800 physicians in the four participating markets for exceeding National Committee for Quality Assurance performance criteria. Thus far, results indicate that physicians can and do participate and report their performance accurately.

A large health plan in New Hampshire launched a quality improvement incentive program in 1998, rewarding primary care physicians for the provision of quality care. The metrics for its quality improvement incentive program are the Health Plan Employer Data and Information Set (HEDIS) measures. The program uses claims and administrative data from its disease management program to assess physician practice performance. Incentive payments are awarded to practices scoring greater than the network average. In 2001, the average physician bonus payment was $1,183 and the highest bonus payment was $15,320. In the first year, the plan's average rates for mammography, immunization, and pediatric exams showed increases. Adult female patients receiving Pap smear tests rose from an overall rate of 80 percent in 1999 to 98.5 percent in 2000 for the top quartile of physician practices. For all performance measures for which 1999 baseline data were available, the average incentive program physician practice conformity with performance measures rose from 51.2 percent to 65.6 percent in 2000.

In 2003 a large health plan in Massachusetts launched a group practice incentive program for groups of specialists. Group practices are measured in three categories: patient satisfaction and access, quality of care, and cost. Group practices that perform better than average on the quality measures earn a bonus that could total up to fifteen percent of the regular fees paid to that physician group.

An Illinois coalition of employers initiated a program in 2000 that provides incentives to physicians for monitoring diabetes patients. Compensation is awarded to physicians in the program who meet annual goals in diabetic treatment thresholds. To gain physician buy-in into the program, a committee of physicians developed the performance goals. The coalition and medical group administrators negotiated the amount of the financial incentives a medical group could receive if they met the goals. Results reveal that diabetic care for patients in the program is significantly better than state averages and cost trends for diabetics are better than trends for all other conditions.

A Hawaiian medical association launched a voluntary practitioner quality and service recognition program. Practitioners who enroll share in a multimillion dollar budget earmarked to recognize practitioners for adhering to recognized standards of quality and clinical practices proven by research to improve clinical outcomes. Each program participant receives an award based on his or her scoring in each of the program components – quality indicators, patient satisfaction, and business operations. Practitioners are measured on a total of 68 clinical measures. Analysis of data on key clinical quality indicators over the six years of the program demonstrates statistically significant improved performance.

In Minnesota a Health Partner's program recognizing outcomes offers annual bonus awards to primary care clinics that achieve superior results in effectively promoting health and preventing disease. Eligible primary care groups are annually allocated a pool of bonus dollars that is awarded if a group reaches specific comprehensive performance targets. Since 1997, bonus awards have totaled over $2.5 million. The impact on quality of care has been substantial. The proportion of diabetes patients meeting optimal care standards nearly tripled since 1999 and the rates of optimal coronary artery disease patients reaching all treatment targets doubled. The rate of members receiving all preventive care doubled. Tobacco use assessment at all visits increased from 45 percent to 85 percent over four years and more patients are routinely provided assistance to quit. Tobacco use rates dropped ten percent to an all time low. Diabetes eye and kidney complications rates dropped by nearly 50 percent and costs are trending significantly

below costs for all other patients. In Minnesota death from heart disease dropped to the lowest rate in the nation and continues to decline.

A health care leadership association of health plans, physician groups, and health systems in California, recently implemented coordinated, state-wide pay-for-performance initiatives. Based on a comparison of data from the first year (2003) and test year (2002) nearly 150,000 more California women received cervical cancer screenings, 35,000 more California women received breast cancer screenings, 10,000 additional California children received two needed immunizations, and 18,000 more Californians received a diabetes test. The program paid an estimated $50 million to 215 California physician groups in the pay-for-performance program in 2003 (paid out in 2004), and an estimated total of $100 million to the same physician groups under all of the association's quality programs.

The American Society of Clinical Oncology's Quality Oncology Practice Initiative (QOPI) is an oncologist-led, practice-based quality improvement initiative. QOPI's goal is to promote excellence in cancer care by helping practices create a culture of self-examination and improvement. The process employed for improving cancer care includes measurement, feedback, and improvement tools for medical oncology practices. Practicing oncologists and quality experts developed the QOPI quality measures, which are derived from clinical guidelines or published standards, adapted from the National Initiative on Cancer Care Quality (NICCQ), and are consensus-based and clinically relevant. Although the measures are not yet linked to financial reimbursement, QOPI is an example of a specialty society-driven quality initiative that can be easily linked to a pay-for-performance program.

Results of these and many more provider-led initiatives, including those in the private sector, lay a sound foundation for CMS to move forward collaboratively with the Congress and with leading provider organizations toward adapting efficiency and performance based payments for Medicare.

These approaches are also aligned with emerging requirements from medical specialty boards for maintenance of certification. While recertification has traditionally involved demonstrating cognitive knowledge only, all boards are moving to link maintenance of specialty certification with demonstrated efforts to improve clinical care quality and performance. We recognize that providers need to be actively engaged in establishing this new direction and will continue close consultation and collaboration to assure improved quality and reduced burden for busy practitioners.

Conclusion

Mr. Chairman, thank you again for this opportunity to testify on physician payments within the Medicare program. We look forward to working with Congress and the medical community to develop a system that ensures appropriate payments for providers while also promoting the highest quality of care, without increasing overall Medicare costs. As a growing number of stakeholders now agree, we must increase our emphasis on payment based on improving quality and avoiding unnecessary costs. I would be happy to answer any of your questions.

Statement For the Record of the Hearing of the House Energy and Commerce Committee Subcommittee on Health On "Medicare Physician Payment: How to Build a More Efficient Payment System."

Testimony of the American College of Physicians In Collaboration with the American Academy of Family Physicians And American Osteopathic Association On The Impact of Medicare Payment Cuts on Access to Primary Care

November 17, 2005

Introduction

My name is Vineet Arora, MD, chair of the Council of Associates of the American College of Physicians and a member of the College's Board of Regents. I am an Instructor of Medicine in the Section of General Internal Medicine at the University of Chicago where I did my internal medicine residency. As an attending physician on staff, I, along with the residents and medical students I supervise, currently see a large number of Medicare patients. We deliver primary care to the residents on the South Side of Chicago; 85% of these patients are African American and the majority is over age 65 and covered by Medicare. I also serve as the Associate Program Director for the Internal Medicine Residency Program and the Assistant Dean for the Pritzker School of Medicine. In this role, I advise students and residents regarding their future careers.

ACP is the nation's largest medical specialty society, representing 119,000 physicians who specialize in internal medicine and medical students. ACP's Council of Associates, which I chair, represents physicians who are being trained in an internal medicine residency program or who have gone on for additional training in a subspecialty medicine fellowship program. *We are the new generation of physicians that your elderly and disabled constituents will be counting on for their primary care.*

Unfortunately, there won't be enough of us. A combination of high student debt and an unfavorable economic environment is causing many of us to choose careers other than general internal medicine or family practice—the two specialties that aged and disabled patients most depend on for their primary care. According to CMS, in 2004 almost half of all Medicare expenditures on office visits were for services provided by primary care physicians. Medicare payment cuts that will result from the flawed Sustainable Growth Rate (SGR) formula will accelerate this looming crisis in access to primary care.

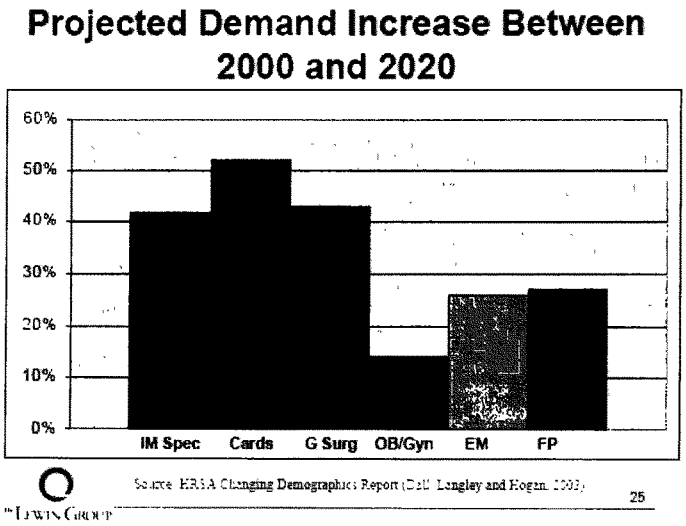
Last week, representatives from the American College of Physicians, American Academy of Family Physicians, and the American Osteopathic Association visited members of both the House and Senate to share our concerns about the impact of Medicare payment cuts on access and quality of care for Medicare patients. Together, our three organizations represent approximately a quarter-million physicians and medical student members. Today's testimony will summarize and elaborate on the points we made in our joint visits. *I am pleased to report that the American Academy of Family Physicians and the American Osteopathic Association participated in the preparation of today's testimony*

and asked for the record of the hearing to reflect that they concur with the views expressed. (The American Academy of Family Physicians and the American Osteopathic Association will also be submitting their own statements for the record of this hearing).

The Looming Crisis in Access to Primary Care

There is growing evidence that shortages are developing for U.S. physicians, particularly in general internal medicine and family practice. Previous expectations of an excess supply of physicians have not materialized. Current projections indicate that the future supply of primary care physicians will be inadequate to meet the health care needs of the aging U.S. population, especially as "Baby Boomers" are beginning to reach retirement age in 2011, when they will be at increased risk for needing health-care services.

The chart below illustrates the dramatic increase in demand for certain physicians:



The aggregate demand numbers do not tell the whole story, however. As illustrated in the following chart, as adult patients age, their need for primary care physicians increases dramatically, requiring proportionately more physicians per 100,000 population to meet the increased demand:

What Aggregate Numbers Don't Show

Est. Demand for Patient Care Physicians per 100,000 Population, by Patient Age: 2000

Age Group	Specialty				
	Primary Care	Medical Specialties	Surgery	Other Care	Total
0–17	97	10	16	30	**153**
18–24	44	15	56	49	165
25–44	60	24	54	64	**202**
45–64	91	42	61	84	**278**
65–74	179	100	129	150	**558**
75+	276	134	166	227	**804**
Total	**96**	34	**57**	73	**261**

- Most specialties disproportionately serve patients of a certain age, gender, etc.

Source: HPSA Changing Demographics Report (Dell, Langley and Hogan, 2003)

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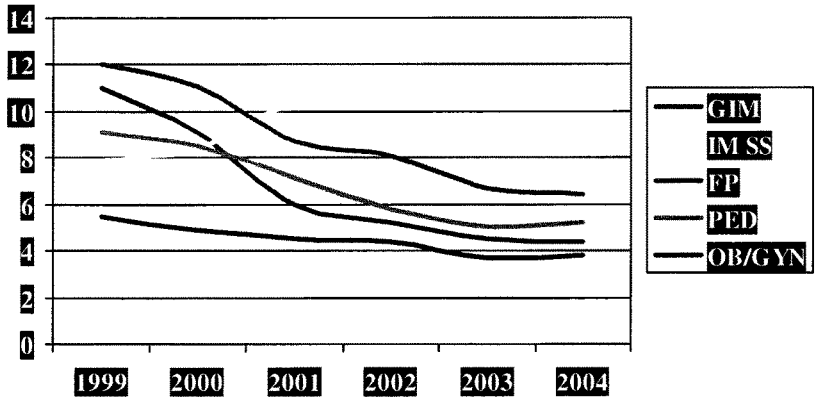
The Lewin Group

The Association of American Medical Colleges exit survey of graduating seniors found that the number of students choosing GIM as a career has dropped precipitously in the past 4 years (12.2% in 1999, 10.2% in 2000, 6.7% in 2001, and 5.9% in 2002).

Interest in Entering Primary Care has been Declining
Among Graduating Medical School Seniors (Percentages)



Source: AAMC Medical School Graduation Questionnaires: All School Reports 1999-2004, Table 25b Choice of Specialty/Subspecialty. http://www.aamc.org/data/gq/allschoolsreports/2004.pdf

Another recently-published study of the career plans of internal medicine residents documents the steep decline in the willingness of physicians to go into primary care. In 1998, 54% of third year internal medicine residents planned to practice general internal medicine compared with 27% in 2003. Strikingly, in 2003, only 19% of first year internal medicine residents planned to pursue careers in general medicine.

The trend away from primary care has been well documented by the annual residency training match sponsored by the National Resident Matching Program (NRMP). The number of U.S. medical school graduates who choose to enter generalist residency training has decreased from 50 percent in 1998 to less than 40% in 2004. The decline has been greatest in family medicine training programs, which has declined 41%. Internal medicine and pediatrics declined by 9% and 8% respectively. In the 2004 match, the

percentage of residency training positions filled by U.S. medical school graduates was only 41% in family practice, 55% in internal medicine residencies and 71% in pediatrics.

Reversing this decline will require immediate action by policymakers. The long pipeline of medical education and training and the retirement and career changes of older physicians necessitates that the nation have a constant influx of new students embarking on medical careers. As the population ages, and larger numbers of patients encounter chronic and more complex illnesses, the need for general internists and family physicians will increase. The need for primary care physicians, who can provide first contact and comprehensive continuing care for adults, will continue to increase as the population ages and its health care needs increase, and as the demand for acute, chronic and long-term care increases.

Economics of Primary Care and Career Choice

The reasons why medical students and young physicians are turning away from primary care are complex and multifaceted. But based on my own experience, and from my conversations with my peers, I can say with confidence that that the dismal economic practice environment associated with primary care today is the major barrier. The pending Medicare payment cuts will only make a bad situation even worse.

Medical students and young physicians learn early on in our training about the joys of having a continuous, ongoing and personal relationship with a patient, which is the hallmark of general internal medicine and family medicine. Unfortunately, we also learn that primary care is under-reimbursed compared to other specialties, and that many primary care

physicians are struggling to keep their practices open at a time of escalating practice costs, excessive paperwork requirements that take time away from patients, and reimbursement from Medicare and other payers that does not keep pace with their rising costs. It is so bad that many of the excellent primary care physicians that we meet in our training programs go as far as to counsel us *not* to go into primary care. Why? Because they tell us that there is no economic future in primary care.

Part of this is due to fact that we are entering practice with very high student debt. Excessive levels of debt mean that it is less likely that we will go into specialties, like general internal medicine and family practice, which are reimbursed so poorly that it will take decades to pay off our debt. Today, a physician entering practice has on average accumulated more than $100,000 in student debt. The median indebtedness of medical school students graduating this year is expected to be $120,000 for students in public medical schools and $160,000 for students attending private medical schools. About 5% of all medical students will graduate with more than debt of $200,000 or more. Many of us are entering practice at the same time we are getting married, buying homes, and starting families. Is it any surprise that more and more of us have concluded that we simply cannot afford to support our families and also practice primary care?

Medicare Payment Cuts Will Accelerate the Access Crisis

Right now, physician payments under Medicare will be cut by 4.4 percent on January 1, 2006. Additional cuts will decrease physician reimbursement by more than 26 percent from 2006 to 2011. According to the Medicare Economic Index from CMS, physician

costs will rise by 15 percent during this same time period. The problem is that the cuts will accelerate the precipitous decline in physicians going into internal medicine and family practice, by making an already poor adverse economic environment even worse. The cuts will also limit the ability of physicians who are already in practice to continue to provide care to Medicare patients.

Because internists and family physicians see so many elderly patients, their practices will be particularly hurt by the cuts. And those in small practices will have the hardest time making ends meet. (According to a 2004 article in Health Affairs, more than half of all practicing physicians are in practices of three or fewer physicians, three-quarters are in practices of eight or fewer.) Small physician practices are small businesses. Like any small business, they cannot continue to provide the same level of service if revenue falls behind costs.

More than a third of today's physicians are age 55 and over. That's 304,641 of the country's 871,535 doctors who could be "pushed over the edge" by these Medicare cuts. They may decide to retire rather than deal with the Medicare cuts, at the same time that fewer young physicians are going into primary care, and those in practice who don't retire may be forced to limit the number of new Medicare patients they will accept. It will become harder for Medicare patients to find a doctor and they will wait longer for appointments.

Medicare will also pay more. According to an article published in the Annals of Internal

Medicine in July "Studies . . . have shown that hospitalization rates and expenditures for those conditions are higher in areas with fewer primary care physicians and limited access to primary care."

Medicare Cuts Will Also Set Back Quality Improvement

The SGR cuts will have other adverse consequences for the quality of patient care.

- *The cuts will set back the national goal of improving health care through Health Information Technology*

These cuts will fall hardest on the doctors who can least afford the investment needed to adopt health information technology (HIT): primary care physicians in small practices who see a large number of Medicare patients. In a landmark study published last month in *Health Affairs,* the authors reported that initial electronic health records (EHR) costs averaged $44,000 per full-time equivalent provider, and ongoing costs averaged $8,500 per provider per year for maintenance of the system. They concluded that "Policies should be designed to provide incentives and support services to help practices improve the quality of care by using EHRs."

A 2004 report by the Center for Studying Health System Change found a large majority of Americans receive their care from small or solo physician practices, but those practices are the least likely to have acquired health information technology to support key quality improvement activities. The report concluded that because barriers to HIT adoption appear to be greatest for smaller traditional physician practices, policy makers may need

to design policies specifically aimed at these physicians, noting that while the use of HIT in physicians' offices potentially can improve quality and reduce costs, implementation is costly because of up-front investments in capital, training and integrating HIT systems with existing administrative and clinical processes.

- *The cuts will set back the national goal of measuring and improving health care quality*

The Medicare fee cuts will fall hardest on the physicians that Medicare is most counting on to participate in quality measurement. Just two weeks ago, CMS proposed a new voluntary physician reporting program; out of the 36 measures proposed, 22 will apply principally to internal medicine specialists and other primary care physicians.

Physicians who participate in the program will need to train and dedicate office staff to tracking quality data and learning new reporting forms, technologies and billing codes that will have to be incorporated into existing office systems. They will then need to review regular reports on their quality and institute action plans to make improvements. Many small practices will simply be unable to take on this commitment if Medicare fee cuts deprive them of the resources needed. According to a study published less than three weeks ago in The Journal of the American Medical Association, one of the possible reasons for low response in a quality improvement program the authors studied is that "the financial rewards for quality were too low." Internal medicine doctors and family physicians are committed to the goal of measuring and improving health care quality, but Congress needs to do its part.

Conclusion

In conclusion, I urge the Subcommittee to recommend that Congress take action now to help avert the looming crisis in access to primary care. Medicare patients depend on internists and family physicians for their care, but there are not enough of us going into primary care. Medicare payment cuts will fall hardest on the primary care specialties that can least afford them. The cuts will accelerate the precipitous decline in medical students and young physicians going into primary care. The cuts will force many of those who are now in practice to retire early or limit how many Medicare patients they can see. The cuts will make it impossible for primary care physicians to make the investments required to obtain electronic health records and participate in quality measurement and reporting.

What can be done to avert this crisis?

First, Congress must stabilize Medicare payments by halting the 4.4 percent cut on January 1, 2006 and replacing the SGR cuts with positive updates for at least the next two years.

Second, Congress must enact a long-term alternative to the SGR. This alternative should base payments on increases in physician practice costs with the opportunity for physicians to qualify for additional payments for meeting quality improvement goals. It should allow physicians to benefit from achieving savings in other parts of Medicare, such as by reducing Part A expenses associated with unnecessary hospitalizations.

Third, Congress must recognize that successful implementation of a Medicare value-based purchasing program or pay-for-performance will require that the SGR be replaced with an alternative that provides stable, adequate and predictable payments to physicians.

Fourth, Congress should work with ACP, AAFP and AOA on developing a coordinated and comprehensive strategy for reversing the decline in physicians going into primary care. Such a strategy should address such factors as inequitable reimbursement, high levels of student debt, and excessive paperwork requirements imposed on primary care practices. It should also provide adequate financing for new and better ways of delivering primary care to patients, such as a "medical home" model where patients would have ongoing access to patient-centered, coordinated care through a personal physician working with a team of health care professionals. Under such a model, physicians would be paid a care management fee for providing managing and coordinating the care that they provide to their patients rather than being paid under the current episodic, volume-based fee for service system.

I am pleased to answer any questions from the Committee.

Mr. DEAL. Thank you.
Mr. Hackbarth.

STATEMENT OF GLEN M. HACKBARTH

Mr. HACKBARTH. Chairman Deal, Congressman Brown, other members of the subcommittee, I appreciate the opportunity to talk to you today about this issue.

Based on your statements, you all understand the reasons why so many people are unhappy with the financial side of Part B of Medicare. Because of the sustainable growth rate system, physician fees confront significant cuts, not just in 2006, but similar cuts for many years into the future. Because expenditures are growing rapidly, Medicare beneficiaries confront significant increases in their premiums. And taxpayers confront a much heavier burden, not just for Part B, but for all of Medicare, and not just for today's retirees, but for a growing retiree population in the future. So there is lots to be unhappy about for all parties on the financial side.

The news on the quality side is better, but still troublesome in some important ways. As a nation, we are regularly amazed by medical progress, steps that mean better care, longer lives, healthier lives for Medicare beneficiaries and for others. At the same time, we can't ignore the fact that many Medicare beneficiaries and Americans in general don't receive recommended care, roughly half of the recommended care is delivered for Americans of and Medicare beneficiaries, and for the most vulnerable patients, failure to deliver that care can have disastrous consequences. On the other hand, research on variation in the medical practices well documents that many patients likely receive many more services than they need.

MedPAC has recommended a series of steps to improve the value received for the Nation's large investment in Medicare Part B. Even more important, we suggest the change in mindset about how to approach Part B of Medicare. The longstanding focus on cost should give way to a focus on value, which combines quality and efficiency in the delivery of services. Medicare's traditional respect for clinician autonomy is appropriate and well deserved, but it must be complimented by a demand for accountability for performance.

Across the board mechanisms, like SGR, should be replaced by much more targeted approaches. Our focus on perfecting service-by-service payment must be combined with analysis of performance based on larger episodes of care.

Specifically, MedPAC has recommended eliminating SGR and replacing it with a year-to-year evaluation of payment adequacy. Payments should be linked to quality. Tools should be developed to measure and assess physician use of resources and provide feedback to physicians on how their performance compares to other physicians.

Medicare should examine rapidly growing areas, such as imaging expenses, to reduce unnecessary spending and ensure quality of care. Medicare's fee schedule must be continually refined to make sure prices are set accurately. For some services, we believe we are paying too much and, for others, too little.

And we also support giving Medicare beneficiaries the option of enrolling in private health plans that may be able to offer a better value for some beneficiaries. By themselves, these recommendations are not going to solve the problem of rapidly growing expenditures in Part B. Controlling volume growth in a free choice fee-for-service program like Medicare part is very, very difficult, and that is not just for Medicare, that is for private insurance programs, that is the experience in other countries as well.

The problem of volume growth and increasing expenditures is not an acute illness, to use a medical metaphor, it is a chronic problem that requires ongoing efforts, careful treatment and monitoring.

If MedPAC's approach does not guarantee a solution, why do we prefer our approach to SGR? Because it is targeted, while SGR is indiscriminate; not all increases in volume are bad, some are much needed; not all services are growing rapidly; not all physicians are high users, yet SGR treats every service, every physician, every area of the country as though they were the same. That is unfair. And not only is it unfair, such a system has no power, no opportunity to motivate and reward improvement, and that should be the ultimate goal of any payment system.

SGR is not a volume-controlled mechanism, but rather simply a means of setting a budget baseline, and it is a baseline that is wholly unrealistic that I don't think anybody in this room thinks is ever going to happen. It has become an impediment, the mechanism has become an impediment to some policy as opposed to an aid, it is time to move on.

I welcome your questions.

[The prepared statement of Glenn M. Hackbarth follows:]

PREPARED STATEMENT OF GLENN M. HACKBARTH, CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Chairman Deal, Congressman Brown, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss payments for physician services in the Medicare program.

Medicare expenditures for physician services are growing rapidly. CMS estimated in March of this year that spending related to the physician fee schedule for 2004 increased by approximately 15 percent, while the number of Medicare beneficiaries in FFS increased by only 1.1 percent. Medicare expenditures for physician services are the product of the number of services provided, the type of service, and the price per unit of service. The number and type of services provided we refer to as volume. To get good value for the Medicare program, the payment system should set the relative prices for services accurately and provide incentives to control unnecessary growth in volume.

In this testimony we briefly outline the history of the Medicare physician payment system and discuss several ideas for getting better value in the Medicare program including: an alternative method to updating payments; differentiating among providers through pay for performance, measuring physician resource use, and setting standards for imaging services; improving the internal accuracy of the physician fee schedule; and creating new incentives in the physician payment system.

Historical concerns about physician payment

Physicians are the gatekeepers of the health care system; they order tests, imaging studies, surgery, and drugs as well as provide patient care. Yet the payment system for physicians is fee for individual service; it does not reward coordination of care or high quality—by definition it rewards high volume. Several attempts have been made to address this tendency to increase volume and payments.

The Congress established the fee schedule that sets Medicare's payments for physician services as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). As a replacement for the so-called customary, prevailing, and reasonable (CPR) pay-

ment method that existed previously, it was designed to achieve several goals. First, the fee schedule decoupled Medicare's payment rates and physicians' charges for services. This was intended to end an inflationary bias that was believed to exist under the CPR method because it gave physicians an incentive to raise their charges.

Second, the fee schedule corrected distortions in payments that had developed under the CPR method. Evidence of those distortions came from William Hsiao and his colleagues at Harvard University who found that payments were lower, relative to resource costs, for evaluation and management services but higher for imaging and laboratory services. Further evidence came from analyses, conducted by one of MedPAC's predecessor commissions, the Physician Payment Review Commission, that revealed wide variation in payment rates by geographic area that could not be explained by differences in practice costs. (As we discuss later, there is evidence that relative prices in the fee schedule may have once again become distorted.)

The third element of OBRA 89 focused on volume control, which is still a significant issue for the Medicare program. Rapid and continued volume growth raises three concerns: is some of the growth related to provision of unnecessary services, is it a result of mispricing, and will it make the program unaffordable for beneficiaries and the nation?

Some volume growth may be desirable. For example, growth arising from technology that produces meaningful gains to patients, or growth where there is currently underutilization of services, may be beneficial. But one indicator that not all growth is good may be its variation.

Volume varies across geographic areas. As detailed in our June 2003 Report to the Congress, the variation is widest for certain services, including imaging and tests. Researchers at Dartmouth have reached several conclusions about such findings:

- Differences in volume among geographic areas is primarily due to greater use of discretionary services that are sensitive to the supply of physicians and hospital resources.
- On measures of quality, care is often no better in areas with high volume than in areas with lower volume. The high-volume areas tend to have a physician workforce composed of relatively high proportions of specialists and lower proportions of generalists.
- Areas with high levels of volume have slightly worse access to care on some measures.

All this suggests that service volume may be too high in some geographic areas.

In addition, volume varies among broad categories of services: Cumulative growth in volume per beneficiary ranged from less than 15 percent for major procedures to almost 45 percent for imaging, based on our analysis of data comparing 2003 with 1999 (Figure 1). Although one would expect some variation as technology changes, one source of concern is that growth rates were higher for services which researchers have characterized as discretionary (e.g., imaging and diagnostic tests).

Impact on beneficiaries—For beneficiaries, increases in volume lead to higher out-of-pocket costs—copayments, the Medicare Part B premium, and any premiums they pay for supplemental coverage. For example, volume growth increases the monthly Part B premium. Because it is determined by average Part B spending for aged beneficiaries, an increase in the volume of services affects the premium directly. From 1999 to 2002 the premium went up by an average of 5.8 percent per year. By contrast, cost-of-living increases for Social Security benefits averaged only 2.5 percent per year during that period. Since 2002 the Part B premium has gone up faster still—by 8.7 percent in 2003, 13.5 percent in 2004, 17.3 percent in 2005, and 13.2 percent in 2006.

Impact on taxpayers—Volume growth also has implications for taxpayers and the federal budget. Increases in volume lead to higher Part B expenditures supported with the general revenues of the Treasury. (The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a trigger for legislative action if general revenues exceed 45 percent of total outlays for the Medicare program.) Medicare is growing faster than the nation's output of goods and services, as discussed in the Medicare trustees' report, and will thus continue to put pressure on the federal budget. Increases in Medicare spending per beneficiary is an important reason for that growth, cited by the Congressional Budget Office and the Government Accountability Office (GAO), among others.

OBRA 89 established a formula based on achievement of an expenditure target—the volume performance standard (VPS). This approach to payment updates was a response to rapid growth in Medicare spending for physician services driven by growth in the volume of those services. From 1980 through 1989, annual growth in

spending per beneficiary, adjusted for inflation, ranged widely, from a low of 1.3 percent to a high of 15.2 percent. The average annual growth rate was 8.0 percent.

The VPS was designed to give physicians a collective incentive to control the volume of services. But, experience with the VPS formula showed that it had several methodological flaws that prevented it from operating as intended. Those problems prompted the Congress to replace it with the sustainable growth rate system in the Balanced Budget Act of 1997.

The sustainable growth rate (SGR) system

Under the SGR, the expenditure target allows growth to occur for factors that should affect growth in spending on physician services namely:

- inflation in physicians' practice costs,
- changes in enrollment in fee-for-service Medicare, and
- changes in spending due to law and regulation.

It then allows for growth above those factors based on growth in real gross domestic product (GDP) per capita. GDP, the measure of goods and services produced in the United States, is used as a benchmark of how much additional growth in volume society can afford. The spending target in the SGR combines all these factors. The basic SGR mechanism only lowers the update when cumulative actual spending exceeds target spending.

However, the SGR approach has run into difficulties as well. The SGR formula has produced volatile updates that in some years have been too high and in others too low. Updates went from increases in 2000 and 2001 of 5.4 percent and 4.5 percent, respectively, much larger than the increases in practice costs, to an unexpectedly large reduction in 2002 of 5.4 percent. This volatility illustrates the problem of trying to control spending with an update formula. The current projection, according to the Medicare trustees, is that annual updates of about negative five percent will occur for six consecutive years. The trustees characterize this series of updates as "unrealistically low" and in terms of budget scoring, these projections make legislative alternatives to the SGR very expensive.

There are two reasons why actual spending has exceeded target spending and the cumulative difference has become so great that multiple negative updates are projected.

- The first is that volume has continued to grow strongly even when updates have been small or even negative. Figure 2 shows that Medicare spending for physician services increased in 2002, the one year when the update was negative, continued to increase at a rate greater than the increase in the update through 2004, and is projected to continue to increase in 2005. The trustees projection assumes that negative updates will take place as determined by the formula and eventually reduce spending.
- The second reason is that the spending target turned out to have been too high several years in a row because growth in the economy slowed. At the same time, inadvertent omissions of some billing codes made actual spending appear lower than it really was. The result was the updates calculated in those years were too large. When the spending target and actual spending figures were corrected, a large gap between actual and target spending resulted. That gap has to be closed under the SGR formula, and can only be diminished by multiple negative updates or very large changes in the other factors.

In the MMA, the Congress attempted to reduce the volatility problem. The GDP factor in the SGR is now a 10-year rolling average, which dampens the effects of yearly changes in GDP growth. However, there is another source of volatility which has not been controlled—estimating changes in enrollment in traditional fee-for-service Medicare. CMS may need to reestimate enrollment growth as it gains experience with shifts in enrollment from traditional Medicare to Medicare Advantage. Under the SGR, this could lead to continued volatility in spending targets and updates.

Even if all estimates of GDP and the other factors were always exactly right, the SGR approach is flawed.

- It disconnects payment from the cost of producing services. The formula produces updates that can be unrelated to changes in the cost of producing physician services and other factors that should inform the update. If left alone, fee cuts might eventually provide a budget control but in so doing would produce fees that in the long run could threaten beneficiaries' access to care.
- It is a flawed volume control mechanism. Because it is a national target, there is no incentive for individual physicians to control volume. There has been no consistent relationship between updates and volume growth, and the volume of services and level of spending are still increasing rapidly.

- It is inequitable because it treats all physicians and regions of the country alike regardless of their individual volume-influencing behavior.
- It treats all volume increases the same, whether they are desirable or not.

The underlying assumption of an expenditure target approach, such as the SGR, is that increasing updates if overall volume is controlled, and decreasing updates if overall volume is not controlled, provides physicians a collective incentive to control the volume of services. However, this assumption is incorrect because physicians do not respond to collective incentives but individual incentives. An efficient physician who reduces volume does not realize a proportional increase in payments. In fact, an individual physician has an incentive to increase volume under a fee-for-service system; moreover, there is evidence that physicians have increased volume in response to reductions in fees. The sum of those individual incentives will result in an increase in volume overall, if fees are reduced, and trigger an eventual further reduction in fees under an expenditure target.

MedPAC has consistently raised concerns about the SGR—both when it set updates above and when it set updates below the change in input prices. The Commission recognizes the desire for some control over rapid increases in volume. However, instead of relying on a formula, MedPAC recommends a different course—one that involves explicit consideration of Medicare program objectives and differentiating among physicians. Updates should be considered each year to ensure that payments for physician services are adequate to maintain Medicare beneficiaries' access to necessary high quality care.

Volume growth must be addressed by determining its root causes and designing focused policy solutions. A formula such as the SGR that attempts to control volume through global payment changes treating all services and physicians alike will produce inequitable results not only for physicians, but also for the beneficiaries and taxpayers who have to pay for unwarranted volume. Volume growth that adds value should be treated differently from volume growth that does not.

Improving value

We recommend a series of steps to improve payment for physician services. They are important steps that will improve quality for beneficiaries and lay the groundwork for obtaining better value in the Medicare program. They will not, by themselves, solve the problem of rapidly growing expenditures for physician services, but neither does the SGR. The SGR does not control volume; it only establishes budget targets, targets that have become unrealistically low. As a result, even sound policies often carry large budget "scores," a problem that will only get worse with time. Meanwhile, the SGR may be encouraging increases in volume, even while it creates serious inequities and the potential for future access problems.

To begin improving payment for physician services, MedPAC recommends the following steps, which we discuss in more detail below:

- A year-to-year evaluation of payment adequacy to determine the update.
- Approaches that would allow Medicare to differentiate among providers when making payments as a way to improve the quality of care. Currently, Medicare pays providers the same regardless of their quality or use of resources—Medicare should pay more to physicians with higher quality performance and less to those with lower quality performance.
- With regard to imaging, a rapidly growing sector of physician services, ensuring that providers who perform imaging studies and physicians who interpret them meet quality standards as a condition of Medicare payment.
- Measuring physicians' use of Medicare resources when serving beneficiaries and providing information about practice patterns confidentially to physicians.
- Ensuring that the physician fee schedule sets the relative price of services accurately.

A different approach to updating payments

In our March 2002 report we recommended that the Congress replace the SGR system for calculating an annual update with one based on factors influencing the unit costs of efficiently providing physician services.

A new system should update payments for physician services based on an analysis of payment adequacy, which would include the estimated change in input prices for the coming year, less an adjustment for growth in multifactor productivity. Updates would not be automatic (required in statute) but be informed by changes in beneficiaries' access to physician services, the quality of services being provided, the appropriateness of cost increases, and other factors, similar to those MedPAC takes into account when considering updates for other Medicare payment systems. Furthermore, the reality is that in any given year the Congress might need to exercise

budget restraints and MedPAC's analysis would serve as one input to Congress's decision making process.

For example, we used this approach in our recommendation on the physician payment update in our March 2005 Report to the Congress. Our assessment was that Medicare beneficiaries' access to physician care, the supply of physicians, and the ratio of private payment rates to Medicare payment rates for physician services, were all stable. Surveys on beneficiary access to physicians continue to show that the large majority of beneficiaries are able to obtain physician care and nearly all physicians are willing to serve Medicare beneficiaries. This August and September for example, we found that among beneficiaries seeking an appointment for illness or injury with their doctor, 83 percent reported they never experienced a delay. This rate was higher than the 75 percent reported for privately insured people age 50 to 64.

A large national survey found that among office-based physicians who commonly saw Medicare patients, 94 percent were accepting new Medicare patients in 2004. We have also found that the number of physicians furnishing services to Medicare beneficiaries has kept pace with the growth in the beneficiary population, and the volume of physician services used by Medicare beneficiaries is still increasing. CMS has found that two subpopulations of beneficiaries more likely to report problems finding new physicians are those who recently moved to a new area and those who state that they are in poor health. Center for Studying Health Systems Change has found that rates of reported access problems by market area are generally similar for Medicare beneficiaries and privately insured individuals. This finding suggests that when some beneficiaries report difficulty accessing physicians, their problems may not be attributable solely to Medicare payment levels, but rather to other factors such as population growth.

Differentiating among providers

In our March Report to the Congress we made several recommendations that taken together will help improve the value of Medicare physician services. Our basic approach is to differentiate among physicians and pay those who provide high quality services more, and pay those who do not less. As a first step, we make recommendations concerning: pay for performance and information technology (IT), measuring physician resource use, and managing the use of imaging services. Although some of these actions may be controversial, we must ask ourselves what the cost is of doing nothing—how long can we afford to pay physicians without regard to quality or resource use?

Pay for performance and information technology

Medicare uses a variety of strategies to improve quality for beneficiaries including the quality improvement organization (QIO) program and demonstration projects, such as the physician group practice demonstration, aimed at tying payment to quality. In addition, CMS recently announced a voluntary quality reporting initiative for physicians. MedPAC supports these efforts and believes that CMS, along with its accreditor and provider partners, has acted as an important catalyst in creating the ability to measure and improve quality nationally. These CMS programs provide a foundation for initiatives tying payment to quality and encouraging the diffusion of information technology.

However, other than in demonstrations, Medicare, the largest single payer in the system, still pays its health care providers without differentiating on quality. Providers who improve quality are not rewarded for their efforts. In fact, Medicare often pays more when poor care results in unnecessary complications.

To begin to create incentives for higher quality providers, we recommend that the Congress adopt budget neutral pay-for-performance programs, starting with a small share of payment and increasing over time. For physicians, this would initially include use of a set of measures related to the use and functions of IT, and next a broader set of process measures.

The first set of measures should describe evidence-based quality- or safety-enhancing functions performed with the help of IT. Some suggest that Medicare could reward IT adoption alone. However, not all IT applications have the same capabilities and owning a product does not necessarily translate into using it or guarantee the desired outcome of improving quality. Functions might include, for example, tracking patients with diabetes and sending them reminders about preventive services. This approach focuses the incentive on quality-improving activities, rather than on the tool used. The performance payment may also increase the return on practices' IT investments.

Process measures for physicians, such as monitoring and maintaining glucose levels for diabetics, should be added to the pay-for-performance program as they be-

come more widely available from administrative data. Using administrative data minimizes the burden on physicians. We recommend improving the administrative data available for assessing physician quality, including submission of laboratory values using common vocabulary standards, and of prescription claims data from the Part D program. The laboratory values and prescription data could be combined with physician claims to provide a more complete picture of patient care. As clinical use of IT becomes more widespread, even more measures could become available.

Measuring physician resource use

Medicare beneficiaries living in regions of the country where physicians and hospitals deliver many more health care services do not experience better quality of care or outcomes. Moreover, they do not report greater satisfaction with care than beneficiaries living in other regions. This finding, and others by researchers such as Wennberg and Fisher, are provocative. They suggest that the nation could spend less on health care, without sacrificing quality, if physicians whose practice styles are more resource intensive moderated the intensity of their practice.

MedPAC recommends that Medicare measure physicians' resource use over time, and feed back the results to physicians. Physicians could then start to assess their practice styles, and evaluate whether they tend to use more resources than their peers. Moreover, when physicians are able to use this information in tandem with information on their quality of care, it will provide a foundation for them to improve the efficiency of the care they and others provide to beneficiaries. Once greater experience and confidence in this information is gained, Medicare might begin to use the results in payment, for example as a component of a pay-for-performance program.

Right now, we know there are wide disparities in practice patterns, all of which are paid for by Medicare and many of which do not appear to be improving care. Yet many physicians have few opportunities to learn about how their practice patterns compare to others or how they can improve. MedPAC and CMS are working on measuring resource use through episodes of care. This recommendation would help inform physicians and is crucial to starting the process of improvement.

Managing the use of imaging services

The last several years have seen rapid growth in the volume of diagnostic imaging services when compared to other services paid under Medicare's physician fee schedule. In addition some imaging services have grown even more rapidly than the average (Figure 3). To the extent that this increase has been driven by technological innovations that have improved physicians' ability to diagnose and treat disease, it may be beneficial. However, other factors driving volume increases and increasing use of imaging procedures in physician offices could include:

- possible misalignment of fee schedule payment rates and costs,
- physicians' interest in supplementing their professional fees with revenues from ancillary services,
- patients' desire to receive diagnostic tests in more convenient settings, and
- defensive medicine.

These factors have contributed to an ongoing migration of imaging services from hospitals, where institutional standards govern the performance and interpretation of studies, to physician offices, where there is less quality oversight. These variations in oversight, coupled with rapid volume growth, may mean that beneficiaries are receiving unnecessary or low quality care. Therefore, we recommended that Medicare develop quality standards for all providers that receive payment for performing and interpreting imaging studies. These standards should improve the accuracy of diagnostic tests and reduce the need to repeat studies, thus enhancing quality of care and helping to control spending.

Requiring physicians to meet quality standards as a condition of payment for imaging services provided in their offices represents a major change in Medicare's payment policy. Traditionally, Medicare has paid for all medically necessary services provided by physicians operating within the scope of practice for the state in which they are licensed. The Commission concludes that requiring standards is warranted because of evidence of low-quality providers, the lack of comprehensive standards for physician offices, and the growth of imaging studies provided in this setting. There is precedent for this approach. According to GAO, the Mammography Quality Standards Act has increased mammography facilities' compliance with quality standards and led to improvements in image quality. After the Act took effect, the share of facilities that were unable to pass image quality tests dropped from 11 percent to 2 percent.

In addition to setting quality standards for facilities and physicians, we recommended that CMS:

- measure physicians' use of imaging services so that physicians can compare their practice patterns with those of their peers,
- expand and improve Medicare's coding edits for imaging studies and pay less for multiple imaging studies perforemed during the same visit, and
- strengthen the rules that restrict physician investment in imaging centers to which they refer patients.

CMS adopted some of these recommendations in the 2006 final rule for physician payment by restricting physician investment in nuclear medicine facilities to which they refer patients and reducing payments for multiple imaging studies.

Improving the physician fee schedule

As progress is made on the steps discussed above, it is also important to assure that the relative rates for paying physicians are correct. Medicare pays for physicians' services through the physician fee schedule. The fee schedule sets prices for over 7,000 different services and physicians are paid each time they deliver a service. It is important to get the prices right because:

- Otherwise, Medicare would pay too much for some services and therefore not spend taxpayers' and beneficiaries' money wisely.
- Misvaluation can distort the market for physician services. Services that are overvalued may be overprovided. Services that are undervalued may prompt providers to increase volume in order to maintain their overall level of payment or opt not to furnish services at all, which can threaten access to care.
- Over time, whole groups of services may be undervalued, making certain specialties more financially attractive than others.

The Commission is examining several issues internal to the physician fee schedule that could be causing the fee schedule to misvalue relative prices:

- The system for reviewing the relative value units (RVUs) which determine the fee schedule prices may be biased. The system identifies undervalued codes for review more often than overvalued codes; it creates a presumption that current relative values are accurate (even though the work associated with some services, especially new services, should change over time); and it may favor procedures over evaluation and management services.
- The method for adjusting payments geographically for input prices may be distorting relative prices and hence misvaluing services. There are two aspects to this issue. First, the boundaries of the payment localities have not been revised since 1997 and may not correspond to market boundaries for the inputs physicians use in furnishing services. Second, the share of the practice expense payment that is not adjusted geographically is the same for all services, although the cost of equipment and supplies (which this share is supposed to represent) is not. This means that payments may be too low for equipment-and-supply-intensive services (such as imaging) in some areas and too high in others.
- New data are needed for determining practice expenses and the current method is complex and not transparent.

The Commission is working on options to improve relative pricing accuracy in the physician fee schedule.

Creating new incentives in the physician payment system

MedPAC has consistently raised concerns about the SGR as a volume control mechanism and recommended its elimination. We believe that the other changes discussed previously—pay for performance, encouraging use of IT, measuring resource use, and reform of payments for imaging services—can help Medicare beneficiaries receive high-quality, appropriate services and improve the value of the program. Although the Commission's preference is to directly target policy solutions to the source of inappropriate volume increases, as discussed in the previous section on imaging, we recognize that the Congress may wish to retain some budget mechanism linked to volume. However, the mechanism should more closely match physicians' incentives to their individual performance. In our March 2005 Report to the Congress, we presented potential ideas for volume control methods that encourage more collaborative and cost effective delivery of physician services in accordance with clinical standards of care; these are described briefly below.

Potentially, the SGR could be modified by creating smaller groups subject to a spending target. Research shows that reducing the size of groups subject to collective incentives may increase the likelihood that the actions of individuals within the group will be influenced by the incentives. Faced with such incentives, smaller, more cohesive groups of physicians may establish new guidelines for care that will reduce volume growth and improve quality. Although these smaller groups will differentiate updates more than a single update, many of the problems that accompany controlling volume growth through an update may persist. These methods will also

require a means of risk adjustment. Four ways in which Medicare could move from one national spending target to multiple spending targets are:

- Create one or more alternate pools based on membership in organized groups of physicians. Alternate pools could be formed, for example, for group practices, independent practice associations (IPAs), or hospital medical staffs. Organized groups of physicians would apply for inclusion, and services provided by group members would be aggregated in this separate pool. In order to participate in the pool, groups would have to meet certain criteria, such as functioning clinical IT systems, quality recognition programs, and a commitment to the use of evidence-based medicine. Continued membership would be subject to performance standards.
- Divide the United States into regions and adjust the annual conversion factor based on changes in the volume of services provided in each region. An SGR-type formula could be used to determine how much spending growth society could afford, but the overall target would be adjusted regionally. Because reducing volume growth would be more difficult to achieve in areas where the volume of services provided was already low, the formula would have to take into account the initial volume level.
- Set targets based on the performance of hospital medical staffs. Research shows that hospital medical centers can function as de facto systems of care. Medical staff would be defined as all the physicians practicing in a given hospital. Updates would be higher for medical staffs that controlled spending growth and lower for staffs for whom spending grew at rates above average.
- Adjust fees differentially by service or types of service. Fees for services with very high volume growth would be reduced, or not increased at the same rate as fees for other services. Either volume targets or growth thresholds would have to be established with exceptions where warranted.

All of these ideas raise many questions about design, implementation, and policy. MedPAC has not endorsed any of these approaches, but we will explore them further if the Congress is interested in investigating them.

Mr. DEAL. Thank you, both.

I will begin the questioning.

Dr. McClellan, there have been several suggestions about what we should do to change the SGR formula, one of them was a suggestion that drugs be removed from the calculations. Would you comment onthat, please?

Mr. MCCLELLAN. Mr. Brown asked about that, too. We have more of a sense of discussion on this in my written testimony. In the final regulation that we issued on physician payment in the beginning of November that made very clear why we don't have the statutory authority, we don't see a path of statutory authority to remove drugs from the sustainable growth rate. The reason for is, to do so retrospectively at least, is there is specific legislation the Congress has passed that said the SGR formula cannot be adjusted more than a limited number of times. We got a lot of useful comments in about how we might see a path to this authority, but nothing that address that fundamental problem, fundamental obstacle to doing so with the way the current statute is written.

Even if we had been able to find a way to do this, though, this would not have solved the problem that we are facing right now. It would have had some very real effects, it would have added $110 billion to Medicare costs over the next 10 years and added close to $40 billion in additional payments and premiums and co-pays by Medicare beneficiaries. Even with all of that additional spending, there would still be a significant negative update for physicians in 2006 and 2007 and subsequent years.

So we don't have a way to have the statutory authority to doing this retrospective removal of drugs, but we will obviously keep looking for comments and input. But it doesn't solve the problem,

you still have a negative update, you have even higher costs for the Medicare program and for beneficiaries, and that is why we are supporting working with you on legislation that would address the negative payment updates, and it would help us move toward a system that provides better support for quality care and avoiding unnecessary costs.

Mr. DEAL. Mr. Hackbarth alluded to the issue of the volume, and the escalating volume that we are seeing in terms of the number of times patients appear in the doctor's offices. Would you comment about that component? And Mr. Hackbarth, I would ask you, after he concludes, if you would comment on that further.

Mr. MCCLELLAN. We both see the same data. In the last few years, spending in physician-related services has increased by 12 or 13 percent or more. In the first 6 months of 2005, we have seen that same 12 percent rate of increase, about a $10 billion, $12 billion increase over where physician spending was a year ago. This is due not only to more use of drugs in physician offices, going back to your earlier question, it is also due to more use of laboratory tests, more use of more intensive imaging procedures in conjunction with that patient care and more use of minor procedures in the office, more frequent visits. All of these types of services are growing at double digit rates. And we have had a lot of discussion with many of the physician groups, and many of these types of increases are unquestionably adding to value of care, they are helping patients stay healthier, better understand and diagnose diseases. But we have seen also a lot of evidence of growth in areas and big variations in care where there is no clear relationship, no clear evidence of what consequences it is actually having for important outcomes for patients. And we need to keep working to get better evidence on how we can support better care, while avoiding some of these potentially unnecessary cost growths.

Mr. DEAL. Mr. Hackbarth.

Mr. HACKBARTH. I think Mark has laid it out well. The only point that I would emphasize is that the rate of growth is highly variable, some areas like imaging are growing very, very rapidly. Others, like major procedures and evaluation and management, are growing much more slowly. So volume is not a generic problem in Part B, it is a very focused one, which is why we think that the approaches also need to be focused, the approaches we are dealing with.

Mr. DEAL. Dr. McClellan, as you know, as we have gone through Medicaid reform, one of the issues is use of drugs and generics, et cetera. Ifwe go to something in a pay performance type model, would there be some way to incentivize from the doctor's end of it the prescribing of generics rather than brand names?

Mr. MCCLELLAN. Well, I think doctors are already taking a lot of steps to help patients find lower cost ways to get their medicines. That is going to be more important next year with the prescription drug benefit starting where just about all the drug plans provide excellent coverage for generic medicines, zero co-pays or a few dollars in co-pays.

The payment reforms that we have been discussing, which would give, for example, internists more opportunities to get paid more when their patients get better results, would definitely be condu-

cive to supporting—to helping doctors support use of generic medicines. If we paid more to help doctors get their patients into fewer complications, the doctors themselves would have more money to invest in electronic record systems and other approaches to help them identify ways to help their patients stay healthy and avoid unnecessary costs. Right now, our volume-based payment system doesn't do all that much to support that directly.

Mr. DEAL. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Dr. McClellan, as I said, beginning in January physicians will see the reductions in payment. Is the President urging Congress to pass legislation preventing that cut before we adjourn this year?

Mr. MCCLELLAN. The administration supports action in the budget reconciliation process to address the negative update for physicians. We would like to see that process, that reform also take steps, not just to put in—not just help for physicians with the negative updates, but also steps toward a better payment system. And we need more information on quality, quality that physicians themselves think is important, and I think it is what our healthcare system and our healthcarefinancing mechanisms ought to support to be part of that effort as well. So we want to see that happen as part of the budget reconciliation process.

Mr. BROWN. What should the deadline be for enacting a payment system that pays health professionals fairly?

Mr. MCCLELLAN. Well, this is something that we have to work on with Congress. We will be looking to you all to see when and how we can act, but we would like to get to work on this reconciliation process.

Mr. BROWN. Has the President set a deadline for when he wants to see this done?

Mr. MCCLELLAN. He has not set a specific deadline. He would like to see that budget reconciliation process completed as soon as possible, and we would like to try to address this issue as part of that process.

Mr. BROWN. Does the President have an opinion on the question of whether it is better to cut taxes by another $70 billion or devote those dollars to paying physicians fairly?

Mr. MCCLELLAN. Well, I think what the administration supports is getting more for our spending in the Medicare program. And what we have seen in our work over the last few years is that physician groups are taking a lot of steps to help us do that by identifying what is working in their practice, identifying ways that we can pay differently to better support quality care and avoid unnecessary costs. That is what is going on in the demonstration programs right now that we are working with physician groups to implement, and that is what we would like to see in legislation.

Mr. BROWN. But when is—what are his ideas about paying for this? Because you didn't really—your answer was fine, and not unexpected, but not as precise as I would have liked. How is this going to work? Explain this to me. You said there is no deadline except sooner rather than later. The reductions start in January. The President, I think, still wants to do the $70 billion in tax cuts. My friends on the other side of the aisle want to pass—or at least

some of them, not quite enough yet—want to pass a reconciliation. I am confused about all this——

Mr. MCCLELLAN. The administration has proposed a budget with a number of areas of proposed savings in it. The administration has also been working with the Congress on the—in the reconciliation process to find ways to reduce government costs while not having adverse impacts on the quality of care or—also while taking steps to improve the way that government programs work, like improving the way that the Medicare program works.

As part of the reconciliation process in the Senate, for example, there have been a number of offsets in spending identified, as well as support for an increase in physician payments next year. That is a good foundation to build on. And we will work closely with the Congress on getting legislation that is offset, but that does address this physician payment problem.

Mr. BROWN. But the savings aren't going to be in time to pay for the—to prevent the reductions next January.

Mr. MCCLELLAN. Yes, they are. If they are part of the reconciliation process, that reconciliation process will result in some overall savings for the government. That bill that passed the Senate includes some new areas of savings as well as new areas of spending, including steps to address the physician payment problem that we are talking about today . That is a foundation that we can start to build on to get this—to get these payment changes implemented ahead of next year.

Mr. BROWN. You said some things passed in the Senate. The Senate cut HMO payments; does the President support cutting these HMO payments?

Mr. MCCLELLAN. The Senate had a number of changes in Medicare payments——

Mr. BROWN. Specifically, I am asking about the HMO payments. Don't go off in——

Mr. MCCLELLAN. No. The administration does not support reducing payments to Medicare advantage plans that now are more widely available than ever before, that are saving beneficiaries an average of a hundred dollars a month, and that should be available to every person on Medicare.

Mr. BROWN. Of course they are saving beneficiaries a hundred dollars a month because we are just dolling out huge numbers of tax dollars directly to insurance companies.

Mr. MCCLELLAN. Well, if you look at the overall numbers, they are saving our healthcare system as well. The total payment——

Mr. BROWN. Not according to the——

Mr. MCCLELLAN. Total payments to the Medicare advantage plans by beneficiaries, plus the government, is lower than, on average——

Mr. BROWN. Well, Mr. Waxman talked about the PBA 1997, part of the whole point was that bringing in Medicare plus choice—is I believe what we called it—that was a way of saving money for taxpayers. I think they paid—it was a 5 percent discount, that was the money saved. And now it is 100 percent plus. So I don't know that I would say those numbers quite add up that way. I guess my time is expired, thank you.

Mr. DEAL. Thank you. Chairman Barton.

Mr. BARTON. Thank you.

Thank you, Chairman Deal, and again, thank each of you gentlemen for being here. I have a few editorial comments.

I listened to the opening statements—even though I was in and out, I have a television in my office here—and a number of members alluded to the fact that my good friend, Mr. Dingell, offered an amendment on this issue in the reconciliation mark-up several weeks ago, and that is absolutely true. What wasn't mentioned was that he probably knew that it wasn't germane. He put it into play, and in trying to expedite the process, I recognized him before I realized that there was a point of order against it. And he kind of caught me with my procedural pants down—and that is okay, that shows how wiley he is—and so we had the debate because he had played by the rules, and he deserved it. We had to defeat that because it wasn't germane, but I promised at the time that we would have a hearing, and if we could get consensus, we would try to move something very quickly, and that is the purpose of today's hearing. It is a serious issue, and if we can find a way to constructively and structurally repair it long term, then I am all for it. As I said, though, I am not for a short-term fix for another year.

So I just kind of want to set the record straight that the previous mark-up was on Medicaid, and it really wasn't on Medicare. Having said that, this issue needs to be addressed.

Dr. McClellan, my first question is pretty straight forward—and nobody is really talking about it, but I would think that one answer to this problem might be to just allow physicians to do balance billing. What is the administration's position on that?

Mr. MCCLELLAN. Well, physician balance billing would be certainly a way of getting additional payments to physicians for quality services they provide, to give physicians an opportunity, where they are offering valuable services that people are willing to pay for, to get the payments that they think are appropriate. As you know, that is not allowed under current law. It is something that Congress is——

Mr. BARTON. This committee can change the law.

Mr. MCCLELLAN. And this committee can change the law. We would be glad to work with you on any number of ideas to get to a better payment system. I think any step in payment changes that get us more toward paying the value of services that patients actually want are steps in the right direction. In doing so, we need to make sure that we are preserving access to care for all beneficiaries. So that is, I think, the right overall goal for the payment discussions we are having, and we would be happy to talk with you about this kind of proposal as well.

Mr. BARTON. Mr. Hackbarth, do you have an opinion on balance billing?

Mr. HACKBARTH. Mr. Chairman, we have not taken a position, we have not looked at that issue specifically.

Our primary focus has been trying to get Medicare's payments directly to physicians that are both in terms of the level——

Mr. BARTON. Is that something you think you could take a look at?

Mr. HACKBARTH. Sure. We would be happy to take a look at it, but we have not looked at it in the past.

Mr. BARTON. Another question—again, I will start with Dr. McClellan—what percentage of Medicare beneficiaries have Medigap insurance? And in most Medigap policies, do they have a provision that they kick in after Medicare has paid whatever it is going to pay to the physician?

Mr. MCCLELLAN. The vast majority of beneficiaries in fee-for-service Medicare have supplemental coverage of one kind or another. Some people get it from Medicaid, some people get it from former employers. Many people purchase Medigap insurance on their own. It is a lot more expensive generally than the Medicare premium itself. And the costs of Medigap have gone up a lot. It does fill in the gaps of Medicare payments, so the copayments, uncovered services or covered limits, rather, things like that are taken care of by Medigap for the people who have it.

Mr. BARTON. So what would happen if this 4.4 cut were to go into effect? Would the physician who takes a Medicare patient actually see that in real dollars received, or would those patients that had Medigap, would Medigap pick that up?

Mr. MCCLELLAN. Well, the physicians would likely see it, and it gets to the point that you were talking about earlier, about the limits of balanced billing. When Medicare reduces its payment rates, as a general matter, physicians can't make up the difference by charging more in copayments. The copayment is statutorily set at 20 percent of the payment rate for the service. So when the payment rate for the physician goes down, the payment rate for the copay goes down as well.

Mr. BARTON. My last question, because my time is expired, have physician costs to Medicare been rising at about a 15-percent-a-year rate the last several years?

Mr. MCCLELLAN. That is true. In the last several years physician-related spending has gone up by close to 15 percent per year. We are seeing a growth rate around 12 or 13 percent for the first half of this year as well.

Mr. BARTON. Thank you, Mr. Chairman.

Mr. DEAL. Mr. Dingell is recognized.

Mr. DINGELL. Mr. Chairman, I thank you. And I thank Chairman Barton for his very kind words about me; it is much appreciated, as is the hearing.

Dr. McClellan, I want to read you a couple of interesting statements: "CMS believes statutory change is needed to improve physician payments." then we hear this in testimony to be given: "as you are well aware, unless Congress intervenes, the certainty SGR method for determining Medicare physician payments will require 4.4 percent payment cut in 2006 with an estimated 26 percent accumulative cut anticipated over the next 6 years".

And then this words: "Medicare payments today are about half what they were in the 1980's, even before inflation is taken into account." Then I see these words: In fewer than 50 days, Medicare physician payments will be cut by 4.4 percent, followed by significant reductions in year 2012. And rates will not return to their 2002 level before 2013. In other words, physicians will receive less reimbursement in 2013 than they did in 2002 for the same—for the exact same procedure. Although reimbursement will likely be cut by more than 30 percent of the current formula during the time pe-

riod, it is estimated that the cost of providing services will rise by close to 20 percent.

Do you agree with all of those statements?

Mr. MCCLELLAN. I think all of those statements are generally correct. We have got a payment system that is not sustainable.

Mr. DINGELL. I think you can understand the frustration of this committee. We have here before us a situation, which according to all accounts, borders on calamitous, and we do not, anywhere, have legislative recommendations from the administration to address the problem they say is very unfair.

Two questions: Why do we not have those recommendations? And when are they coming?

Mr. MCCLELLAN. In my testimony, I specifically stated——

Mr. DINGELL. I read your testimonly, and I didn't find either answer.

Mr. MCCLELLAN. Well, what it said was, as you know, that we would like to address the negative update for physicians and do it in a context of providing a differential—report on quality——

Mr. DINGELL. We are having a hearing now. Where are your recommendations?

Mr. MCCLELLAN. There are a number of proposals that have been developed by bipartisan Members of Congress——

Mr. DINGELL. Dear friend, I just want to know where they are and when they are coming and what they are. And if you will submit them in writing, we will try to see that they are enacted. If you do not have any at this time, I would appreciate if you would say so.

Mr. MCCLELLAN. We don't have a specific legislative proposal because there is strong bipartisan interest in taking steps like the ones that we would support to address this problem.

Mr. DINGELL. And I note that your interest is piqued by these hearings, which comforts me, we may have to have more hearings in order to get greater interest on the part of the administration.

Now two questions, can you please—well, no. We understand that this administration is concerned about the taxpayer's money. Can you please explain to me why CMS has ignored MedPAC and GAO reports that Medicare payments are excessive?

Mr. MCCLELLAN. The Medicare advantage payments are bringing better benefits and lower costs to people in Medicare. The GAO and others have been concerned in the past that Medicare beneficiaries who choose Medicare advantage plans are healthier than people in fee-for-service Medicare. What we have seen——

Mr. DINGELL. That is a very fine answer, but it doesn't respond to the question.

Mr. MCCLELLAN. Well, what we have seen——

Mr. DINGELL. Why not?

Mr. MCCLELLAN. As we have improved the Medicare advantage payment systems and the plan availability is that a lot of people are enrolling in these plans.

Mr. DINGELL. I have 30 seconds remaining. I am going to assume that you are telling me that you are not interested in those matters.

Now, Dr. McClellan, can you please explain why Medicare HMOs, who only provide service to 15 percent of the Medicare pop-

ulation yet are responsible for 2.9 percent of the 2006 premium increase, while doctors provide care to a much larger percentage of seniors, are only responsible for 2.5 percent of the 2006 premium? Now that is one of your actuary's findings.

Mr. MCCLELLAN. Well, I think what the actuary's finding showed is that a much larger part of the increase was due to making up for reductions in the reserves that were available in the Part B trust fund, and that is because spending grew faster than expected in the past year, and that in turn was due to the rapid growth in physician-related services. So I don't think that is a complete picture of the causes of the spending growth that you just described.

Mr. DINGELL. Well, I do not read that in the statement of the Medicare actuary, and I must confess I find that they are being permitted to cut a fat hog, while at the same time the doctors are seeing themselves with their benefits and their payments cut in rather startling fashion——

Mr. MCCLELLAN. That is why we need to work together to address this.

Mr. DINGELL. It is a shameful situation, and I look forward to you bringing some solution to us in an early time. Remember, we only have 50 days in which to address the matter.

Thank you, Mr. Chairman.

Mr. DEAL. Mr. Bilirakis,.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Dr. McClellan, in your written testimony you noted that much of the increase—I guess I think I am using your words here—much of the increase in Medicare spending cannot be easily explained by changes in treatments based on new medical technologies. So my question is, to what extent—and you didn't mention this in that statement, that is why I bring it up—to what extent does defensive medicine and skyrocketing medical liability premiums contribute to this increased spending?

Mr. MCCLELLAN. Well, it is a good question. And there is considerable evidence that in areas where doctors are facing some real——

Mr. BILIRAKIS. I want to make sure that the people on the other side of the aisle hear your answer.

Mr. MCCLELLAN. Where doctors are facing increased pressure from liability that cost increases are higher, with no impact or no measurable impact on patient health. And you know from the State of Florida, where there have been some real problems with liability in the past, that not only do you tend to get more services, more defensive medical practices, you also start to see real problems in access to care as physicians in high-risk specialties are no longer even able to practice. We could go a long way toward paying for addressing this physician payment problem by implementing the kind of commonsense liability reforms that many States have already successfully put into place and that the administration has advocated should be put in place nationally to help save money, while protecting patients in the Medicare program.

Mr. BILIRAKIS. Can that information be documented? By that what I mean is, how much of these increased costs really—are the result of——

Mr. MCCLELLAN. There are a number of studies that have documented the relationship between Medicare liability and healthcare costs, and also the lack of impact on stricter liability laws on patient health. We would be happy to provide that information to you. The administration's done a number of reports and many independent academic studies on this topic, and I believe CBO in the past has scored substantial savings for the Medicare program from liability reform, savings that could go right into helping provide appropriate compensation for physicians.

Mr. BILIRAKIS. Well, Doctor, does the SGR account for this spending?

Mr. MCCLELLAN. The SGR is—the features of the SGR program are that you get paid less when overall physician spending goes up. And that is the vicious circle that we have gotten into, more use of all these specific procedures leads to a decline in payment rate for physicians, and you get into a vicious circle. So the SGR problem is—the payment system itself isn't doing as much as it should to help doctors focus on high-quality care, giving the financial support that they need.

Mr. BILIRAKIS. But I guess what I am wondering is, does it specifically take into account the defensive medicine that is practiced and the premiums that are——

Mr. MCCLELLAN. There are some limited adjustments in the Medicare physician payment system for malpractice costs, it doesn't take full account of the cost of defensive medicine except that it all goes into this overall reduction that is the direct consequence of the increase in utilization——

Mr. BILIRAKIS. But should it not take all that into account?

Mr. MCCLELLAN. Right. I mean, if increases of utilzation are greater in areas where doctors are facing defensive medicine pressures, then that does contribute to the overall SGR scheduled payment reductions.

Mr. BILIRAKIS. Well, now, in the process of—we all hope we can work up a sort of a permanent—if I can call it that—change to the overall system so that we won't have to have these fixes every year, et cetera, could that formula, whatever it it might turn out to be, be developed to account for this spending?

Mr. MCCLELLAN. I think it is worth looking into, but I think the best solution here is to take a step that has been proven to lead to lower costs without any adverse consequences on quality, and also better access to care, and that is implement effective liability reforms. That would be best way——

Mr. BILIRAKIS. We are having trouble doing that, as you well know about, so but the point is it can be done——

Mr. MCCLELLAN. We could try to look at that more closely.

Mr. BILIRAKIS. I would ask you, maybe sort of as an aside, very quickly, all the members of this committee have indicated a concern for the doctors and things of that nature, but I would ask you to what extent does the defensive medicine and the skyrocketing medical liability premiums contribute to M.D.s leaving certain specialties, leaving certain geographical areas—as we know, moving from one State to another for various reasons—leaving the practice of medicine?

Mr. MCCLELLAN. It is unquestionably a significant contributor. Our liability system is a big problem in inside.

Mr. BILIRAKIS. And there is information available——

Mr. MCCLELLAN. Absolutely, strong information. We have developed indpeendent studies, the American Medical Association, a lot of evidence on this.

Mr. BILIRAKIS. Thank you very much, Doctor. Thank you, Mr. Chairman.

Mr. DEAL. I thank the gentelman.

As you know from the bells going off, we have a series on the floor. We are going to stand in recess and vote and return immediately. I would ask the members to do that so that we may resume with the questioning. If you would just wait for us few minutes, thank you. Stand in recess.

[Brief recess.]

Mr. DEAL. I will call the hearing back to order.

Mr. Pallone is next to ask questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask some questions about the pay-for-performance standard or suggestion. I guess I will start with Dr. McClellan. I am concerned there will be a lot of pitfalls associated with a pay-for-performance model and implementing that initiative. There is some risk to physicians. And just to give you some examples, what if a doctor uses evidence-based care but fails to meet quality standards, are they penalized for that? Or if a patient refuses a certain kind of treatment? I mean just for an example, what about a doctor who was possible skimming or cherry picking the healthiest beneficiaries in order to achieve quality measures? What would be your response to some of those, particularly the idea of the cherry picking?

Mr. MCCLELLAN. Those are all important concerns, and it is appropriate to raise them and work on them through the process of getting to a better payment system. We have been working closely with physician groups and other stakeholders to identify measures that could be a basis for supporting quality of care better, measures that are typically led in their development by physician groups themselves.

We have been working with an alliance called the ambulatory care quality alliance. It has a lot of involvement from physician groups and other health care stakeholders, other health care organizations to make sure that those kinds of concerns are addressed, I think starting with physician leadership on what we ought to be focusing on in supporting better quality.

Mr. PALLONE. Let's use the cherry picking. How would you prevent that? What would you do?

Mr. MCCLELLAN. You develop measures and develop a system that prevents that kind of gaming, that you really do focus on——

Mr. PALLONE. How would you go about it?

Mr. MCCLELLAN. We are doing this now. We have pilot programs, demonstration programs going on right now, paying physicians more for supporting better care. For example, in our physician group practice demonstration program, physicians get additional payments when their group has better use of preventive

care, better management of the quality of care of their chronically ill beneficiaries, when they help save overall costs in Medicare.

Mr. PALLONE. I understand all that. I am not trying to take away from it.

Mr. MCCLELLAN. It is a good question.

Mr. PALLONE. I just don't know how you prevent it. Maybe Mr. Hackbarth can answer.

Mr. HACKBARTH. You can deal with the issue in part by carefully choosing the type of measures of performance. If for example you used an outcome measure performance, what was the ultimate outcome of care, that kind of measure heightens the risk that physicians could be punished for caring for more seriously ill patients.

If on the other hand, instead of using ultimate outcomes you use measures of clinical process, evidence-based measures of process so every patient with this kind of condition ought to get this care based on evidence, then you have narrowed down the range of patients that you are talking about, making it a more homogenous group and less risk.

Mr. PALLONE. That's a good point.

Mr. MCCLELLAN. If I can be clear about what I talked about in my testimony, that we would like to do this in a step-wise fashion. First, we need to make sure we have—we know what we want to support better quality and work with physician groups on that, and that is why we are getting better information on quality, which is the best place to begin and then move from there to paying more to help doctors deliver better care.

Mr. PALLONE. Let me ask Mr. Hackbarth another thing. Pay-for-performance I think should apply to both physicians and HMOs, but is there any reason that we are not moving to a pay-for-performance system for HMOs? I mean, I see that it seems like it is being oriented toward fee-for-service as opposed to HMOs, and how soon could you implement something for HMOs?

Mr. HACKBARTH. In fact, MedPAC's first recommendation in this field of pay-for-performance was that the concept be applied to HMOs and private plans, and that was a couple of years ago now. So that was actually our starting point, and we started there because the way the industry is developed, there is a consensus set of measures of basic performance for private plans that we thought Medicare could quickly adopt and piggyback on through established mechanisms for collecting that information and verifying it. I think the HMOs should be at the front of the list.

Mr. PALLONE. So are you moving toward the HMOs at the same time with the individual physicians?

Mr. HACKBARTH. Our role in this process is simply to make recommendations to the Congress and to CMS. We think it is very important that there be measures of performance for private plans. As I said in my opening comment, MedPAC believes that there is an important role for private plans in Medicare. We think that some private plans can offer Medicare beneficiaries a high value for both the government's investment and beneficiaries' payments, and by high value, I mean a good mix of efficiency and high quality. So we think it is a great program, but not all private plans are created equal. Some are better than others. And so we think it is important

for the program, important for the beneficiaries that we have a pay-for-performance mechanism that rewards the superior plans.

Mr. PALLONE. Okay. Thank you.

Mr. DEAL. The gentleman's time has expired.

Dr. Norwood.

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

I know we have little time, but let me just do a little bit of history on this. In the beginning, we decided that if I took an x-ray of a patient, that the Government would pay me for that x-ray. Lo and behold, we find out this is costing a lot of money, people are going to use this free service, so now, why don't we set the price under usual and customary? So we go to that feature. Not only are we going to pay for the x-ray but tell you what we are going to pay for it.

That didn't work because people kept using the service, and we go to a system called SGR. Now, in 1997, in the BBA, a lot of people were patting themselves on the back about this great new payment system. Well, my point of view, it has been a disaster. In 2002, when we applied SGR, we cut the payments 5.4 percent. Then, in 2003, Congress turns around and adds an increase of 1.6 percent. Then Congress, through our Medicare Modernization Act of 2003, we increased the payments again 1.5 percent for 2004 and 1.5 percent for 2006.

Now we are looking at this thing that we all patted ourselves on the back about, SGR, and we find that we are going to have next year a 4.4 cut. In addition to that, probably if you project out for several years, we are looking at probably a 26 percent cut. Well, everybody at CMS and Congress says that is a terrible idea; we really shouldn't do that. We have got to find another way to pay our physicians. So now we are coming up with another idea of how we should pay, certainly not in my mind concerning ourselves with what actual costs are, what actual payments ought to be, but we are going to do this thing called pay-for-performance.

Now it is beyond me what that means because you already pay me to perform when I take that x-ray. Granted, you pay me what you set the price for, but you do pay me to perform. So what does pay-for-performance mean. Surely, you can assure me it doesn't mean pay for nonperformance. I hope we are not going there with that. Yes, that is not right; we are not going to do that; are you? You are not going to pay me so I won't take x-rays; are you?

Mr. MCCLELLAN. No.

Mr. NORWOOD. Good. So we aren't really talking about performance, so what are we really talking about here? Are we talking about, when I take my x-ray, did I take a good x-ray? Is that what we are talking about? Or are we talking about, you are going to pay me because I read that x-ray well? Are we talking about the quality here? Is that what you are going to pay me now, according to the quality of what I do? Is that what I am hearing?

Mr. HACKBARTH. Yes, in a word.

Mr. NORWOOD. A word is all I need. You are going to pay me for the quality. Now who is going to determine the quality of my x-ray?

Mr. HACKBARTH. The idea is to pay for quality as determined by evidence-based standards of care, not standards of care developed by MedPAC.

Mr. NORWOOD. So we are going to the radiologist and saying, guys, we would like to you to work with us; why don't you set up evidence-based standards that all radiologists should perform? In other words, if you do A, B and C, then that is a quality procedure. Is that where we are?

Mr. HACKBARTH. One of the parts of this whole process that we think is very important is to engage with the various specialty societies and experts in the different specialties in determining what those standards of performance ought to be.

Mr. NORWOOD. Is that what quality means? If I do A, B and C, if I follow these three protocols, then am I considered doing a quality job?

Mr. HACKBARTH. Typically, the way a standard would work, it would be for a particular set of patients. This is evidence-based recommended care; was that provided?

Mr. NORWOOD. What if I do A, B and C and I misread the x-ray and don't pick up that malignant tumor that later kills the patient. Now, have I done a quality job?

Mr. HACKBARTH. One of the key issues—and this gets back to the earlier question that Mr. Pallone was asking about—is, what are the units that we are trying to measure to apply the quality standards to? And for the reasons that he was alluding to, initially, I think we are going to be talking about relatively closely defined experiences, and so it is going to be, did certain tests happen? Were certain results achieved for a particular type of patient as opposed——

Mr. NORWOOD. So it is not just quality but outcome, too.

Mr. HACKBARTH. In fact, that was my point, as opposed to trying to say, well, the patient died; we are going do reduce the physician's fee. Measuring ultimate outcomes in assessing, adjusting for differences in risk is very technically difficult to do so that is not where we would start. We would start in a much more confined, focused way. Are evidence-based standards of care applied in the care of a diabetic or a patient with congestive heart failure?

Mr. NORWOOD. Mr. Chairman, are we going to have another round with these?

Mr. DEAL. It depends. We have got a second panel waiting.

Mr. NORWOOD. Can I ask for a last question then if you are not going to do another round?

Mr. WAXMAN. Do the same for our side.

Mr. NORWOOD. Then I yield back my time.

Mr. DEAL. Ms. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman.

Dr. McClellan, I hope by now you are aware the doctors in my congressional district, in fact in ten counties in California, face a very serious problem. Because of the way the geographic practice cost index lines are drawn in California, Santa Barbara, San Luis Obispo and eight other counties are lumped in with many other counties with significantly lower costs. This grouping into what is called locality 99, or the rest of California, means that the payment rates are artificially lower because they are averaged with the lower-cost counties.

I have been trying to get CMS to address this and fix it for years. I brought your predecessor to meet with our medical societies. We

have had numerous meetings in San Francisco and were told that a statewide fix needed to be proposed.

Last year, we submitted a proposal from the California Medical Association. This proposal would have fixed this problem for all ten counties, protected the other counties in locality 99 and budget-neutral, yet CMS refused to fix it.

This year, CMS, using the same authority we suggested you use last year, proposed to fix just two of the counties, Sonoma and Santa Cruz, leaving the other eight counties high and dry, in fact cutting their payments out of that same fix. Not surprisingly, there was negative feedback about leaving out these other counties.

In a recent meeting, it was suggested that MedPAC would look at this issue, but it would not resolve the matter until 2008. This is completely unacceptable. So I want to know now, why hasn't CMS taken this matter seriously? The president of the California Medical Society was in my office yesterday. Doctors in California are waiting for your answer. Why didn't you accept the CMS proposal when it was offered? And why did you try to make a fix for just two of the counties?

Mr. MCCLELLAN. First of all, Congresswoman, as you know, I care deeply about this issue as well and am very frustrated, too, with how things have worked out. I have been a practicing physician in California. I know a lot of the people who are directly affected by a payment system that isn't working as well as it should and have been working hard over the past year that I have been in this job to address it.

As you said, the approach to solving this problem requires a change in the way Medicare allocates funds from county to county. The way that we make those regulatory changes is we look to the State medical society to give us input as to how the allocation should be changed.

Mrs. CAPPS. Which did happen.

Mr. MCCLELLAN. When we made our proposal in the regulation this year, we put in a specific proposal about two counties including Santa Cruz and Sonoma.

Mrs. CAPPS. But the proposal submitted was for ten counties.

Mr. MCCLELLAN. We left open any other proposal. We specifically said any supportable proposal that the medical society can get behind and that we can implement administratively, we would support.

Mrs. CAPPS. It was done.

Mr. MCCLELLAN. Let me tell you the comment we received from the California Medical Association—I am going to read from a letter signed by Dr. Sexton and Dr. Lewen. What they said was: We support a legislative solution at a cost of $114 million a year to this problem.

They specifically rejected our two-county proposal. They rejected any suggestion for an eight county or any other administratively implementable proposal and said that instead what they want is a legislative solution because of its great potential for enactment, and I'll quote from them: This is the only, the only gypsy solution that we are supporting at this time. That was the comment that we received on our opening the door to any proposal that could be implemented.

Mrs. CAPPS. Excuse me, with all due respect, you have not answered. Why you did not accept that original proposal?

Mr. MCCLELLAN. Because the California Medical Association said that they did not want an——

Mrs. CAPPS. The one they submitted regarding ten counties.

Mr. MCCLELLAN. I am reading from their letter.

Mrs. CAPPS. That is in response to the two counties that were chosen. I am asking for an answer regarding the initial proposal by CMS.

Mr. MCCLELLAN. We mentioned a two-county proposal in the rule. We also said we would take any other proposal.

Mrs. CAPPS. Excuse me, but you didn't answer the question of why you didn't——

Mr. MCCLELLAN. If we had gotten a letter from the CMA on the proposed regulation saying we want this ten county proposal implemented, we would have implemented it.

Mrs. CAPPS. That was the original proposal. In response to your fixing two counties——

Mr. MCCLELLAN. They may have told you something in your office, what they told us in formal comments on the regulation was the only solution they want to the gypsy problem is legislative; something that we cannot do.

Mrs. CAPPS. Well, I see my time is up.

Mr. MCCLELLAN. I am very frustrated.

Mrs. CAPPS. This is very frustrating to know that there has been this impasse over several years now. This is your job to do. CMS is responsible for this. Now I am bringing this up today because now they are going to get over 4 percent cuts on top of this.

Mr. MCCLELLAN. It is not an acceptable situation. All we needed was any proposal this year on our regulation that we could do administratively. We could do a ten county, two county, but all we got in comment from CMA was saying that they wanted a legislative solution and a legislative solution only. I don't know what they told you in their office, but that is not what they supported in terms of our regulation.

Mrs. CAPPS. I yield back. I will be in touch.

Mr. DEAL. The time is expired.

Mr. MCCLELLAN. We should be in touch about this. It needs to be fixed.

Mr. DEAL. Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman.

Health care financing issues, whether it is the government-run programs or it is for private profit, if we don't get the consumer engaged in addressing issues of cost and quality, we are going to continue to follow these battles, and that is just an opening statement based upon kind of what the Chairman said about reform. Reform is not a bad word. Reform is needed because with the Baby Boom generation and people living longer, we can't sustain this. We are going to continue to have these fights about funding until we get people engaged.

So I know it is a challenge. We are working through it. I have talked with professions from all aspects of the health care arena, so I applaud you being in the gap and trying to take the slings and arrows and trying to move public policy. Now, after saying those

nice things I will yield the balance of my time to Dr. Norwood who will continue to ask you some diligent questions.

Mr. NORWOOD. We were talking about the failure of SGR. Eight years ago, we were celebrating it. Today we are trying to solve the problem, it seems to me, of two things. One is, how do we fairly reimburse our physicians so that they will keep treating Medicare patients, a thing that comes to mind to me might be Medicare economic index is probably a good start. But we are confusing that with another thing we want to solve which is quality of care, and you are basically, I think, saying that we want to pay you more if your outcomes and your quality is better.

Now why mix those two together? Why not set aside how we want to fairly pay our physician community? Then if you want to experiment with this thing called pay-for-performance—I presume it is an experiment—you are doing a demonstration project. I know that the private insurance companies are doing it where they can, and that is not a good sign at all when they do that because there is only one reason they do that, and that is to protect their bottom line. We know that they are doing it in Great Britain. So we ought to maybe at least know enough to know some of the unintended consequences which we are going to have with pay-for-performance.

So, gentlemen, why not solve this problem and then play around with your academic games of trying to determine how you get people to practice so the quality of it suits you or suits somebody over at CMS or suits somebody who is going to determine what is a good outcome or what is a quality surgery. I fail to understand mentally how it can work.

And, Dr. McClellan, if you know, I have got 1 minute and 54 seconds for you to tell me how this can possibly work without terrible consequences.

Mr. MCCLELLAN. I am looking forward to taking some more time with you beyond this time to work on this issue, but you are absolutely right that we shouldn't be playing academic games. This is patients' care, patients getting access to needed care and doing it at a cost that they and taxpayers can afford. We would like to take some steps to address the payment reductions that are coming now. You have got legislation to do it. We want to work with you on proposals to address this payment reduction. That costs a lot of money.

Mr. NORWOOD. I understand it costs a lot of money. The Senate is over there saying, gosh, we are going to pay you costs, but for gosh sakes, we are not going to do that unless we do pay-for-performance. We have got a bill out of Ways and Means that says, we don't really want you to have that 4.4 cut but we are going to hold the axe over your head to do this pay-for-performance. You keep talking about working with these different physician groups. You know why you are working with them? Because they don't have any choice. When you come and say, we are going to put in pay-for-performance, do you want to play, of course, what choice do they have but to say we don't like this but——

Mr. MCCLELLAN. I have heard from a lot of physician groups that agree that the cost growth in Medicare spending, 14 percent, 15 percent a year, we can do better than that. They can do better than that. It is not a question of them needing incentives. It is a ques-

tion of physicians needing financial support for doing what they think is the right thing for patient care. They are not getting that support now.

Internists aren't getting support for taking simple steps to prevent complications for their patients. Surgeons are not getting support for taking steps that prevent complications operatively in the services that they deliver.

Mr. NORWOOD. Excuse me, but we thought we were getting there with SGR, and we didn't, period. And now we think we can get there maybe with this. All I am asking you to do is don't go out there experimenting.

Mr. MCCLELLAN. I agree with that.

Mr. NORWOOD. And explain to everybody—if somebody asked me what pay-for-performance is, I still don't know what to say.

Mr. WAXMAN. I ask unanimous consent he be given an additional minute. I think he is getting on to a very good point.

Mr. DEAL. Without objection.

Mr. NORWOOD. Henry, I can't believe it. All I am trying to get you to agree to is stop forcing these groups—they want to work with you because, yes, we can do better, and I think you are right, I think we can do better, too. But if we don't watch out, we are going to turn around and codify into law a new payment system called pay-for-something that could well be disastrous.

Mr. MCCLELLAN. Just to be clear, what I said at the outset, that what we supported was addressing the negative physician update, No. 1; No. 2, getting some better data, some better information from the physicians on how we could provide better support for their delivering quality care. Those are the short-term steps. I think we do need to get to a better long-term payment system but not via experiments; via confidence that we are going to support physicians in delivering better care at a lower cost.

Mr. NORWOOD. Would you agree not only do we not need to do a 4.4 cut, that we need to determine how we in the future are going to pay physicians?

Mr. MCCLELLAN. The best way to start that process is to get some better information from the physicians on the kind of care that they want to provide and how we can best support it. That is what I essentially proposed to do earlier.

Mr. NORWOOD. That is what we will spend our time talking about if that is indeed in the best way, because maybe it isn't.

Mr. MCCLELLAN. We need to learn more and keep working to get to that better payment system because you are right, the ones up until now haven't done the job.

Mr. NORWOOD. Maybe they will work with you a little better if you will take their feet out of the fire and say, look, we know you need to be paid at least cost for what you do, and make that arrangement and put it in the law and then let's sit down altogether and talk about how we can decrease expenses and increase quality, doing these other things that you are suggesting. Don't combine them.

Mr. MCCLELLAN. I appreciate that. We are under a lot of—the growth rates that we have seen in physician-related spending, the growth rates in Medicare have made it a real challenge to not take any steps at the same time as we are addressing physician pay-

ment to also help physicians improve quality and avoid unnecessary costs. That is just a constraint that we are operating under. The kind of bills that would just do the economic index update as you said would be $180 billion over 10 years or more. That is just a constraint we are going do have to work with.

Mr. DEAL. The gentleman's time has expired.

Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman.

Dr. McClellan, Mr. Hackbarth said earlier that the MedPAC's first recommendation about pay-for-performance was to apply it to HMOs. He said the industry has developed seven measures for performance, something like that, so my question to you, I have been here long enough so I can't not ask this question, has the administration decided that it is better to experiment with a physician community than with the HMO community? If the answer to that is, no, then why not? If pay-for-performance is such a good idea, why not try it out first on HMOs and Medicare?

Mr. MCCLELLAN. Absolutely, we are not going to experiment first with doctors. In fact, we are already providing information on quality of health plans to people in Medicare to help them make their choices about the plans. The Medicare Advantage Plans exist today. The HMOs report on the quality of care they provide. We are expanding these reports to give people even better information.

Mr. ALLEN. But you don't have a pay-for-performance.

Mr. MCCLELLAN. There is a performance system in there in that if a plan is not delivering good care at a good price, people are not going to sign up. They will stay in traditional Medicare or Medicare Advantage Plan that has a lower premium. We have already got a system in place for Medicare Advantage Plans where they get paid more if—the only way they can get paid more is if people want to pay for that service. It is not bad. I think some of the members here today have talked about giving physicians that same kind of opportunity.

Mr. ALLEN. Those of you who from rural States don't think it is such a grade model. We don't have those plans. We don't miss them, frankly, because we think the fee-for-service plan is cheaper and more effective. But I will say this, I have trouble with the fact, you said earlier that Medicare Advantage Plans provide better benefits at a lower cost. Well, yeah, I mean, they are being overpaid. That is the analysis. So the equitable problem, people in Maine are in Medicare, too, just like everyone else, they pay the same premiums. Why should money go to people in more urban areas to give them better benefits at a lower cost and leave out those areas which don't have the Medicare Advantage Plans? I am not asking for Medicare Advantage Plans. I am simply saying, it seems to make more sense to me to do what MedPAC constantly urges you to do which is take some account of the equity between those who have those plans and those who don't and not overpay the HMOs.

Let me just deal with one question that I think is important. It is also related to the smallness, the small size of—not just physicians' offices in Maine but around the country. You said that this new physician voluntary reporting program is going to ask physicians to voluntarily report to CMS on a number of evidence-based quality measures. These physician payments will not increase or

decrease based on that individual reporting, but, frankly, there is a cost involved to the doctors themselves and their offices. There may be increased costs of overhead, information technology upgrades, the cost of new diagnostic equipment, all of that.

So if we are going to do pay-for-performance, we have got to remember that the average physician's office is fairly small. Three-quarters of them are eight physicians or fewer, and so, who is going to pay? I mean, is CMS's view that the pay-for-performance should be an add-on to the current reimbursement rate or should be taken out of the physician reimbursement as it exists today?

Mr. MCCLELLAN. What I talked about earlier in my testimony was, we would like to start with paying for reporting, paying more for reporting on quality-related issues where the physician community, other experts have all come together and said, this is good evidence-based care that we should be seeing more of in the Medicare program, and we would pay more for that and——

Mr. ALLEN. That would be an add-on?

Mr. MCCLELLAN. Right, a larger update for physicians who report on quality care. Then, as we see what those measures of quality show, as they help us and help physicians identify better ways to deliver care at a lower cost, we can make further reforms in our payment systems to support that. So it is a step-wise process, and there are some costs involved. We are right now working with some physician groups on a voluntary system for reporting to help us find the least burdensome way, the easiest way for small office practices, including rural practitioners, to provide this information. Right now, we can't rely on electronic records because doctors don't have them.

Mr. ALLEN. Mr. Hackbarth, I have very little time, but do you have any comments on that?

Mr. HACKBARTH. On the issue of small practices? Just two quick comments. One is that I don't think we should assume that smaller practices including practices in rural areas will fair poorly under pay-for-performance. When you look at the Nation as a whole and you look at how States, various States' information on quality measures, in fact, many of the highest performers are in the States with large rural areas. They have lower costs and higher quality.

Mr. ALLEN. Often lower reimbursement, too. This would address that.

Mr. HACKBARTH. For their performance, their high quality, they would get additional funds. On the issue of investing in clinical information systems, which we think is a very important step forward for a health care system to get the value that Medicare beneficiaries deserve, as we see the problem right now, physicians and other providers have little incentive, too little incentive to invest in valuable clinical information technology. Capital is scarce so what do they spend it on, things that are going to generate economic returns, bring in new patients, new services, new equipment. So medical information technology, automated medical reports don't produce those things.

Under a pay-for-performance system though, you start getting paid for quality, and so your investment decisions are different, and so, as opposed to buying a new piece of diagnostic equipment, you might say I can get a return from improving patient care, and

that is the sort of change in mindset that we need to try to encourage across the whole health care system.

Mr. DEAL. The gentleman's time has expired.

Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. Just to continue along that line of thought, a wonderful opportunity was missed with Y2K, and as a practicing physician who was told you better upgrade your stuff or else you are not going to be open for business January 2, we had to make those hard decisions. It was a decision to buy a new sonogram machine and deliver more care or buy a computer system. And unfortunately, there was very little leadership from the administration at that time, no leadership from HHS to help doctors offices decide to buy equipment that would interface with what HHS was going to be using down the road, what hospitals might be using down the road, so our office, a five-physician office went out and spent $60,000 on a computer system only to find out the next year that ours was compatible with what the hospital next door was using. So it was an opportunity lost, and certainly, we ought to be on the lookout for new opportunities as they come forward.

That is why I am so glad that Dr. McClellan is in the office he is in. I think, for the first time, we see the marriage of science and technology and what medicine is supposed to be about and Medicare trying to deliver what medicine is supposed to be about in the Medicare system.

Gosh, we heard from Chairman Barton earlier, and he mentioned the same words I used, pay-for-performance—I am sorry, balanced billing. It was wonderful to hear those words from the Chairman's lips, and heard the ranking member Mr. Dingell, he told you, if you go back to the White House and get a proposal and bring it back here, he will pass it.

So I would ask you to go to the White House, get a proposal that has balanced billing in it, bring it back here; we will get Mr. Dingell to vote for it, and we will be happy to carry it on to the full House.

Mr. MCCLELLAN. I am not quite sure of the last part of that, but we certainly want to work with him.

Mr. BURGESS. On the issue of pay-for-performance, and I am concerned like Dr. Norwood is, I know we have to have better support for quality care. Do you think from the pilot studies you have done so far that you can in fact deliver on that promise to make—bring that to fruition without additional burdensome paperwork and regulation that would be shuffled on to the backs of the practicing physicians?

Mr. MCCLELLAN. We are seeing some promising results. I mentioned earlier that in our hospital payment system we are doing a demonstration program with the Premier Hospital System where it is working, saving lives; it is a lot better way to spend the money. Our physician demonstrations are a little bit earlier along, but we have some in place already where when you start paying for better results for patients. You start getting more investments in things like e-mail reminder systems or interoperable electronic health care records, systems that can help patients stay well, stay out of the hospital, maybe even stay out of the doctors office, but until now,

Medicare would pay less in those circumstances so the physician practice couldn't get the resources they needed to provide these kinds of services. We are starting to see that, but the evidence is pretty early on, and there are a number of programs being implemented in the private sector supported by employer groups, by physician groups, not just by the insurers that Dr. Norwood mentioned, that are already showing some promising results in terms of better quality of care at a lower cost.

We need to learn more, but I think there is enough to show that we can start moving down this road toward a better payment system that supports doctors and what they really want to do, which is provide better quality care and do it at the lowest possible cost.

Mr. BURGESS. I think to channel all of the IT stuff that has to deal with Medicare, Medicaid, VA and try to have one platform that works in all venues, there you have captured 50 percent of the health care market in this country.

One of the things that really concerns me, because my district is so diverse, one of the things that concerns me about pay-for-performance is, we always hear about health care disparities, different ethnic groups having different outcomes, and it is something we in medicine should focus on and try to correct, but I see pay-for-performance and young people getting out of their residencies, do I want to practice in the intercity or suburbia? And my patients will be better educated and have greater health literacy in suburban markets. And if I go in the intercity, I am going to be penalized. Are we addressing that in the pay-for-performance platforms?

Mr. MCCLELLAN. Absolutely. We would not want to support any payment reform that harms the people who have the most to gain in terms of better quality care, facing some of the biggest quality problems and access problems right now. Our payment system should support efforts to get better quality care to where it can make the most difference and that is why I think we do need to be careful as many of the members here have emphasized and adopt steps that really are going to lead to better care and not just cherry picking. I think there are promising steps.

Mr. BURGESS. One last thought, and Mr. Bilirakis was on the money, we do practice defensive medicine. You can't walk into the emergency room on a Friday night with a headache and not buy an MRI. We need to work on that. And if you can provide us some additional data, the last data is 1996, a study in Stanford, California, that you might be familiar with, but I bet in 2005 or 2006 dollars, that savings would be much greater.

Mr. MCCLELLAN. There is plenty more evidence.

Mr. BURGESS. I would like to thank you for all the work you have done on the prescription drug issue, part B rollout. I have done several town halls in my district. This is not hard; people can understand it. Health care is complex, and it is not a sound bite, but you can impart that information if a Member of Congress is willing to do it and willing to take the effort to do it. Their constituents, their seniors will benefit.

I yield back, Mr. Chairman.

Mr. DEAL. The gentleman's time has expired.

Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

Dr. McClellan, you are the head of CMS. I assume that in that capacity you have to deal with Department of HHS and people at the White House; is that right?

Mr. MCCLELLAN. Yes.

Mr. WAXMAN. So you have communications with them which would, I assume, mean conversations, memos, e-mails; is that right?

Mr. MCCLELLAN. When there is an important topic that we are working together to address, yes.

Mr. WAXMAN. Now when you are communicating to people in your bureaucracy—obviously you need to communicate with them. Do you communicate through e-mails, conversations and memos to them?

Mr. MCCLELLAN. Depends on the issue. I do talk with my senior staff informally about whatever issues are coming up. When there is a decision that comes to me, I will send back a response if something like that arises.

Mr. WAXMAN. I want to ask you about the time you were commissioner of the Food and Drug Administration because the General Accounting Office just came out with a report saying that the decision on plan B—the science was pushed aside and the application was rejected because even though the expert panel and the professional reviewers at FDA wanted it, they were told that others in FDA didn't want that decision. Obviously, the decision was made, or a decision was in fact made after you left FDA, but they were reviewing it during the time you were at the FDA. Did you have any communications with any official at the White House about this plan B issue?

Mr. MCCLELLAN. First of all, I am not sure that the GAO report quite said what you characterize it as, and I want to be very clear that I did not make a decision nor did I recommend a decision on plan B. And as you said, that decision was made; the release of the non-provable letter came 2 months after I left.

Mr. WAXMAN. That is absolutely right. But my question to you is, while you were the commissioner of the Food and Drug Administration, did you have any communication with any official at the White House about plan B?

Mr. MCCLELLAN. Not any specific communications about information that wasn't publicly available and only occasional communications at that. Certainly nothing related to the plan B decision or any recommendations on plan B.

Mr. WAXMAN. Were there any communications between you and people at the Department of Health and Human Services on this question?

Mr. MCCLELLAN. Same thing.

Mr. WAXMAN. That?

Mr. MCCLELLAN. It didn't involve information that was already public or publicly available and nothing that involved a decision or a recommendation on a decision.

Mr. WAXMAN. When you had communications with somebody at the White House, who would that have been?

Mr. MCCLELLAN. I don't even have any specific recollections about specific conversations related to plan B because it did not come up very often. That was not a decision that was made while

I was there, and the only information that I received on it was information that happens generally in the course of being the commissioner of Food and Drugs where you need to be familiar with all of the major issues and the science behind all the major issues at your agency.

Mr. WAXMAN. Were there any communications between other officials at FDA and anybody at the White House about plan B?

Mr. MCCLELLAN. I don't know anything about any other conversations, and let me just be very clear about this, there was no decision made while I was there. I did not make any decisions or any recommendations, and I did not have any communications making any decisions or recommendations.

Mr. WAXMAN. Why did you refuse to talk to the GAO. They wanted to contact you and they said: We attempted to interview the individual who had been the commissioner of FDA until March 2004. We were unable to arrange an interview. He did not respond to written questions we submitted.

Mr. MCCLELLAN. I did respond to the GAO with a written response that said basically what I have told you just now.

Mr. WAXMAN. Why wouldn't you make yourself available for an interview?

Mr. MCCLELLAN. Because my written response plus all the materials that the GAO had requested from the agency covered what was in their questions.

Mr. WAXMAN. So it is your testimony that you don't know of anybody in the White House, the Department of Health and Human Services that communicated to anybody at FDA on the plan B issue.

Mr. MCCLELLAN. I didn't have any communications about a plan B decision or a recommendation.

Mr. WAXMAN. That wasn't my question. Do you know—listen to my question first. Do you know of anybody that received a communication from the White House or the Department of Health and Human Services about the plan B issue?

Mr. MCCLELLAN. I wouldn't know about any specific conversations that other people had about recommendations or decisions.

Mr. WAXMAN. Well, you wouldn't ordinarily, but did you know, do you know of any such conversations or communications?

Mr. MCCLELLAN. I, again, did not have any communications about——

Mr. DEAL. The gentleman's time has expired.

Mr. WAXMAN. Mr. Chairman, everybody has been given——

Mr. DEAL. Everybody has asked questions with regard to the subject matter of this hearing.

Mr. WAXMAN. I would ask 1 minute.

Mr. DEAL. Your time has expired. I object.

Mr. WAXMAN. On the subject matter of the issue.

Mr. DEAL. You used your time on a subject matter not the subject of the hearing. Maybe one of your colleagues will yield to you as they yielded to Mr. Norwood.

Mr. WAXMAN. You have been very lenient with your members on that side of the aisle. You have not given me any leniency. I would request it.

Mr. DEAL. I would have if you had asked questions relating to the subject matter of this hearing. These gentlemen have given their time. There is a second panel waiting to testify. We are about to have another series of votes and interrupt this hearing again, and if one of your colleagues wishes to yield their time——

Mr. WAXMAN. They have been waiting a long time. I want to ask 1 minute of questions on the subject matter of this hearing.

Mr. DEAL. Are there objections?

Mrs. CUBIN. I object.

Mr. DEAL. Objection is heard.

Mrs. Cubin, you are recognized for questions.

Mr. WAXMAN. Better stay within 5 minutes.

Mrs. CUBIN. Thank you, Mr. Chairman, and I would like to apologize to the panel for the fact that political questions are being asked here today rather than issues related to the subject for which we are here, which is how to build a more efficient payment system for the benefit of doctors and especially patients. Unfortunately, the other side of the aisle seems to be using this tactic on every issue that comes before the Congress to the detriment, I might say, of the public and of the country as a whole.

Dr. McClellan, I will start with you. You are an advocate of payment for purchase—or pay-for-performance; excuse me. Do you believe that Congress should appropriate additional funding in order to implement pay-for-performance? Or do you think we should redistribute the funding in order to reward high-performing doctors?

Mr. MCCLELLAN. It is a good question, and there are a lot of proposals out there that would go both ways. The best approach I think is we are going to need to keep working with the Congress and with the medical community. I do think, in the short run, the most important thing to do is to take some steps to stabilize the payment system and do it in a way that moves toward an effective performance-based payment system, however exactly that works out. And that is why, earlier in my testimony, I talked about addressing the negative physician update and paying more to physicians who report on quality of care and help us develop better evidence on the best way to pay for physicians and other services in the Medicare program.

Mrs. CUBIN. Thank you.

Mr. Chairman, the committee is not in order. Mr. Chairman, the committee is not in order.

Mr. DEAL. The committee is not in order. Committee will be in order.

Mrs. CUBIN. Thank you.

Mr. DEAL. You may continue.

Mrs. CUBIN. Mr. Hackbarth, going back to you, MedPAC identified in-office imaging services such as MRI, CAT scan as growing exponentially between 1999 and 2002. Are in-office imaging procedures subject to the same quality and safety standards as hospital imaging services in relation to maintenance and personnel training and so on?

Mr. HACKBARTH. No, they are not.

Mrs. CUBIN. Do you think lack of such standards could lead to improper utilization of imaging procedures and possible over-exposure of patients to radiation?

Mr. HACKBARTH. We are concerned about that. Let me emphasize, I think that a lot of wonderful things are happening with imaging. The capabilities to improve care for patients are just mind-boggling, and so this is an area where we think much of the increase in volume may well be appropriate and helpful to patients.

We are concerned, however, about the migration of imaging from arenas where there are clear standards and oversight into places like physician offices where that is not the case, and we believe it is in the interest of both the patients and the program that we assure that the imaging that is done is of high quality and not dangerous to patients, and that requires some new rules.

Mrs. CUBIN. Would you be opposed to Congress requiring the Secretary of HHS to implement quality and safety standards for imaging services if it would help off-set implementation costs of physician SGR increase?

Mr. HACKBARTH. We have in fact recommended that such standards be set.

Mrs. CUBIN. Would the implementation of quality and safety standards reduce improper utilization or over utilization?

Mr. HACKBARTH. The main reason for doing them is to protect the quality of care and patient safety. It is possible that there might be some reduction in utilization, but that is not the principle reason for doing it.

Mrs. CUBIN. Do you think that the standards would produce any significant Medicare savings?

Mr. HACKBARTH. Again, there could be some. There might be some test that would have been done that won't be done in the future because of quality standards. That is not the principle objective, however. The principle objective is a quality objective.

Mrs. CUBIN. Thank you, Mr. Chairman. So as not to go over my time, I yield back my 33 seconds.

Mr. DEAL. I thank the gentlelady.

Ms. Eshoo, you are recognized.

Ms. ESHOO. Thank you, Mr. Chairman.

Dr. McClellan, back to the subject that you don't want to hear me talk about, but I am going to raise it anyway. You know how disappointed I am in the CMS final rule. It is a failure because there isn't—you don't present any solution to the problem, to the fix of the payment localities.

You said earlier something about—I know that I am paraphrasing—you know that we want efficient systems that reimburse people properly in the proper areas. I know I am paraphrasing, but it made me think of this.

Just to refresh your memory, the draft rule that CMS recommended included a fix for two counties. I was more than pleasantly surprised—and I wrote to you and thanked you—when, to my amazement, that CMS even acknowledged in that draft rule that ultimately—that you were ultimately responsible for establishing fee schedule areas.

Now CMS has issued its final rule. You not only remove the fix for the two counties that were deeply affected, but you have failed to address a State-wide solution; and I think, to add insult to injury, you suggest no alternatives.

Now I have to tell you that, you know, I wish I had known this ahead of time. I mean, I worked with all of you absolutely on the level on this; and I think it is like a year, 2 years where you just strike a match to it.

I raise this because I think you have responsibility for this. I mean, this isn't just going to go away. This isn't something that is a nitpicking issue in one corner of California. There are physicians that are leaving, that are leaving an area that is no more rural than Washington, DC, is. So it affects the system. We have a responsibility together to do something about this.

So my first question is, other than waiting for MedPAC recommendations and a fix in 2008, what are you going to do?

My second question is—and it is a follow-up to a comment that you made this morning—did we understand you to say that the administration would consider charging or changing the balanced billing protections in the law? I mean, something that is clearly designed to protect beneficiaries in order to pay doctors more? Is this the way you want to solve the problems with the physician fee payment system, by shifting costs onto the beneficiaries? I don't know if this is—if I misunderstood what you said.

Mr. MCCLELLAN. What I said was that we wanted to work with the committee and the Congress on a way of addressing the physician payment problem that they are facing now. We would want to do so in a way that it not jeopardize access to quality of care for any beneficiary. So we will work together with the committee on that.

Ms. ESHOO. Well, with all due respect, I am going to harkenback to what the ranking member said. It really is, I think, the responsibility of the administration to bring legislation forward, Dr. McClellan. Administrations do that; and when they do, they carry a great deal of clout because they say, this is our position, bring it to the Hill, and it is carefully considered. We are flailing. This thing is all over the place. So there is, you know——

Mr. MCCLELLAN. Well, there is bipartisan legislation that would work in the direction that we have talked about. We often find——

Ms. ESHOO. Has there been a letter from the White House that says, this is our position——

Mr. MCCLELLAN. I just stated the administration's position this morning again in my testimony, and we found in many cases that building on bipartisan legislation that already has support in Congress may be the best way to get this done.

Ms. ESHOO. Let's get back to the two questions.

Mr. MCCLELLAN. Let's get back to the first question about the situation in California. And I can imagine how frustrated you are. I am frustrated. You have been involved with this from a payment perspective longer than I have. I have been involved with this since I came into this job over a year ago. Since I have practiced in your district, I know exactly how serious this problem is——

Ms. ESHOO. It is hard to explain to everyone. We knew each other some time ago, which is great. You know I respect you, but I am furious.

Mr. MCCLELLAN. As you know, we had an approach that involved you working with California——

Ms. ESHOO. But what are you going to do about it now?

Mr. MCCLELLAN. Well, what the California Medical Association has left us with is no alternative but legislation. We proposed a two-county solution that would address this problem, would solve this problem with a minimal impact on other counties——

Ms. ESHOO. You announced in your draft—you said, CMS is ultimately responsible for establishing fee scheduling areas. This is getting to be a ping pong game. It is not good enough.

Mr. MCCLELLAN. And we also added that CMS has never taken action to change the payment rates affecting physicians in a State without the support from a State medical society or at least without the—support isn't even needed at this point. I would just settle for something short as strong opposition. Yet when we put that regulation out for comment, Congresswoman, what the California Medical Association said was that they opposed the solution that you and I had thought might work; they opposed any other administrative solution that we could implement.

Again, I will quote from their comments to me on the regulation, the only gipsy solution that we are supporting at this time is a legislative solution. So they are basically telling you that you need to find new legislative money to solve this problem.That is the only approach——

Ms. ESHOO. This is just great. I am telling you, I am going to write a short story on this one.

Can you answer the other question?

Mr. MCCLELLAN. What is the other question?

Ms. ESHOO. Did you clear up the misunderstanding about the balance——

Mr. MCCLELLAN. I thought I had answered that one before, that we are open to ideas from Congress. It could get bipartisan support to address this problem. I think there is already bipartisan legislation. The Senate passed some legislation that would move in the direction of fixing the physician payment system. Any solution should not jeopardize quality of care for beneficiaries, and we would be happy to work with the committee on something within those bounds. There is definitely bipartisan interest and bipartisan legislation that we can build on.

Ms. ESHOO. Thank you.

Mr. DEAL. The time is expired.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman; and I thank Dr. McClellan for being here.

I think we are going to probably see lots of political questions, as they say. I want to follow up with one that Mr. Bilirakis talked about in liability issues.

In Texas, we have dealt with medical liability now for 30 years. Most medical liability lawsuits are filed in State courts. In fact, I am trying to think of one in history that has been filed in a Federal court. But, typically, those are in State courts. I think States have the opportunity—and they are doing it—to deal with it. I just wish we could quantify the savings to our physicians on the increased liability protections that they are getting through State law, and maybe once we can do that we would like at a national law.

The other thing from my colleague, Dr. Burgess from north Texas, I can tell you, sure, there may be overutilization in the

emergency room, but I can give you an experience in a Texas case that even with blunt trauma of the head there wasn't an MRI done, and it happened to be to my son about a year, 2 years ago. When I found out, I demanded to know why. I went all the way up to the administration; and they said, oh, that is our standard practice. I said, you are opening yourself up for a lawsuit; and we went and paid for one elsewhere. Thank goodness, nothing happened. There wasn't a problem. So it is not automatic in emergency rooms.

The problem with emergency rooms is they are being used as clinics, and people are showing up not because they had an auto accident but because they have some medical problem that really should be at a clinic down the street if they had late hours. And I thank the administration for the effort on community-based clinics. I wish our Labor/H appropriation bill today had provided more funding for the community-based clinics, and that is one of the issues I know we can agree on.

I said in my opening statement the frustration is how we can quantify the overutilizations compared to over—the better effort to treat under Medicare. And my concern and one of the questions, services offered under Medicare are certainly increasing. We are seeing an increase in preventive services such as screenings under Medicare, and I think that is a positive development, hopefully, to—you are not going to cure diabetes, but if we do things earlier we can cut the costs not only to the family but also to the taxpayers.

Our frustration on the committee is that we can't quantify some of that, at least CBO won't do it. That is how—I think that is one of the questions I want to ask, has CMS or MedPAC analyzed the future budget benefits on current spending on the preventive care that we can see? Because it just seems reasonable for someone who—instead of losing a leg, we may postpone that for years maybe if we do preventive care with them; and, of course, the patient accepts that suggestion on different lifestyle changes.

Mr. MCCLELLAN. Well, it is certainly a lot better way to spend the money. While the evidence isn't as extensive as many people would like, and that is one reason I think we would like to see better measures, better information developed on how we can have the most impact on patient health at the lowest cost, there is some evidence out there. Our actuaries and others have been looking at the experience of programs that focus on preventing the complications of heart failure, for example. That is the No. 1 coster in the Medicare program today, and much of the cost involves emergency room admissions or hospital admissions for people who have had breathing problems—what is clinically called decompensation—from their heart failure condition. And there are proven steps that can help prevent those from happening.

So I think there is some potential for scorable savings from these programs already. I think we can work harder to develop more as we get to a better payment system in the next few years. And you may have something to——

Mr. HACKBARTH. No, I think Mark covered it well.

In specific response to your question, Mr. Green, I don't know of any study that says here is the savings that would be achieved from that. Certainly there are savings, but I am just not aware of

any specific number that we can give you or to CBO or to anybody else.

Mr. GREEN. Giving it to us would be great, but CMS is the one who tells us what we can do and how we can pay for these.

One of the concerns I have—and getting back on the diabetic issue—doctors in my area that pay for performance. My concern is if we do look at the problem of pay for performance, we will end up seeing doctors who may not take a person who is diabetic because they know that they will end up being cut in the long run. Can CMS or MedPAC address that issue?

Mr. HACKBARTH. This goes back, again, to Mr. Pallone's question earlier. I think it is critically important that the pay for performance system be designed so that it does not discourage physicians from taking complicated patients, sick patients; and we think one way to do that is by using evidence-based process standards of care, as opposed to trying to measure ultimate outcomes and pay based on ultimate outcomes. If you tried to do it on ultimate outcomes, you would need very sophisticated risk adjustment, probably more sophisticated risk adjustment than currently exists. But if you narrow it down and say, when you have the diabetic patient, are you doing these things that, based on evidence, is shown to help improve results, then I think there is no reason to avoid the diabetic patient, that you will get paid for good performance.

Mr. GREEN. Thank you.

Mr. DEAL. The gentleman's time is expired; and, Ms. Baldwin, you are next.

Ms. BALDWIN. Thank you, Mr. Chairman.

Mr. Hackbarth, I have a couple of questions for you.

Some physician groups have long asserted that CMS can take action on its own to prevent the cuts from being implemented, and I am wondering if MedPAC has taken a position on whether CMS can administratively act to prevent or relieve the negative updates? Has MedPAC addressed this issue?

Mr. HACKBARTH. We have not taken a position on that issue.

Ms. BALDWIN. On another matter, at the end of your written testimony you discuss creating new incentives in the physician payment system. I am particularly interested in this idea, as we have seen, that national spending targets like the SGR have had little effect on physician behavior, and that is one of the reasons why the SGR doesn't work.

In Dr. McClellan's testimony he talks about the growth in the volume of services physicians have provided, which in 2004 increased by a factor of 14 percent. While the increase in volume of physician services is concerning, I think it is important to recognize that this is not a trend we see everywhere and uniformly in the United States.

For example, in my home State of Wisconsin there is the example of Marshfield Clinic that only realized a 1.5 increase in volume for Medicare services in 2004, and this relatively low level of increase in volume is something that we see throughout the State of Wisconsin. In effect, doctors in Wisconsin and other areas of the country with low levels of increase in volume of services that physicians provide are being punished, I think, by the way the system currently works. So I am particularly interested in the four ways

that you suggest that Medicare can move from one national spending target to multiple spending targets or multiple alternate pools, and I am wondering if you can expand a little bit on these options.

Mr. HACKBARTH. Sure, I would be happy to.

As you point out, one of our most fundamental objections to SGR is that unfairness that you refer to. Everybody is punished equally, even if they didn't contribute equally to the problem facing the program. That is unfair, and it means there is no incentive for good performance, and that is the road to ruin.

We are a bit leery in general of formulating systems like SGR that says that you can reduce down to a calculation what the right amount of spending should be. We are a little concerned that they may be simplistic.

Should Congress decide, however, that in view of the long-term financial projections for the program or immediate budget circumstances that it wants to retain such a formula-driven system, we think the most important step that could be taken that would move it in the proper direction would be to have it applied to smaller, more accountable units. So that in the case of Wisconsin and in other States in the upper Midwest who have a very different pattern of care and rate of increase in costs they would not be punished for what happens in another group of States that have a much higher level of cost and more rapid increase in cost. So a geographic subdivision of the country might be one direction you might go.

Another direction that you might take is not to do it geographically but to identify smaller groups of physicians who could be accountable not for what happens on the other side of the country but what happens within their group practice or what happens within their hospital medical staff. If that is the sort of group that is held accountable, physicians can deal with one another face to face and say, we have got a challenge. We have got a risk of having our payments cut. What can we do to better manage care and control costs? That is a more meaningful accountability than you get under the SGR system, and it can lead to a constructive incentive to improve care.

Now having said that, let me emphasize again that MedPAC has not endorsed any of these alternatives. What we have said is, if Congress decides it wants an overall formula-driven system, you would want to go to smaller units. We would be happy to look at the strengths and weaknesses of various options, and they would all have those strengths and weaknesses.

Ms. BALDWIN. I notice that your last sentence in your written testimony presents that invitation for those of us interested in seeing you explore those further to do so, and I suspect—I can't speak for other members, but I suspect there is interest.

Mr. DEAL. I will second that.

The gentlelady's time is expired.

I believe all members of the subcommittee have asked questions, and we thank the two gentlemen part of this panel. We kept you here for 4 hours——

Mr. ENGEL. Mr. Chairman, I wonder if I would be given the opportunity——

Mr. DEAL. You would have to ask unanimous consent. I don't believe you are a member of this subcommittee, are you?

Mr. ENGEL. Not this committee, no.

Mr. DEAL. Do you ask unanimous consent?

Mr. ENGEL. Yes, I do.

Mr. DEAL. Do I hear an objection?

If not, you will be allowed to ask questions. I would urge you to do so rather quickly because I think we are getting close to a vote on the floor.

Mr. ENGEL. Okay.Thank you, Mr. Chairman; and although I am not, this Congress, a member of the Health Subcommittee, I appreciate the opportunity to ask questions.

Obviously, the SGR system is seriously flawed and needs to be fixed; and physicians deserve to be fairly and appropriately compensated for the important work that they do. And, obviously, we are facing a serious access problem, and access to health care for beneficiaries would be hurt if physicians continue to drop out of the Medicare system. But increasing payments under the current SGR system means that beneficiaries will also be subject to higher cost sharing and premiums. They face 2 years or record premium increases because their premiums are based on Medicare spending. Any further large increases are another barrier to care. It is time to really reform this unsustainable system, and long-term solutions are needed so that our doctors don't face the same uncertainties next year.

I have two questions essentially. Dr. McClellan, obviously, this hearing is about creating a more efficient payment system. The Senate amendment during the reconciliation debate seeks to include marriage and family therapists and mental health counselors under Medicare in an effort to expand access to mental health services in rural areas. In 2002, MedPAC reported to Congress that including marriage and family therapists and mental health counselors under Medicare would likely increase costs to the Medicare program without expanding access to mental health services in rural areas; and they voted 12 to 2 against, including MFTs and MHCs under Medicare. Instead, MedPAC suggested addressing other barriers, like the 50 percent co-insurance payment. The mental health care and other all medical care requires a 20 percent co-insurance payment.

According to the report, and I quote, addressing the barriers to mental health services embedded in Medicare payment and coverage policies may have greater potential to improve mental health services to the largest number of beneficiaries than would expanding the list of recognized providers. So I have to tell you, I think one of the cruelest injustices in our Medicare program is the continued disparity in payment between these equally important services. They should be no different.

So my question is, in determining a more efficient Medicare program, MedPAC has found it is more efficient to pay appropriately for mental health services than to add non-physician providers to the already burdened payment system. Do you agree with MedPAC's assessment of this situation?

Mr. MCCLELLAN. Well, I certainly agree with the expansion to other types of providers not being as high priority as addressing

the physician payment problems and moving to a better physician payment system and taking other steps that can improve care for patients with mental illnesses. Now we haven't taken any position on the reduction in co-pays that MedPAC recommended for mental health services. We have been focused on other steps to improve access to treatments for mental illness among seniors and people with disability. The most important one is the new prescription drug benefit, which not only doesn't have any disparity in how mental illnesses are treated—in fact, all of the prescription drug plans are required to cover essentially all of the treatments for mental illness that are available. That is a big step toward greater access to care that will improve outcomes related to mental illness for seniors.

Mr. ENGEL. Would you recommend to Congress that Congress eliminate this disparity?

Mr. MCCLELLAN. Well, I think we can look at ways to reduce problems in access to mental health care and find cost-effective ways to do that. Many of the Medicare advantage plans that we have already been talking about provide additional mental health services, for example, that are not covered by Medicare. We have not taken a specific position on that proposal, though.

Mr. ENGEL. Let me just finally, before I have—the second question is, MedPAC has certainly convinced me that we should pay for, appropriately, for mental health services. I think it is very, very important. My last question is, has CMS looked at how further cuts in the Medicaid conversion factor because of the SGR formula would harm resident physician teaching programs?

For example, CMS recently failed to take any positive action on the anesthesiology teaching rule, despite lots of support from Members of Congress, including me. My doctors back home tell me that academic anesthesiology teaching programs are really struggling under the inflexible Medicare payment policy. The policy, which reduces payments to teaching anesthesiology by 50 percent, has had a significant adverse impact on the ability of academic programs to train future generations of anesthesiologists; and many programs therefore are having difficulty filling faculty positions and are operating at negative revenue margins. So I feel that these programs, like in my area in the Albert Einstein College of Medicine in the Bronx, New York, would be further battered by cuts in physician payments; and I am wondering if you could comment on that.

Mr. MCCLELLAN. Well, I think you are talking about the limit on the number of residents that an anesthesiologist in a teaching program can supervise at one time, and we did ask for comments related to changes in this policy. We did get some comments back on both sides. While there were some in support, a number of anesthesiology programs, as you mention, in support of a change in the payment, there were other groups that were saying, basically, if you make that change here, hey, you need to make similar changes in a bunch of other programs. That would have had considerably larger cost implications; and so that is something that we are still looking at now, whether this is a financially viable approach.

But I agree with you about the need to pay some close attention to the viability of the anesthesiology and other teaching programs. We have seen some big changes in medical practice, and our teach-

ing support systems have not kept up with that. So we are paying a lot of attention to possible reforms in teaching payments.

Mr. ENGEL. Well, I am hoping we can continue the dialog on this; and I thank you, Mr. Chairman, for your indulgence.

Mr. MCCLELLAN. Absolutely, thank you.

Mr. DEAL. I thank the gentleman, and thanks to both panel members. We kept you now in excess of 4 hours. We thank you for yourindulgence, and we look forward to hearing from you again in the very near future. Thank you.

I am going to ask the second panel, if you will come to the table, I probably will only be able to introduce you before the bell goes off for votes on the floor, but we will do that and then probably have to recess for votes.

All right. Very good. Well, thanks again. You have been patient as well since you had to sit out there and listen all this time, and we thank you for your presence.

Let me introduce the panel: Dr. Frank Opelka, a surgeon from New Orleans, Louisiana, who is here on behalf of the American College of Surgeons; Dr. Vineet Arora, an internal medicine physician from Chicago, who is representing the American College of Physicians; Dr. Elizabeth Davis, an ophthalmologist from Minnesota, who is representing the Alliance of Specialty Medicine; Dr. Duane M. Cady, a surgeon from Upstate New York and the Chairman for the Board of Trustees for the American Medical Association; our former colleague, the Honorable Barbara Kennelly, who is currently the President and CEO of the National Committee to Preserve Social Security and Medicare; and Ms. Nora Super, from the Center for Health Services Research and Policy at the George Washington University Medical Center.

Ladies and gentlemen, we are pleased to have you here. Since you have been waiting so long, I am going to go ahead and start.

Dr. Opelka, we will start with you. We probably will be interrupted by bells in just a few minutes, but you are free to proceed.

STATEMENTS OF FRANK OPELKA, ON BEHALF OF AMERICAN COLLEGE OF SURGEONS; VINEET ARORA, CHAIR, COUNCIL OF ASSOCIATES, AMERICAN COLLEGE OF PHYSICIANS; ELIZABETH DAVIS, ON BEHALF OF ALLIANCE OF SPECIALTY MEDICINE; DUANE M. CADY, CHAIR, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; HON. BARBARA B. KENNELLY, PRESIDENT AND CEO, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE; AND NORA SUPER, CENTER FOR HEALTH SERVICES RESEARCH AND POLICY, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

Mr. OPELKA. Thank you, Chairman Deal. And I appreciate the opportunity, the distinguished members of the panel, to present to you on behalf of the 70,000 fellows of the American College of Surgeons. As you said, my name is Frank Opelka. I am from New Orleans. I am a practicing surgeon there. I am also a professor of surgery and the Associate Dean for Louisiana State University.

Before I get into my remarks, may I just thank you and all the Members of the Congress and the constituents from all of the

States across the country who have poured out their hearts in helping us in Louisiana. We appreciate that.

For my remarks themselves, I would like to direct attention toward the SGR that we have talked about today, as well as I would like to direct some remarks about pay for performance.

Regarding the SGR, as everyone has said, this is a flawed problem. It is a unique problem for surgeons. It is a little bit different for surgeons as compared to other practices where there may be volume and intensity opportunities.

In the surgical arena, there has been a relatively flat growth of surgery, as you can see in our graphic illustration. Surgery is the deep purple, and it is pretty much a flatter or relatively minimum growth over years. The other services have increased because of opportunities for improving patient care. Those volume increases and those intensity increases have an impact on helping other practices try and deal with these intense reductions.

Surgeons don't have that opportunity. Much like the example that was given in the Marshfield Clinic in Wisconsin, those surgeons can't make up those opportunities. Therefore, they end up getting into niche practices, focusing down and limiting services. So it becomes a quality and access issue. We need your help in stopping this reduction and moving forward with you in looking at different types of solutions in the SGR, and that is where the College stands with that program.

We may actually see this as a link with pay for performance or value-based purchasing. We are in strong support of value-based purchasing, but we think that, like SGR, it may not be a one-size-fits-all situation. The ambulatory care quality initiatives are much different from the surgical inpatient quality initiatives. The American College of Surgeons has worked for a long time in establishing a very active data base that deals with risk-adjusted outcomes, employs processes and systematic solutions that really work with hospitals to enhance quality care. In fact, there is even a business model for this, too. There is cost savings that we can appreciate by limiting complications, limiting length of stay and improving overall proper evidence-based utilization.

So the College strongly asks you from the SGR standpoint to limit this reduction. We are willing to work with you, realizing there is probably not a one-size-fits-all solution there. And, also, we strongly support pay for performance, realizing there is probably one set of solutions in an ambulatory environment and another set of solutions in the hospital environment where the surgeon and the hospital are working together can improve overall outcomes and save money on behalf of the beneficiaries. Thank you very much.

[The prepared statement of Frank Opelka follows:]

PREPARED STATEMENT OF FRANK G. OPELKA ON BEHALF OF THE AMERICAN COLLEGE OF SURGEONS

Chairman Deal, Ranking Member Brown, and distinguished subcommittee members, thank you for the opportunity to testify today on behalf of the 70,000 Fellows of the American College of Surgeons. My name is Frank Opelka. I practice colorectal surgery in New Orleans, and serve as Associate Dean for Healthcare Quality and Safety at Louisiana State University. I also serve as the College's Alternate delegate to the AMA/Specialty Society RVS Update Committee, or "RUC."

We are grateful to you for holding this hearing on the challenges posed by the sustainable growth rate (SGR) method for determining Medicare payments to physi-

cians. While it is important to consider the impact the current system is having in general on physicians and on patient access to care, a wise course for reforming Medicare payment must also consider what is happening across the range of specialties and subspecialties. Spending trends, practices, billing rules, and the way patient care is delivered all vary substantially among specialties, and the current payment system simply is not designed to accommodate that diversity.

As you are well aware, unless Congress intervenes the current SGR method for determining Medicare physician payments will require a 4.4 percent payment cut in 2006, with an estimated 26 percent cumulative cut anticipated over the next 6 years. As a first step toward bringing some rationality and predictability to the Medicare physician payment system, Congress must act to stop the cut from going into effect on January 1. In the long run, we need a system that enables reimbursements to keep pace with physicians' costs. The SGR system has to be reformed, with future payments linked to a reasonable measure of practice cost inflation such as the Medicare Economic Index.

While these pending cuts threaten the financial viability of physician practices across the range of the specialties, surgeons are uniquely threatened by the current payment system. Policymakers seem to lose sight of the fact that, for many key surgical services, Medicare payments today are about half what they were in the 1980s, even before inflation is taken into account. In addition, as surgeons continue to confront rising practice costs associated with day-to-day operations, they also are faced with some of the highest liability insurance premiums in medicine—a major cost that has escalated in recent years, and one that has not been addressed by the current payment system.

At the same time, by the nature of the services they provide and differences in the way their services are billed, surgeons are less able to compensate for payment losses by increasing the volume of services they provide. For example, patients rarely self-refer to surgeons; rather, most are referred by other physicians who have determined that a surgical assessment is needed. In addition, major operations are reimbursed on a global basis that reflects not only the procedure itself but also the pre- and post-operative care that occurs within a 90-day period. This payment is based on the typical rather than average patient, and remains the same regardless of complications or how many post-operative services an individual requires. Further, unlike most physician services, major procedures can generally be performed only once on a given patient.

As a result, surgery is disproportionately affected by the correlation between the price that Medicare pays for specific physician services and the overall volume target set for all physician services under Medicare. This is because the growth in major operations performed by surgeons is consistently lower than the growth rate for other services provided to Medicare patients. For example, major procedures accounted for 6 percent of total Medicare physician spending in 2004, and for only 3 percent of the growth in Medicare physician spending that year. Practically, this means that the current formula requires surgeons to bear the cost of increased utilization of services that they do not provide—whether or not that increased utilization is justified.

We did some back-of-the envelope calculations, projecting forward the 2004 growth rates for the major categories of physician services and estimating what surgical services would be paid in the future under a surgery-specific SGR. Under such a system, major operations would be awarded payment increases totaling 14.5 percent by 2011, as opposed to the 26 percent cumulative cut that has been estimated under the current system. Under this scenario most other service categories, of course, would see their cuts deepen over the same period. Clearly, the SGR system is siphoning payments away from surgery toward other services that are experiencing significantly higher rates of growth.

The attached chart compares surgery with the largest category of physician spending—evaluation and management (E/M), or visit services. As you can see, in 1998 Medicare spent about $575 per Medicare beneficiary for visit services; that amount grew by over 36 percent to about $784 in 2003. For major procedures, on the other hand, the comparable figures are $212 in 1998 and $226 in 2003—an increase of less than 7 percent. (I should point out that we expanded the specific services typically classified in the "major procedures" category by Medicare to include several high-volume ambulatory services, including the number one Medicare procedure--cataract surgery.)

We have no reason to suspect that the relatively high rate of spending growth for E/M services is inappropriate. Indeed, it is clear that public health experts and policymakers are very concerned about access to the primary care services that comprise the largest portion of this E/M service category. And, many efforts are underway—including value-based purchasing proposals—that we expect will accelerate

the E/M growth rate through improved immunization rates, greater access to screening services, better management of chronic conditions, and so forth. But, what impact will that have on surgery? As the government encourages primary care physicians to provide more of these office-based services, the SGR requires the money to come from other services—regardless of any spending or access issues that may be involved. Surgeons simply cannot continue to foot the bill for increases in the volume of unrelated services provided by others—no matter how valuable those services may be.

In other words, the current Medicare payment and update system is simply inadequate to the task of appropriately pricing services as diverse as E/M and surgery.

With respect to pay for performance or value-based purchasing, the College is optimistic that such a program, if properly designed, holds great promise for truly imposing some rationality on the physician payment system. We agree that it is time to shift the focus away from the "price" Medicare pays for a service and toward the "effectiveness" of the care that patients receive.

Since the College's founding over 90 years ago, it has demonstrated its commitment to ensuring high-quality surgical care for patients. This commitment to excellence in surgery is evident in the professional standards to which our Fellows are held and in the wide range of educational services that the College offers to ensure that they maintain their skills and learn about advances in technology and practice. We set standards for trauma care, we approve hospital cancer programs, and we have developed standards for bariatric surgery programs. With respect to promoting processes and data collection to improve surgical outcomes, the College has partnered with CMS and the Centers for Disease Control and Prevention in the Surgical Care Improvement Project (SCIP), and first with the Department of Veterans Affairs and now with hospitals and health plans in the National Surgical Quality Improvement Project (NSQIP). The College believes strongly that, if value-based purchasing in Medicare is to be successful, physician measures must be based on physician-led efforts such as these public-private partnerships, which have been shown to improve outcomes for patients and lower healthcare costs.

Again, it is important to note that the diversity of physician services and the settings in which they occur must be taken into account in the design of a value-based purchasing program. Surgeon-led quality improvement initiatives, for example, tend to focus on the entire episode of care and the system in which patient care is provided. Surgery is a team effort, and our quality and safety efforts incorporate all elements of that team. This is a very different approach from the more narrowly drawn process measures that have been developed for other service types. Surgical care also lends itself more readily to risk-adjusted outcomes measurement than many primary care services for which success relies more heavily on patient compliance factors beyond the physician's control. Finally, the potential for cost savings through improvements in the quality of surgical care can be tremendous. For example, it has been estimated that taking the necessary steps to prevent post-operative pneumonia can save $22,000 to $28,000 per patient admission. However, for Medicare these savings are achieved outside the Part B physician payment system, a complex issue that needs to be addressed if payment incentives are to truly be aligned to favor cost effectiveness and quality improvement.

Nevertheless, the College and its Fellows stand ready to work with Congress and with CMS to ensure that any value-based purchasing reforms are structured in such a way to properly reward high-quality care and to promote advances that will improve the quality of surgical care in the future.

Finally, with respect to the reconciliation process, we note that the Senate's package (S. 1932) proposes to replace the 4.4 percent cut in 2006 with a 1 percent payment increase. While we certainly appreciate this effort at a time when the committee was seeking budget savings, we are deeply concerned that the value-based purchasing program included in the bill is unworkable and holds the potential of causing even greater financial instability. Value-based purchasing simply cannot succeed in a system that is producing steep, annual payment cuts. By-and-large, physician offices are small businesses—the majority of surgeons are in solo practice or in groups of two or three partners. They need a reasonably stable and predictable revenue stream to make effective practice decisions.

When a conference committee convenes, members of this Subcommittee will be asked to help draft revisions and ultimately vote on value-based purchasing provisions. In that effort, we ask that you be mindful of the commitment that will be required by both physicians and the government to truly align incentives and make value-based purchasing work toward achieving the goal of higher-quality patient care.

Mr. Chairman, the College appreciates this opportunity to share its perspective on the challenges facing surgeons under the Medicare program today. We are ready

to work with you to reform the Medicare physician payment system to ensure that our patients have access to the high-quality surgical care they need.

Mr. DEAL. Thank you, Dr. Opelka.

1As you heard the bell, we do have two votes on the floor, so if you will indulge us for just a few more minutes we will go vote. And maybe I can find some more members to come back with me. Hopefully, that will be the case. But we will be back, and we stand in recess subject to return.

[Brief recess.]

Mr. DEAL. We will call this hearing back to order.

I understand that Dr. Davis has a flight to catch; and, Dr. Davis, I would simply ask, would you be inclined to respond to written questions that panel members may submit to you?

Ms. DAVIS. Yes, I will.

Mr. DEAL. You are recognized.

STATEMENT OF ELIZABETH DAVIS

Ms. DAVIS. Thank you very much.

Mr. Chairman, members of the Subcommittee, in addition to serving as a partner in a private ophthalmology practice in Minneapolis, Minnesota, and as a clinical assistant professor at the University of Minnesota, I am also the Chair of the American Society of Cataract and Refractive Surgery's Young Physicians and Residents Committee and a member of the ASCRS Government Relations Committee.

I am here today representing the Alliance of Specialty Medicine, a coalition of 13 societies, including ASCRS, representing more than 200,000 specialty physicians. I am pleased to have this opportunity to testify before the subcommittee on the issue of Medicare payment to physicians and in particular on the issue of the flawed sustainable growth rate formula and to offer possible solutions.

As advocates for patients and physicians, the Alliance of Specialty Medicine supports modifications to the current Medicare physician payment formula to ensure continued beneficiary access to timely, quality health care. The current SGR formula has significant flaws, however, causing steep reductions in physician reimbursement and prompting an increasing number of specialty physicians to reconsider their participation in the Medicare program, limit services to Medicare beneficiaries, or restrict the number of Medicare patients they will treat.

The sad reality of the current situation is that the only way physicians can avert negative updates to is somehow limit care to the population that needs quality health care the most, our Nation's elderly and disabled. No physician wants to turn away patients or leave a practice and the patients he or she has been serving for years. No physician wants to end a career earlier than he or she intended. To take such actions goes against the very reason they became physicians.

Flaws in the complex Medicare reimbursement update formula include, but are not limited to:

No. 1, including the cost of Medicare-covered outpatient drugs and biologicals in setting the expenditure target for physician services, even though these items are not physicians' services and

therefore, under the formula, lead to decreases in the annual payment update.

No. 2, linking Medicare physician fees to the GDP, which does not accurately reflect changes in the cost of caring for Medicare patients.

No. 3, inadequately accounting for changes in the volume of services provided to Medicare patients due to new preventative screening benefits, national coverage decisions that increase the demand for services, a greater reliance on drugs to treat illnesses, and a greater awareness of covered health benefits and practices due to educational outreach efforts.

And, No. 4, improperly accounting for costs and savings associated with new technologies.

Although the problem with the SGR were, in some respects, anticipated when the law was passed in 1997, the first detrimental effects were not experienced until 2002, when physicians received a 5.4 reduction to the conversion factor. Since then, the flaws of the SGR formula have been so pronounced that Congress has been forced to pass two temporary measures to keep the system from falling apart completely, and we are again faced with a 4.4 reduction January 1, 2006, and significant reductions beyond.

In 2003, after the Centers for Medicare and Medicaid Services delayed a second payment reduction for 3 months, Congress passed the first law which required CMS to fix accounting mistakes that were made during 1998 and 1999. Fixing these errors restored $54 billion to the Medicare payment system and prevented another year of reductions in reimbursement, but the legislation did nothing to fix the overall problems that plague the formula.

With physicians anticipating a 4.4 reduction in 2004, Congress again acted and included a provision in the Medicare Prescription Drug Improvement and Modernization Act of 2003 that mandated an increase of at least 1.5 percent in both 2004 and 2005. Although we appreciate the leadership of this committee in preventing the reductions in the eventual intervention of Congress, the statutory increase did nothing to change the underlying formula. In fact, while the statutory update in MMA prevented the additional reductions for 2004 and 2005, no additional funds were provided to pay for this temporary fix, therefore exacerbating the problem. As a result, the money used to fund the increased in these updates must be paid back to the Medicare program with interest over the next 10 years.

In fewer than 50 days, Medicare physician payments will be cut by 4.4, followed by significant reductions until 2012, and rates will not return to the 2002 level until well after 2013. In other words, physicians will receive less reimbursement in 2013 than they did in 2002 for the exact same procedure, regardless of inflation and increased practice costs.

Although reimbursement will likely be cut by more than 30 percent under the current formula during that time period, it is estimated that costs for providing services will rise by close to 20 percent. Such cuts will further inhibit each physician's ability to provide services to Medicare beneficiaries, as many physicians will be unable to afford to treat Medicare patients.

As I have previously stated, Congressional action has delayed the imminent meltdown of the Medicare problem and has allowed some breathing space to evaluate approaches to fixing the payment update formula. Although we prefer that Congress repeal the SGR and replace it with a system that takes into account the actual cost of providing care to Medicare patients, such as the Medicare Economic Index, we recognize that this is unlikely this year, given the current fiscal constraints facing the Congress. Providing short-term relief, therefore, is absolutely necessary to maintain access to care for beneficiaries and to stabilize the Medicare program until the SGR problem is resolved.

We also believe that it would be unwise to legislate a punitive pay-for-performance system for Medicare at this time. We clearly understand that the administration and Congress are intent on moving the Medicare into a quality reporting and value-based purchasing system. However, the SGR and a value-based purchasing or pay-for-performance system are incompatible. For physicians to embrace a value-based purchasing system, the SGR must be replaced with a more equitable and stable payment system so that physicians can invest in health information technology and pilot test data collection methods and quality measures as steps toward establishing a pay-for-performance system that actually improves care for Medicare patients.

Moving too rapidly by legislating pay-for-performance now without first resolving the SGR, especially a pay-for-performance system which is not supported by the physician community, amounts to replacing one broken system with another. Again, pay-for-performance is unworkable applied on top of the current unstable payment system. Simply put, value-based purchasing system and the SGR are not compatible and cannot work together.

The Alliance's member specialty physician organizations are continually striving to offer the highest specialized quality care to all Medicare beneficiaries. Over the past 8 months, the members of the Alliance of Specialty Medicine have worked diligently to prepare physicians for a value-based purchasing system. We have cooperated with CMS on the initial development of quality measurements that could be voluntarily reported through a claims-based system. In fact, physician specialty organizations played a role in developing the newly announced CMS Voluntary Physician Reporting Program and look forward to working with CMS to address some concerns that we have with the selected measures and process. All specialty groups in the Alliance have made tremendous progress in developing quality measures and preparing their physician members for this new payment system, and we stand ready to continue our involvement as the process moves forward.

We also continue to believe that quality reporting measures should be evidence-based developed by the specialty societies with expertise in the area of care in question and based on factors physicians can directly control. Quality measures must be pilot-tested and phased in across a variety of specialties and practice settings to help determine what does and does not improve quality. This is critical as we move to a system that produces a more efficient, reliable and stable patient system.

Therefore, the Alliance understands that there is an opportunity to work with Congress and the administration to enhance quality measurement for the specialty care provided to our Nation's seniors and individuals with disabilities. Patient safety and quality care are the cornerstones on which all patient care is delivered by the more than 200,000 specialty physicians the Alliance represents and the millions of patients they care for each year.

We stand ready to continue to work with Congress and the administration and ask that the following issues be addressed:

Physician payment reduction scheduled for January 1, 2006, and future years be prevented.

Before a mandatory value-based purchasing system is put into place, the current SGR must be replaced with a system that is more predictable and recognizes the true cost of providing physician services to Medicare beneficiaries.

Any new value-based purchasing program must be nonpunitive and use consensus-driven, evidence-based quality and efficiency measures developed by the medical specialties, and it must be phased in over several years.

All quality and efficiency measures should be consensus-driven and pilot-tested across a variety of specialties and practice settings.

Congress must find a solution to implement a rational Medicare physician payment system, and the Alliance of Specialty Medicine looks forward to working with you to develop a system that is more predictable and ensures fair reimbursement for physicians as well as continued beneficiary access to quality specialty health care.

Thank you very much.

[The prepared statement of Elizabeth Davis follows:]

PREPARED STATEMENT OF ELIZABETH A. DAVIS ON BEHALF OF THE ALLIANCE OF SPECIALTY MEDICINE

Mr. Chairman, Members of the Subcommittee, in addition to serving as a partner in a private ophthalmology practice in Minneapolis, Minnesota, and as a Clinical Assistant Professor at the University of Minnesota, I am the Chair of the American Society of Cataract and Refractive Surgery's (ASCRS) Young Physicians and Residents Committee and a member of the ASCRS Government Relations Committee. I am here today representing the Alliance of Specialty Medicine—a coalition of 13 societies, including ASCRS, representing more than 200,000 specialty physicians. I am pleased to have this opportunity to testify before the Subcommittee on the issue of Medicare payment to physicians, and in particular on the issue of the flawed Sustainable Growth Rate (SGR) formula and to offer possible solutions.

As advocates for patients and physicians, The Alliance of Specialty Medicine supports modifications to the current Medicare physician payment formula to ensure continued beneficiary access to timely, quality health care. The current SGR formula has significant flaws, however, causing steep reductions in physician reimbursement and prompting an increasing number of specialty physicians to reconsider their participation in the Medicare program, limit services to Medicare beneficiaries, or restrict the number of Medicare patients they will treat.

The sad reality of the current situation is that the only way physicians can avert negative updates is to somehow limit care to the population that needs quality health care the most, our nation's elderly and disabled. No physician wants to turn away patients or leave a practice and the patients she or he has been serving for years. No physician wants to end a career earlier than he or she intended. To take such actions goes against the very reasons we became physicians.

Why the SGR Formula Is Flawed

Flaws in the complex Medicare physician reimbursement update formula include, but are not limited to:

- Including the costs of Medicare-covered outpatient drugs and biologicals in setting the expenditure target for physicians' services, even though these items are not

physicians' services and, therefore, under the formula, lead to decreases in the annual payment update;

- Linking Medicare physician fees to the Gross Domestic Product (GDP)—which does not accurately reflect changes in the cost of caring for Medicare patients;
- Inadequately accounting for changes in the volume of services provided to Medicare patients due to new preventative screening benefits, national coverage decisions that increase the demand for services, a greater reliance on drugs to treat illnesses, and a greater awareness of covered health benefits and practices due to educational outreach efforts; and
- Improperly accounting for costs and savings associated with new technologies.

Recent Congressional Action

Although the problems with the SGR were, in some respects, anticipated when the law was passed in 1997, the first detrimental effects were not experienced until 2002, when physicians received a 5.4% reduction to the conversion factor. Since then, the flaws of the SGR formula have been so pronounced that Congress has been forced to pass two temporary measures to keep the system from falling apart completely, and we are again faced with a 4.4% reduction January 1, 2006—and significant reductions beyond.

In 2003, after the Centers for Medicare and Medicaid Services delayed a second payment reduction for 3 months, Congress passed the first law, which required CMS to fix accounting mistakes that were made during 1998 and 1999. Fixing these errors restored $54 billion to the Medicare physician payment system and prevented another year of reductions in reimbursement, but the legislation **did nothing to fix the overall problems** that plague the formula.

With physicians anticipating a 4.4% reduction in 2004, Congress again acted and included a provision in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) that mandated an increase of at least 1.5% in both 2004 and 2005. Although we appreciate the leadership of this committee in preventing the reductions and the eventual intervention of Congress, the statutory increase did nothing to change the underlying formula. In fact, while the statutory update in the MMA prevented the additional reductions for 2004 and 2005, no additional funds were provided to pay for this temporary fix, therefore exacerbating the problem. As a result, the money used to fund the increase in these updates must be paid back to the Medicare program, with interest, over the next 10 years.

Reimbursement Rates in 2006 and Beyond

In fewer than 50 days, Medicare physician payments will be cut by 4.4%, followed by significant reductions until 2012, and rates will not return to their 2002 level until well after 2013. In other words, physicians will receive less reimbursement in 2013 than they did in 2002 for the exact same procedure, regardless of inflation and increased practice costs. Although reimbursement will likely be cut by more than 30% under the current formula during that time period, it is estimated that costs for providing services will rise by close to 20%. Such cuts will further inhibit each physician's ability to provide services to Medicare beneficiaries as many physicians will simply be unable to afford to treat Medicare patients.

The Solution

As I have previously stated, Congressional action has delayed the imminent meltdown of the Medicare program and has allowed some breathing space to evaluate approaches to fixing the payment update formula. Although we prefer that Congress repeal the SGR and replace it with system that takes into account the actual cost of providing care to Medicare patients, such as the Medicare Economic Index (MEI), we recognize that this is unlikely this year given the current fiscal constraints facing the Congress. Providing short-term relief, therefore, is absolutely necessary to maintain access to care for beneficiaries and to stabilize the Medicare program until the SGR problem is solved.

We also believe that it would be unwise to legislate a punitive pay-for-performance system for Medicare at this time. We clearly understand that the Administration and Congress are intent on moving the Medicare program into a quality-reporting and value-based purchasing system. However, the SGR and a value-based purchasing or pay-for-performance system are incompatible. For physicians to embrace a value-based purchasing system, the SGR must be replaced with a more equitable and stable payment system so that physicians can invest in health information technology and pilot test data collection methods and quality measures as steps toward establishing a pay-for-performance system that actually improves care for Medicare patients. Moving too rapidly by legislating pay for performance now without first resolving the SGR, especially a pay for performance program that is not supported by the physician community, amounts to replacing one broken system with another.

Again, pay-for-performance is unworkable applied on top of the current unstable payment system. Simply put, value-based purchasing and the SGR are not compatible and cannot work together.

Pay for Performance

The Alliance's member specialty physician organizations are continually striving to offer the highest specialized quality care to all Medicare beneficiaries.

Over the past 8 months, the members of the Alliance of Specialty Medicine have worked diligently to prepare physicians for a value-based purchasing system. We have cooperated with the CMS on the initial development of quality measures that could be voluntarily reported through a claims-based system. In fact, physician specialty organizations played a role in developing the newly announced CMS Voluntary Physician Reporting Program (PVRP) and look forward to working with CMS to address some concerns that we have with the selected measures and process. All specialty groups in the Alliance have made tremendous progress in developing quality measures and preparing their physician members for this new payment system, and we stand ready to continue our involvement as the process moves forward.

We also continue to believe that quality reporting measures should be evidence based developed by the specialty societies with expertise in the area of care in question, and based on factors physicians can directly control. Quality measures must be pilot-tested and phased in across a variety of specialties and practice settings to help determine what does and does not improve quality. This is critical as we move to a system that produces a more efficient, reliable, and stable patient system.

Therefore, the Alliance understands that there is an opportunity to work with Congress and the Administration to enhance quality measurement for the specialty care provided to our Nation's seniors and individuals with disabilities. Patient safety and quality care are the cornerstones on which all patient care is delivered by the more than 200,000 specialty physicians the Alliance represents and the millions of patients they care for each year. We stand ready to continue to work with Congress and the Administration and ask that the following issues be addressed:

- The physician payment reductions scheduled for January 1, 2006, and future years be prevented.
- Before a mandatory value-based purchasing program is put into place, the current SGR system must be replaced with a system that is more predictable and recognizes the true costs of providing physician services to Medicare beneficiaries.
- Any new value-based purchasing program must be non punitive and use consensus-driven, evidence-based quality and efficiency measures developed by the medical specialties, and it must be phased-in over several years.
- All quality and efficiency measures should be consensus drive and pilot tested across a variety of specialties and practice settings.

Conclusion

Congress must find a solution to implement a rational Medicare physician payment system, and the Alliance of Specialty Medicine looks forward to working with you to develop a system that is more predictable and ensures fair reimbursement for physicians as well as continued beneficiary access to quality specialty health care.

Mr. DEAL. Thank you, Dr. Davis.

Dr. Arora.

STATEMENT OF VINEET ARORA

Ms. ARORA. I would like to thank Chairman Deal, Ranking Member Brown and distinguished members of the subcommittee for holding today's hearing on Medicare physician payment.

My name is Vineet Arora. I am a physician and Chair of the Council of Associates of the American College of Physicians and a member of the College's Board of Regions.

I am an instructor of medicine in the section of general internal medicine at the University of Chicago, where I recently completed my internal medicine residency. We deliver primary care to the residents of the South Side of Chicago. Eighty-five percent of our patients are African-American, and the majority is over age 65 and covered by Medicare.

I also a currently serve as the Associate Program Director for the Internal Medicine Residency Program and am an Assistant Dean for the Pritzker School of Medicine at the University of Chicago.

ACP's Council of Associates, which I chair, represents physicians who are being trained in an internal medicine residency program or who have gone for additional training in a subspecialty medicine fellowship program. Together, we are the new generation of physicians that your elderly and disabled constituents will be counting on for their primary care; and, unfortunately, there won't be enough of us. A combination of high student debt and an unfavorable economic environment is causing many of us to choose careers other than general internal medicine or family practice, which are the two specialities that aged and disabled patients must most depend on for their primary care. Furthermore, Medicare payment cuts that will result from the flawed sustainable growth rate formula will accelerate this looming crisis in access to primary care.

Today, I am pleased to report that the American Academy of Family Physicians and the American Osteopathic Association have participated in the preparation of today's testimony.

There is growing evidence that shortages are developing for U.S. Physicians but particularly in general internal medicine and family practice. Current projections indicate the future supply of primary care physicians will be inadequate to meet the health care needs of the aging U.S. Population, especially as baby boomers are beginning to reach retirement age in 2011.

In 1998, over half of graduating internal medicine residents plan to practice general internal medicine. Compare that with less than one-third in 2003. Strikingly, in 2003, only 19 percent of all internal medicine residents planned to pursue careers in general internal medicine. In my own residency program, I was one of only two of our nearly 30 graduating residents that did not enter a subspecialty fellowship training program. Moreover, primary care careers are too often becoming the default pathway of those students that could not enter competitive specialties.

The reasons why medical students and young physicians are turning away from primary care are complex and multifaceted. But based on my own experience and my conversations with peers I can honestly say with confidence that the dismal economic practice environment associated with primary care today is the major barrier.

The pending Medicare payment cut will only make a bad situation even worse. Right now, physician payments under Medicare will be cut by 4.4 percent on January 1, 2006. Additional cuts will decrease physician reimbursement by more than 26 percent from 2006 to 2011. In this same period, CMS projects physician costs will rise by 15 percent.

Now we learn early in our medical training about the importance and joy of having a continuous and on-going personal relationship with a patient, and these are the hallmarks of general internal medicine and family medicine. Unfortunately, we also learn that primary care is under-reimbursed compared to other specialties and that many primary care physicians are struggling to keep their practices open at a time of escalating practice costs, excessive paperwork requirements that take time away from caring for patients, and reimbursement from other Medicare and other payers

that does not keep pace with the rising costs. It is so bad that many of the excellent role models in primary care that we meet every day in our training programs go so far as to counsel us not to go into primary care, and you may wonder why, and that is because they tell us there is no economic future in primary care.

Today, a physician entering practice like myself has, on average, accumulated more than $100,000 in student debt, but the average doesn't tell the whole story. The median indebtedness of medical school students graduating this year is expected to be $120,000 for students in public medical schools and $160,000 for students attending private medical schools. About 5 percent of all medical students will graduate with a debt of $200,000 or more. Unfortunately, many of those young graduates facing the highest debt burden are of modest means and diverse backgrounds that are underrepresented in medicine, exactly the type of physicians we want to recruit to provide primary care for our increasingly diverse population.

In addition, many of us are entering practice at the same time we are getting married and buying homes and starting families. Just this week I was visiting my friend, a new mom who is also completing her family medicine residency in New Hampshire. She is married to another medical trainee, and together they have nearly $400,000 in medical student debt and another baby on the way. When interviewing for jobs, she realized that she could not accept a job in office-based primary care and expect to pay for her child care while continuing to pay off their debt. And there are countless others like her. Is it any surprise that more and more of us have concluded we simply cannot afford to support our families and also practice primary care?

Now reversing this decline will require immediate action by policymakers. The long pipeline of medical education, which is sometimes in some cases greater than 10 years, and retirement or career changes of older physicians necessitates that the Nation have a constant influx of new students embarking on medical careers. As the population ages, larger numbers of patients encounter chronic and more complex illnesses. The need for general internists and family physicians will increase. The need for primary care physicians who can provide first contact and comprehensive continuing care for adults will continue to increase as the population ages and its health care needs increase and as the demand for acute, chronic and long-term care increases.

Unfortunately, unless Congress acts now, the Medicare cuts will result in fewer physicians going into primary care; and many of those who are already in practice will be forced to retire or limit how many Medicare patients they will see.

In conclusion, I strongly urge the subcommittee to recommend that Congress take immediate action now to help avert the looming crisis and access to primary care by the following:

First, Congress must stabilize Medicare payments by halting the 4.4 percent cut and replacing the SGR cuts with positive updates for at least the next 2 years.

Second, Congress must enact a long-term alternative to the SGR.

Third, Congress must recognize that successful implementation of the Medicare value-based purchasing program or a pay-for-per-

formance type of program will require that the SGR be replaced with an alternative that provides stable, adequate and predictable payments to physicians.

And, fourth, Congress must work on developing a coordinated and comprehensive strategy for reversing the decline of young physicians going into primary care.

I am pleased to answer any questions from the committee.

[The prepared statement of Vineet Arora follows:]

Mr. DEAL. Thank you.

Dr. Cady.

STATEMENT OF DUANE M. CADY

Mr. CADY. Thank you, Mr. Chairman.

I thank you, Mr. Chairman. My name is Duane Cady. I am the chairman of the Board of Trustees of the American Medical Association and a general surgeon in upstate New York.

Today I, too, want to talk about the Medicare physician payment formula, or the SGR. As we have all heard today over and over, it is severely broken, and the patient access crisis is looming. Congress must take action this year.

As of today, there are 44 calendar days until the 4.4 percent cut goes into effect. This will be the first in a series of steep cuts over 6 years that will total 26 percent. A recent AMA survey shows that these Draconian cuts will impair access. It will also have a ripple effect across other payers, including TRICARE, which pays for medical care for military families and dependents.

The fatally flawed SGR led to a 5.4 percent cut in 2002, and physicians are grateful for congressional intervention to stave off additional reductions from 2003 through 2005. However, despite Congress's good-faith efforts over the last 4 years, physicians have received less than half of CMS's own conservative measures of increases in medical practice costs.

If the 2006 is imposed, average physician payments will be less in 2006 than they were in 2001, and that is in real terms, not adjusted for inflation.

The graph on the easel shows a grim view of the future. Physicians practice costs are expected to rise by an additional 15 percent from 2006 to 2011, yet during that same time, Medicare physician payments will decrease by 26 percent, as you see on the right-hand side on the lower line on the graph.

Now no business could survive these unsustainable cuts, especially physician practices, which typically operate as small businesses. The bar chart shows that only physicians face updates of 7 percent below the annual increase in their practice costs. Updates for hospitals, long-term care providers will keep pace with their market increase. Medicare advantage plans will see an average update of 4.8 percent in 2006. And as you see on the right-hand side of the bar graph in the tan color, that are the physician cuts.

Physicians form the foundation of our Nation's health care system. Without an adequate Medicare payment structure, this foundation will crumble. Congress is considering linking quality and Medicare physician payment through value-based purchasing legislation. The AMA and the leadership of the national medical spe-

cialty societies have invested extensive resources in quality improvement initiatives well before the concept of value-based purchasing evolved over the last several years we have been involved in this. We work diligently to develop countermeasures that are the basis for value-based purchasing, and we will continue to do so.

Value-based purchasing and the SGR, however, are not compatible. Value-based purchasing may save dollars for the program as a whole. However, in the beginning there may be an increase in cost. But many performance measures ask physicians to deliver more care, such as vaccines or mammogram or tests for diabetes. If the SGR is linked to value-based purchasing, more physician services will result in more cuts.

Further, the success of value-based purchasing depends on greater physician adoption of information technology. We are well aware of that. Without positive updates, IT investment will not be possible. A recent AMA survey indicates that steep pay cuts would cause more than half of the physicians to defer IT purchases, as well as other medical equipment. Thus, implementation of value-based purchasing proposals should be deferred until the SGR is repealed and a stable Medicare system is in place that reflects increases in physician's practice costs, as we saw on the graph.

Now this doesn't mean that we cannot continue to move forward with some kind of quality reporting system, but details should be refined among the physician community, Congress and the CMS. In fact, the AMA recently requested another meeting between Administrator McClellan and physician leaders for meaningful dialog on future quality activities.

Congress has a long-held commitment to seniors and disabled persons under the Medicare program. They deserve to have continued access to their physicians of choice, along with high-quality medical services. Working together, Congress, the administration and the physician community can strengthen this program and correct problems that undermine its goals.

In the meantime, what is needed now, this year, is at least 2 years of positive updates to reflect increases in medical practice costs. This would prevent Congress from having to struggle with this problem, as I witnessed today again, early next year. It will would also give Congress time to enact a long-term solution. The AMA looks forward to working with Congress in carrying out our long-held mission: service to patients, with assurances of access and quality of care.

Thank you very much.

[The prepared statement of Duane Cady follows:]

PREPARED STATEMENT OF DUANE M. CADY ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association (AMA) appreciates the opportunity to provide our views today regarding the urgent need for Congressional action to replace steep Medicare physician pay cuts with positive updates for at least the next two years, giving Congress and the Administration time to enact a permanent solution to the fatally flawed Medicare physician payment formula. Pending physician pay cuts will affect nearly one million physicians and other health care professionals whose Medicare payment rates are determined by the Medicare physician fee schedule.

Physicians have been working with Congress over the last several years to achieve a solution to the Medicare physician payment formula. A permanent solution to this problem is critical for maintaining access to and quality of care for Medi-

care patients. In fact, in 2004, the Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan, MD, underscored to Congress the agency's "concern about making sure that Medicare payments to physicians are adequate and encourage better care, because physician decisions can have such a critical impact on all Medicare costs and on patient health." That statement still rings true today. Indeed, there is widespread agreement—from many in Congress (both sides of the aisle) and the Medicare Payment Advisory Commission (MedPAC)—that the physician payment formula should be scrapped altogether. Further, Congress and CMS agree that an adequate payment structure for physicians is vital for maintaining a strong foundation under which Medicare can properly provide quality health care for our nation's seniors and disabled citizens. Yet, here we are today, with 44 calendar days until a 4.4% Medicare physician pay cut goes in effect. Congress must act now, or the foundation upon which the Medicare program is built will crumble.

CONGRESSIONAL ACTION NEEDED THIS YEAR TO STOP MEDICARE PHYSICIAN PAY CUTS

CMS recently confirmed that Medicare physician payments will be cut by 4.4%, effective January 1, 2006. This will be the first in a series of cuts projected over the next six years by the Medicare Trustees, with cumulative cuts of 26% from 2006 through 2011. Congress must act this year to stop the pending cuts and provide positive payment updates for at least 2006 and 2007. This will help preserve access to health care services for seniors and persons with disabilities while Congress and the Administration jointly work to enact a permanent fix to the current Medicare physician payment formula.

FUNDAMENTAL PROBLEMS WITH THE FATALLY FLAWED MEDICARE PHYSICIAN PAYMENT FORMULA: THE SGR

A fatally flawed Medicare physician payment update formula—called the sustainable growth rate (the SGR)—is responsible for the projected cuts. Under the SGR, payment updates are tied to GDP growth, which factors in neither patients' health care needs nor physicians' practice costs. Physicians are penalized with pay cuts when Medicare spending on physicians' services exceeds SGR spending targets that are based on GDP growth, but make no allowance for government policies and other factors that increase utilization of services.

Because of these fundamental defects, the SGR led to a negative 5.4% update in 2002, and additional reductions in 2003 through 2005 were averted only after Congress intervened and replaced projected steep negative updates with positive updates of 1.6% in 2003 and 1.5% in each of 2004 and 2005. We greatly appreciate these short-term reprieves. Even with these increases, however, Medicare physician payment updates during these years were only about half of the rate of inflation of medical practice costs. To make matters worse, if the 2006 cut is imposed, average physician payment rates will actually be less in 2006 than they were in 2001 (in real terms, not adjusted for inflation). Further, a 4.4% cut in January 2006, would mean that from 2002-06, payment rates will have fallen 16% behind the government's index of inflation in physicians' practice cost.

As shown by the graph below, these reductions come at a time when, even by Medicare's own conservative estimate, physician practice costs are expected to rise by an additional 15% from 2006-11 (with Medicare physician payments decreasing by 26%). The vast majority of physician practices are small businesses, and the steep losses that are yielded by what is ironically called the "sustainable growth rate," would be *unsustainable* for any business, especially small businesses such as physician office practices.

Only physicians and health professionals face updates of 7% below the annual increase in their practice costs. Hospitals and long-term care providers are slated for updates that fully keep pace with their market basket increases, and Medicare Advantage plans will see average updates of 4.8% in 2006, as illustrated in the bar graph below. Medicare physician payments must be re-structured to ensure access for fee-for-service patients as well.

ACCESS PROBLEMS FOR MEDICARE BENEFICIARIES UNDER THE CURRENT MEDICARE SGR PHYSICIAN PAYMENT FORMULA

Physicians simply cannot absorb the pending draconian payment cuts. In fact, a recent AMA survey indicates that if the cuts begin January 1, 2006:

- More than a third of physicians (38%) would decrease the number of new Medicare patients they accept;
- More than half of physicians (54%) plan to defer information technology purchases;

- A majority of physicians (53%) would be less likely to participate in a Medicare Advantage plan; and
- One-third (34%) of physicians whose practice serves rural patients would discontinue their rural outreach services.

A physician access crisis is looming for Medicare patients. More than 20 states each face cuts in Medicare funding of more than one billion dollars from 2006-2011. The MMA promised important new benefits for patients. An adequate payment structure for physicians' services must be in place in order for the government to deliver on its promise of these important benefits.

Yesterday, Medicare patients began enrolling for the new Medicare drug benefit that will become effective January 1, 2006. **Physicians are the foundation of our nation's health care system, and Medicare patients' access to physicians' services is imperative for the success of the new prescription drug benefit.** Continual cuts put such access at risk. Indeed, there are already signs that access to care is deteriorating. A MedPAC survey found that 22% of patients already have some problems finding a primary care physician and 27% report delays getting an appointment.

The physician cuts that threaten to destabilize the Medicare program will also create a ripple effect across other programs. Indeed, these cuts jeopardize access to medical care for millions of our active duty military family members and military retirees because their TRICARE insurance ties its payment rates to Medicare. The Military Officers Association of America (MOAA) recently sent a letter to Congress urging Congressional action to avert the 4.4% cut because it will "significantly damage" military beneficiaries' access to health care services. MOAA stated that "[w]ith our nation at war, Congress should make a particular effort not to reduce health care access for those who bear and have borne such disproportionate sacrifices in protecting our country."

MEDICARE QUALITY OF CARE INITIATIVES DEPEND ON ADEQUATE PHYSICIAN PAYMENT STRUCUTRE

An adequate Medicare physician payment structure is also imperative for Medicare quality of care initiatives. There is a growing consensus that greater physician adoption of information technology is vital to improvements in quality of care. Unless physicians receive positive payment updates, however, these investments will not be possible.

Further, inclusion of value-based purchasing (or pay-for-performance) provisions as part of any final budget reconciliation bill, without a long-term solution to the SGR, will only compound the looming access problem and make future SGR reforms more expensive. Value-based measures will lead to higher volume of physicians' services. Under the SGR formula, more services will result in more cuts. **Value-based purchasing and the SGR formula are incompatible. The SGR formula needs to be repealed in order for value-based purchasing proposals to succeed.**

PERMANENT SOLUTION TO THE SGR IS NEEDED TO PROTECT PATIENT ACCESS AND QUALITY OF CARE

The Medicare physician payment problem continues to exist because, as discussed above, it is inherently flawed and has led to deep cuts that were not projected when the formula was implemented in 1997. While we greatly appreciate the short-term reprieves achieved by Congress and the Administration in recent years, these temporary fixes have led to even deeper and longer sustained cuts because Congress recouped the cost of temporarily blocking the severe cuts in physician payments in the out-years. Without a long-term solution, repeated Congressional intervention will be required to block payment cuts that jeopardize continued access to high quality care for the elderly and disabled. A one-year fix would provide a temporary respite and lead to another struggle to deal with this problem early next year. **Thus, at least a two-year fix is urgently needed this year to allow time for a permanent solution to the SGR.**

Some government officials have cited the SGR formula as a method for restraining the growth of Medicare physicians' services. Yet, there are many reasons for such growth, and there are no studies documenting systematic inappropriate care. Without valid studies, it is impossible to determine what volume growth is appropriate or inappropriate. Earlier this year, for example, Medicare officials announced that spending on Part A services is decreasing. This suggests that, as technological innovations advance, services are shifting from Part A to Part B, leading to appropriate volume growth on the Part B side. If there is a problem with volume growth regarding a particular type of medical service, the AMA looks forward to working

with Congress and the Administration to address it, rather than retaining a formula that penalizes both patients and physicians for growth that may not be inappropriate at all.

ADMINISTRATIVE ACTION NEEDED TO ASSIST CONGRESS IN REPLACING THE SGR

CMS Administrator McClellan recently stated that "the current system of paying physicians is simply not sustainable." We agree and urge the Subcommittee to continue pressing CMS to use its authority to take administrative action to help Congress avert physician pay cuts and ensure that a stable, reliable Medicare physician payment formula is in place for Medicare patients.

Despite their protestations, the AMA firmly believes that CMS has the authority to remove the costs of drugs, back to the base period, from the calculation of the SGR. Because this would significantly reduce the cost of legislation and allow Congress to address the looming Medicare pay cuts more easily, CMS should take this step as soon as possible. Indeed, CMS told Congress earlier this year that removing drugs prospectively is worth about $36 billion in lowered costs, while removing them from the base-year forward reduces $111 billion from the cost of an ultimate fix.

Drug expenditures are continuing to grow at a very rapid pace. Over the past 5 to 10 years, drug companies have revolutionized the treatment of cancer and many autoimmune diseases through the development of a new family of biopharmaceuticals that mimic compounds found within the body. Such achievements do not come without a price. For example, in 2004 alone, six oncology drugs received FDA approval or expanded approval, and two others received approval in 2003. As Dr. McClellan noted in testimony earlier this year, spending for one recently-developed drug, Pegrilgrastim (Neulastra) totaled $518 million last year, more than double the 2003 total. This drug strengthens the immune systems of cancer patients receiving chemotherapy, thereby improving and extending the lives of many and potentially reducing hospital costs in the process.

Growth rates for drug spending dwarf those of the physician services the SGR was intended to include. Between the SGR's 1996 base year and 2004, the number of drugs included in the SGR pool rose from 363 to 445. Spending on physician-administered drugs over the same time period rose from $1.8 billion to $8.6 billion, an increase of 358% per beneficiary compared to an increase of only 61% per beneficiary for actual physicians' services. As a result, drugs are consuming an ever-increasing share of SGR dollars, nearly tripling from 3.7% of total SGR spending in 1996 to 9.8% in 2004.

It is not equitable or realistic to finance the cost of innovative drug therapies through cuts in payments to physicians and other health care professionals. CMS must act now to remove these costs form calculations of the SGR. The longer CMS waits to make this policy change, the more costly it will be for the government to do so.

The AMA appreciates the opportunity to provide our views to the Subcommittee on these important matters. We look forward to working with the Congress and the Administration to: (i) stop the pending Medicare cuts; (ii) provide at least two years of positive Medicare physician payment updates beginning in 2006; and (iii) defer implementation of value-based purchasing proposals until the SGR is repealed and replaced with a formula that does not unfairly penalize physicians for volume increases. These measures will assist the Medicare program in providing broad-based access and quality of care for seniors, persons with disabilities, and military beneficiaries.

Mr. DEAL. Thank you.

Ms. Kennelly.

STATEMENT OF HON. BARBARA B. KENNELLY

Ms. KENNELLY. Thank you, Chairman Deal and Ranking Member Brown, Mr. Bilirakis and Congressman Burgess. I am really delighted to be able to participate in this hearing and to present the beneficiary's point of view in this discussion about physician payment rates.

The National Committee to Preserve Social Security and Medicare is a nonprofit member association. We have roughly 4.5 million members, and the vast majority of them are seniors.

Mr. Chairman, I am not here today to take a specific position on how to reimburse physicians who are participating in the Medicare program. That is going to be your very difficult task. Instead, as an advocate for seniors, I amhere to remind this committee and all Members of Congress that access to health care can be denied in many ways. Financial barriers can deny needed health care to millions of older Americans.

One of the reasons most seniors choose fee-for-service Medicare over managed care is that most older Americans like their current doctors and want to be able to choose their own doctor when they need a new one. They have long histories with the doctors and feel most comfortable with someone who is familiar with their medical history. For this reason, seniors tend to be very sensitive to the slightest prospect that more doctors might limit their practices.

But access is more than a personal issue. The vast majority of seniors receive the bulk of their health care in doctors' offices or clinics. Adequate access to physicians is therefore a key component to keeping seniors healthy.

Although there are always cases of closed access, Medicare beneficiaries are generally able to see the doctor of their choice at least as often as seniors with private insurance. The fear of access problems is often greater than reality.

Physician payment reductions are controversial every year. With physicians raising the spectrum of future restrictions on access if projected cuts are not reversed, we strongly believe doctors should be fairly compensated for their service. However, I would like to remind the members of the subcommittee of the flip side of that coin. Access can also be denied as seniors are priced out of the health care market.

Two out of three retirees today receive more than half of their income from Social Security, and for one out of five retirees Social Security is their only source of income. Fortunately, these seniors have Social Security costs of living adjustments to help them keep up with inflation, but the Social Security COLA can only help so much because it is based on annual increases in the Consumer Price Index. Medicare premiums, which are set at a level to finance about one-fourth of the cost of Part B, rise significantly faster because they are based on health care inflation, which rises much faster than general inflation.

Since 2000, Medicare Part B premiums have doubled, while Social Security COLAs have lagged far behind, with increases averaging under 3 percent. If this trend continues, Medicare out-of-pocket costs will consume one-half of the average Social Security benefit by 2021. If this prediction proves to be accurate, it won't make much difference whether physicians are willing to take new Medicare patients or not. Many seniors will find it more and more difficult to afford the Part B premium at all. This is why any expenditure which increases Part B costs must be looked at as a part of the whole, rather than in isolation.

Reversing the planned payment reduction, when combined with normal increases tracking health inflation, will significantly erode seniors standard of living. It would also merely postpone the problem, as physician payments are scheduled to decrease in future years.

Physician payments do not alone add cost to Medicare, of course. The treatment managed care plans also have a negative impact on traditional fee-for-service Medicare. A recent MedPAC report found that Medicare pays HMOs an average of 107 percent of what it pays to cover individuals enrolled in a traditional fee for service. Older, less healthy, seniors who are left behind in traditional Medicare help subsidize younger, healthier seniors in managed care. This makes Medicare less accessible to those seniors who need insurance the most: the frailest, the most economically vulnerable.

There are also two costly items in the Medicare Modernization Act instituted for the first time which are known as the "soft cap" for the Medicare program. The soft cap is designed to shift more costs from the Federal Government to seniors and could become a problem as early as 2007.

Finally, the new Medicare law for the first time tied the Medicare Part B deductible to health inflation. In only 2 years the deductible has already increased 24 percent, with further increases expected in the future. This increase could affect every senior who is covered under Medicare Part B. Whether or not they enroll in a Part B or not, this change should be revisited.

To conclude, Mr. Chairman, the National Committee believes in protecting access to health care services for seniors, both financial as well as physical. We urge Congress to keep both in mind as you consider provisions that affect the Medicare program.

Thank you, Mr. Chairman.

[The prepared statement of Hon. Barbara B. Kennelly follows:]

PREPARED STATEMENT OF BARBARA B. KENNELLY, PRESIDENT & CHIEF EXECUTIVE OFFICER, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. Chairman and Members of the Committee: Thank you for inviting me to participate in this hearing, to present the beneficiary's point of view in this discussion about physician payment rates.

The National Committee to Preserve Social Security and Medicare is the second largest organization representing seniors in this country. Our 4.6 million members and supporters come from all walks of life and all political backgrounds—what we share in common is our dedication to the preservation of Social Security and Medicare, two of the most successful social insurance programs in our nation's history.

Mr. Chairman, I am not here today to take a specific position on the various methods of reimbursing physicians participating in the Medicare program. Instead, as an advocate for seniors, I am here to remind this Committee and all Members of Congress that any decision you make relating to the Medicare program has a direct and powerful impact on millions of older Americans.

One of the reasons most seniors choose fee-for-service Medicare over managed care is because most older Americans like their current doctors, and have a strong desire to chose their own doctors. Many seniors have long histories with their family physician, not to mention a host of specialists, and they are loath to start anew with someone who is not extensively familiar with their medical history.

Although there are always cases of closed access, Medicare beneficiaries are generally able to see the doctor of their choice. According to a MedPAC report to Congress on Physician Services in March of this year, 88 percent of Medicare beneficiaries reported that they experienced no problem, or only a small problem, finding a primary care physician. This percentage was the same for privately insured seniors. And while 11 percent of seniors reported significant problems seeing the primary care physician of their choice, the percentage of privately insured patients in the same age category who reported significant problems was higher, at 13 percent.

Specialists were even more available, as 94 percent of Medicare beneficiaries and 91 percent of privately insured individuals reported either no problem, or a small problem, accessing specialists.

The reason access matters is because physicians are often the most important link between Medicare beneficiaries and health care. According to a 2003 CMS study, about 80 percent of non-institutionalized Medicare beneficiaries report that a doc-

tor's office or clinic is their usual source of care. Adequate access to physicians is therefore a key component to keeping seniors healthy.

It should not be a surprise that the threat of losing access to their physicians is one that seniors take very seriously. It is also no surprise that Congress takes this risk equally seriously, as you should. While the Senate has included a "fix" for the physician payment problem in its budget reconciliation bill, the House has not budgeted for this "fix". This seems to be an unrealistic assumption, as Congress has eliminated planned reductions to physicians in all but one earlier fiscal year.

But while we strongly believe doctors should be fairly compensated for their services, I would like to remind you of the flip side of that coin—access can equally be denied if seniors are priced out of the health care market.

Two out of three retirees today receive more than half of their income from Social Security, and for one out of five retirees, Social Security is their only source of income. Social Security is even more important to women. It makes up nearly three-fourths of the income of the average elderly widow, and ninety percent of the income of four out of five widows. This reliance on Social Security is unlikely to change significantly in the future, as only one-half of today's workforce has access to private pensions at work, and the mean 401(k) balance hovers around $50,000—hardly enough to finance a lengthy retirement.

Unlike private pensions, most of which do not have cost of living adjustments, Social Security's annual COLA helps seniors keep up with inflation. However, the Social Security COLA can only help so much, because it is based on annual increases in the Consumer Price Index. Medicare premiums, which are set at a level to finance about one-fourth of the cost of Part B, rise significantly faster because they are based on health care inflation. Beneficiaries pay 25 percent of any increase in Part B costs, and that has resulted in dramatic premium increases in recent years.

Since 2000, Medicare Part B premiums have doubled, with increases of 13 percent in 2004, 17 percent in 2005 and 13 percent announced for 2006. In the meantime, Social Security COLAs have lagged far behind, with increases averaging 2.7 percent. If this trend continues, the CMS Office of the Actuary predicts Medicare out-of-pocket costs will consume one-half of the average Social Security benefit by 2021.

If this prediction proves to be accurate, it won't make much of a difference whether physicians are willing to take new Medicare patients or not—many seniors simply won't be able to afford the Part B premiums at all.

That is why any expenditure which will increase Part B costs must be looked at as part of a whole rather than in isolation. The Social Security Office of the Chief Actuary has projected that converting a 4.3 percent reduction in physician payments into a 1 percent increase (as is currently in the Senate reconciliation bill) will result in a premium increase of $2.90 in 2007. While this may not seem like a dramatic increase standing alone, when combined with the additional increase already projected by CMS, this represents yet another significant erosion of seniors' standard of living. I would also note that such a provision would merely postpone the problem, as physician payments are scheduled to decrease further in future years.

Although not related directly to physician payments, I would also like to bring to the Committee's attention the impact of managed care plans on traditional fee-for-service Medicare. Managed care plans receive flat benefits per enrollee, rather than receiving compensation based upon specific services rendered. For that reason, regardless of the roadblocks Congress places in their way, they have a natural inclination to recruit younger and healthier seniors. These seniors are the most likely to be familiar with the concept of managed care, and the least likely to have long-standing relationships with specific doctors—this makes them the most receptive to managed care recruitment efforts.

As managed care plans siphon off healthier seniors, the older, less healthy population is left in fee-for-service Medicare, breaking up the risk pool that makes Medicare, as well as all insurance programs, work. A recent MedPAC report found that Medicare pays HMO's an average of 107 percent of what it would pay to cover individuals enrolled in the traditional fee-for-service Medicare program. All Medicare beneficiaries, regardless of whether they enroll in a managed care plan, subsidize these overpayments in the form of higher premiums. In effect, the older, less healthy seniors who are left in traditional Medicare are helping subsidize younger, healthier seniors in managed care.

This drives costs for the fee-for-service program higher, and makes Medicare less accessible to those seniors who need insurance the most—the frailest and most economically vulnerable.

Among MedPAC's recommendations is a proposal to compensate managed care plans at 100% of costs. We believe such an action would remove the most egregious incentive given to managed care plans, and minimize the subsidy participants in traditional fee-for-service provide to those in managed care.

Two final concerns I would like to bring to your attention relate to the Medicare Modernization Act. I know this is not a hearing on the new Part D prescription drug benefit, so I won't digress by discussing that issue, but there is a little known provision in MMA relevant to this hearing that I would like to briefly mention. As you may recall, MMA instituted, for the first time, what is known as a "soft cap" for the Medicare program. Under this soft cap, if at any point the Social Security Trustees project that the federal contribution to the Medicare program will exceed 45 percent within a seven year window of time, they issue an "excess general funding" determination in their annual report. If the Trustees issue two such findings in a row, a series of expedited procedures is triggered that requires the President and Congress to consider legislation that would reduce the federal contribution to the program.

I should point out that the expedited procedures do not apply to legislation that would increase payroll taxes, or change the 45 percent threshold, which was an arbitrary limit set without hearings or public input. The expedited procedures only apply to legislation that would cut benefits or increase premiums—either one would result in significant cost shifting from the federal government to seniors.

This year's Trustees report projected the first time the government share would exceed 45 percent in 2012—just outside the seven year window. Because the cost sharing ratio between beneficiaries and the federal government is 25 to 75 percent, any significant increase in program expenses hastens the day when the 45 percent limit will be reached, and increases the costs that will need to be borne by seniors to bring the federal share back down to the 45 percent limit. Unless increases in health care costs are contained, at some point, Medicare will become unaffordable for all but a few.

Finally, MMA for the first time tied the Medicare Part B deductible to health inflation. In only two years, the deductible has already increased 24 percent, from the flat $100 per year beneficiaries had paid for years, to $124 per year announced for 2006—with further increases expected into the future. This increase affects every senior who is covered by Medicare Part B, whether or not they enroll in the new Part D prescription drug benefit and deserves to be revisited.

To conclude, Mr. Chairman, the National Committee believes in protecting access to health care services for seniors, both financial as well as physical. We urge Congress to keep both in mind as you consider provisions that affect the Medicare program.

Thank you.

Mr. DEAL. Thank you.

Ms. Super.

STATEMENT OF NORA SUPER

Ms. SUPER. Mr. Chairman, ranking member Brown and distinguished members of the subcommittee, I am Nora Super, senior research associate at George Washington University's Center for Health Services Research and Policy. I appreciate the opportunity to be here today to discuss how to build a more efficient physician payment system for the Medicare program.

As a health services researcher from George Washington University, I studied many broad aspects of the Medicare program. Physician payment reform continues to be one of the most challenging and important issues facing the program today. Many experts have concluded that improving the quality of care ultimately requires changes in individual physician behavior. However, aligning incentives at the national level to reduce inappropriate care while simultaneously improving quality has so far proved elusive.

Under the fee-for-service system, it is faster and therefore more remunerative for physicians to order more tests or procedures than to spend time with patients, for example, discussing recommended preventive services to help them manage their chronic diseases.

Sicker patients with multiple chronic conditions are likely to take up more of a physician's time. Our current system does not reward physicians for spending time with these patients. In fact, it pro-

vides incentives to avoid them. At present, Medicare makes no distinctions based on appropriateness or quality of care. A physician who orders and performs procedures that are not truly necessary or indicated is paid better than one who is judicious and only employs complex interventions when the cost effectiveness is clear and the benefit clearly outweighs the risk.

Essentially, physicians who see more patients per hour, do more procedures, make and receive the most specialty referrals, make more money. In contrast, lengthy discussions with patients and family members to discuss treatment options or preventive care are reimbursed at much lower rates if at all.

In a recent case study I conducted of a multi-specialty practice physician group in Cincinnati that switched from capitation to fee-for-service after 30 years, physicians quickly responded to changing financial incentives by ordering more tests and seeing patients frequently, demonstrating that payment incentives can markedly change the way physicians practice medicine.

Let's look for a moment at an example of what we might gain if health care financing actually created incentives for physicians to spend time communicating with patients and their families. Palliative care is a growing service in hospital and nursing homes in the U.S. And is a response to abundant evidence of poorly treated pain and other symptoms for patients with advanced illnesses.

Interestingly, in addition to improving quality of care, multiple studies have demonstrated that palliative care, which involves talking to patients and family, managing complex symptoms and coordination and communication across settings, also reduces spending. Data demonstrates that palliative care lowers costs by reducing hospital and intensive care unit length of stay and by reducing direct cost per day. It achieves these outcomes in a low-tech but highly intensive and time-consuming discussion, clarifying goals of care with patients and their families and helping them select medical treatments and care settings that meet their goals. Yet, our payment system not only fails to incentivize high-qualify management of such payments with proven palliative care approaches, it powerfully rewards and encourages through it its payment methods just the opposite, more costly procedures, more specialist visits and more hospital stays for the patients least likely to benefit from them.

As the single largest purchaser of care, many have concluded that the Medicare program must begin to tie payments to physician behaviors that are demonstrably linked to better outcomes. Congressional leaders, CMS and MedPAC have all called for financial incentives to be targeted to promote high value and efficient resource use under Medicare's fee-for-service system.

While I applaud these pay-for-performance efforts as a critical step in the right direction, I encourage you, Congress, as others have suggested today, to not simply adopt programs that have been successful in younger commercial populations and assume they will transfer seamlessly to the Medicare population. Adjustments will need to be made to ensure that pay-for-performance does not create adverse incentives for physicians seeking to deliver high-quality care to patients with multiple chronic conditions and advanced

complex illness who account for over two-thirds of Medicare spending. Thank you very much for your attention.

[The prepared statement of Nora Super follows:]

PREPARED STATEMENT OF NORA SUPER, SENIOR RESEARCH ASSOCIATE, DEPARTMENT OF HEALTH POLICY, CENTER FOR HEALTH SERVICES RESEARCH AND POLICY, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

Chairman Deal, Ranking Member Brown, and members of the Subcommittee on Health of the House Energy and Commerce Committee, I am Nora Super, a senior research associate at George Washington University's Center for Health Services Research and Policy. I appreciate the opportunity to be here today to discuss how to build a more efficient physician payment system for the Medicare program.

As a health services researcher from George Washington University, I study many broad aspects of the Medicare program, ranging from implementation of the new drug benefit to coordination of care for those who are dually eligible for Medicare and Medicaid. Nonetheless, physician payment reform continues to be one of the most challenging and important issues facing the program today. Many experts have concluded that improving the quality of care ultimately requires changes in individual physician behavior.[1] However, aligning incentives at the national level to reduce inappropriate care while simultaneously improving quality have thus far proved elusive.

Drivers in Fee-For-Service Utilization

As you know, the vast majority of Medicare beneficiaries receive care under Medicare's fee-for-service system. In fee-for-service medicine, the incentives are clear: a physician or other practitioner charges separately for each patient encounter or service rendered. Under this payment system, expenditures and incomes increase if more units of service are provided or more expensive ones are substituted for less expensive ones. Thus, individual physicians have an incentive both to increase the volume of patients that they see, and to recommend the highest cost and best reimbursed procedures under these incentives.

Physicians, like anyone, respond to incentives. Under the fee-for-service system, physicians are paid based on the number of procedures or encounters provided and are paid much more generously for doing interventional procedures, such as coronary stenting or colonic polypectomy than they are for so-called evaluation or management services—time spent with a patient and family weighing the benefits and risks of alternatives and/or discussing treatment options.

I recently completed a case study of a multi-specialty physician practice group that switched to fee-for-service reimbursement after nearly 30 years as a capitated-based medical group in Cincinnati, Ohio.[2] The group did not do so willingly, but in response to an evolving marketplace that no longer rewarded small capitated products. Nevertheless, the physicians in the 100+ physician group quickly responded to the changed financial incentives by seeing patients more frequently and ordering more tests, demonstrating that payment incentives can markedly change the way physicians practice medicine.

Under the fee-for-service system, it is faster and therefore more remunerative for a physician to order more tests or procedures than to spend time with patients, for example, discussing recommended preventive services to help them manage their chronic diseases. Sicker patients, with multiple chronic conditions, are likely to take up more of a physician's time. However, our current system does not reward physicians for doing so. According to a study by Duke University Medical Center, the amount of time spent with a patient in discussing preventive services can increase three-fold if one or more chronic conditions are uncontrolled at the time of the patient visit.[3] Under the current payment incentive structure, physicians are encouraged to avoid these patients rather than to embrace them.

At present, Medicare makes no distinctions based on appropriateness or quality of care—a physician who orders or performs procedures that are not truly necessary or indicated is paid better than one who is judicious and conservatively employs complex interventions only when the cost-effectiveness is clear and the benefit clearly outweighs the risks. Essentially, physicians who see more patients per hour, do more procedures, and make and receive the most specialty referrals, make more money. In contrast, lengthy discussions with patients and their family members to discuss treatment options are reimbursed at much lower rates, if at all, for roughly the same amount of physician time. For example, the national average Medicare reimbursement for placement of two coronary artery stents via cardiac catherization was $1,012 in 2002; a two-hour family meeting was reimbursed on average between $75 and $95.

One of the explicit objectives of the Resource Based Relative Value Scale (RBVBS) physician fee schedule that was implemented in 1992 was to redistribute payment in such a way that rates for "cognitive" or "evaluation and management" services (as they are called today) would rise relative to other services, such as surgery and other procedural services. However, preliminary work done by the Urban Institute on behalf of the Medicare Payment Advisory Commission has found that the desired redistribution has stopped for a number of reasons, primarily the interaction between changes in the relative value units (RVUs) and the growth in the volume of services, as well as the effects of introducing new services.[4]

Valuing Physician-Patient Communication: Palliative Care as a Model within the Current System

An example of the benefits of care focused on quality of life, maximizing clear doctor-patient communication, and expert coordination of care across settings may be found in the recent rapid growth of palliative care services and specialists in the U.S. Through research funded by the Center to Advance Palliative Care—a national program initiative of the Robert Wood Johnson Foundation based at the Mount Sinai School of Medicine in New York City—I have learned that meeting the needs of the most complex and vulnerable Medicare beneficiaries will require physicians to employ skills that are not recognized or rewarded in the current Medicare payment system.[5] Studies of doctor-patient communications have found that clinicians typically fail to discuss patients' values, goals of care, and preferences regarding treatment.[6] Not only are these skills rarely taught in medical school, any physician who tries to provide these services will soon be forced out of practice due to under-reimbursement. Physicians in practice quickly learn what they have to do to pay their overhead and themselves—see more patients faster and spend most time doing the highest-paid procedures. Talking to patients and families, managing complex symptoms, coordination and communication of care across settings—the kind of care patients and families say they want[7] and what most of us would agree we would want for ourselves and our loved ones—is a sure path to bankruptcy under the current physician payment system.

Let's look for a moment at what we might we gain if health care financing actually created incentives for this kind of high quality care. Palliative care is a growing service in hospitals and nursing homes in the U.S., and is a response to abundant evidence of poorly treated pain and other symptoms. It aims to relieve suffering and improve quality of life for patients with multiple chronic conditions and advanced illnesses. It is offered simultaneously with all other appropriate medical treatment and is not limited to the care of the terminally ill. In practice, palliative care involves expert pain and symptom assessment and management, communication among the patient, family and providers about the goals of care, and coordination of care across multiple settings.[8] Studies demonstrate that palliative care is effective at reducing suffering of all causes, and those patients and families are more satisfied when they receive it.[9]

Interestingly, in addition to improving quality of care, multiple studies have demonstrated that palliative care also reduces spending. Data demonstrate that palliative care lowers costs (for hospitals and payers) by reducing hospital and intensive care unit length of stay, and by reducing direct costs per day (such as pharmacy and imaging utilization).[10] Palliative care achieves these outcomes in a low-tech but highly intensive and time consuming discussion—clarifying goals of care with patients and their families and helping them select medical treatments and care settings that meet their goals. This kind of in-depth conversation about the benefits and burdens of treatment alternatives often lead to more resource-conservative decisions on the part of patients'—such as going home rather than remaining in the hospital—but there is no way to help patients and families make these difficult decisions without a major commitment of physician time and effort—time and effort which is rewarded at less than 10 percent of the level we reimburse invasive cardiologists for placing coronary stents.

These findings are especially significant for patients with chronic illnesses. We know that Medicare per capita spending increases as health status declines. For example, Medicare spends twice as much for beneficiaries living in long-term care facilities than what it spends for those living in the community. Medicare spending is also much higher for the sickest beneficiaries—those in their last year of life. In 1999, Medicare spending reached $24,856 for beneficiaries who died that year compared to $3,669 for those who were alive at the conclusion of the year.[11]

More than 80 percent of Medicare beneficiaries have at least one chronic condition, and the prevalence of chronic conditions, which typically require ongoing care and treatment to maintain health and functional status and to slow the progression of the disease, has been strongly linked to high utilization of medical resources.

More than 75 percent of high cost Medicare beneficiaries were diagnosed with one or more of seven major chronic conditions (e.g., chronic obstructive pulmonary disease, congestive heart disease, diabetes).[12] A striking 68 percent of all Medicare spending is spent on the 23 percent of Medicare beneficiaries with five or more chronic conditions and these patients receive services from an average of 14 different physicians each year.[13] The clinical need for care coordination is immense.

Yet our payment system not only fails to incent high quality management of such patients with proven palliative care approaches, it powerfully rewards and encourages through its payment methods just the opposite—more costly procedures, more specialist visits, and more hospital stays for the patients least likely to benefit from them. Jack Wennberg's data from the Center for Evaluative Clinical Sciences at Dartmouth suggests that the higher utilization that results from current Medicare payment incentives is not only not associated with improved quality of care for seriously ill Medicare beneficiaries, counter to the prevailing assumption, more services are actually associated with *higher* (not lower) mortality. In contrast, a healthcare system that provided comprehensive palliative care as the default approach, rather than the exception, would result in more satisfied patients and families, a lower burden of pain and suffering, equivalent or better survival rates, and markedly lower but more appropriate use of complex high cost procedures and care settings.

Changing the Incentives: Is Paying for Performance the Answer?

The latest fascination in Washington and in the business community has been a move to influence physician behavior by paying for health care services based on quality of care. "Pay-for-performance" seeks to reward physicians and other health care providers for delivering health care services that meet specified standards or achieve defined levels of quality. These payment methods have been adopted across the country by public and private purchasers with some demonstrated success; however, they face important impediments and challenges too. Most notably, the incentives are not likely to change physician behavior unless they apply to "enough patients to make a noticeable difference in office income."[14]

As the single largest purchaser of care, many have concluded that the Medicare program must begin to link payments to physician behaviors demonstrably linked to better outcomes. CMS has several pay-for-performance pilot and demonstration projects underway. Congressional leaders and the Medicare Payment Advisory Commission (MedPAC) have also stepped up efforts to align the incentives of Medicare's payment systems to improve the quality of care. A key component of MedPAC's vision for paying for performance is that Congress "should pay more to physicians with higher quality performance and less to those with lower quality performance."[15] Recognizing that the current FFS payment system encourages individual physicians to increase the volume of services they provide, MedPAC also recommends measuring physician resource use over time and providing information about practice patterns confidentially to physicians. Given that Medicare payment systems are currently negative or neutral toward quality, these efforts are important steps in the right direction.

At the same time, clinicians and advocates have raised concerns that P4P could create adverse incentives for physicians seeking to deliver high quality care to patients with multiple chronic conditions and advanced complex illness.[16] Quality of care for this very costly and very sick patient population involves more than remembering to order a mammogram—one of the measures associated with higher pay for performance. In fact a mammogram, or a bone density test or a gait assessment may be impossible or completely irrelevant to the care of some of these patients—such as a bed-bound person with advanced dementia and recurrent pneumonias. Despite the fact that this highly complex chronically ill population accounts for over two-thirds of Medicare spending, the physicians caring for them will be predictably paid less for failing to conduct these procedures, even though they are delivering high quality care tailored to the needs of this particular subset of beneficiaries. An undifferentiated P4P process could create strong monetary incentives to care only for younger healthier Medicare beneficiaries, those for whom the P4P quality measures were developed and in whom they make sense. If P4P is to be relevant to the costliest Medicare beneficiaries it will have to utilize measures truly correlated with quality care in this patient population—things like assessing and treating pain, conducting family meetings, and completing advance directives. Thus I conclude that we cannot simply adopt programs that have been successful in (younger) commercial populations and assume they will transfer seamlessly to the Medicare population. Adjustments will need to be made.

Conclusion

Medicare's attempt to control volume through its sustainable growth rate (SGR) system has been widely recognized as flawed. National volume controls, such as the SGR, are based on a faulty assumption—that physicians have a collective incentive to reduce the volume of services. To the contrary, when fees are reduced, individual physicians have an incentive to increase the number of services they provide in an effort to keep income steady. Thus, across-the-board fee reductions ultimately penalize the most prudent physicians and reward those who do more procedures and provide more, not necessarily better, services.

We cannot assume that the market alone will ensure that appropriate services are rendered. Indeed, cost escalation is almost guaranteed without some controls. A thought-provoking analysis of 12 markets over time by prominent researchers at the Center for Studying Health System Change concluded that market forces alone were limited in their ability to deliver efficient health care systems, mostly because of local provider market power vis-à-vis payers and patients.[17] As both public and private purchasers look for ways to align the incentives to improve the quality of care as well as reduce inappropriate care, financial incentives should be targeted to promote high value and efficient resource use under Medicare's fee-for-service system. The demonstration and pilot projects being undertaken by CMS in the fee-for-system to study ways to improve care for beneficiaries with high medical costs and chronic conditions will give us important information about how to better care for patients.[18] However, the underlying physician payment system—and the incentives inherent within it—must be addressed if we are to achieve any significant improvements over the long term.

The Medicare system of the future should assure access to a well trained primary care physician who is compensated as well for his time and effort as his colleague doing cardiac catheterization across the street. If society rewards high quality primary care physicians, allowing them to make a good living commensurate with their lengthy training and sufficient to repay their medical student loans, the best and the brightest will stop flocking solely to highly subspecialized and highly compensated procedural specialties. Data from the new field of palliative care suggests that comprehensive management of the sickest and most complex patients not only measurably improves quality of care and patient satisfaction, but does so at substantially lower cost to Medicare. This kind of rational system—where chronically ill elderly patients and their families can reliably expect expert continuity of care—is within our reach. If we want to effectively redesign the Medicare payment system, we need to make sure we pay for the performance Medicare beneficiaries really need.

Notes

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[2] Super, N. "From Capitation to Fee-For-Service in Cincinnati: A Multi-Specialty Practice Group Responds to a Changing Marketplace," *Health Affairs,* forthcoming.

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[4] Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program,* June 2005.

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[16] Boyd, C., Darer, J., Boult, C., Fried, L., Boult, L., and Wu, A. "Clinical Practice Guidelines and Quality of Care for Older Patients with Multiple Comorbid Diseases: Implications for Pay-for-Performance," *JAMA,* 2005: 294:716-724.

[17] Nichols, L. *et al.* "Are Market Forces Strong Enough To Deliver Efficient Health Care Systems? Confidence is Waning," *Health Affairs,* 2004 23(2) 8-21.

[18] See information on CMS website regarding the Medicare Health Support Programs (MHSPs) and the Care Management for High Cost Beneficiaries (CMHCB) demonstration (www.hhs.cms.gov).

Mr. DEAL. Thank you.

It was worth waiting to hear your testimonies.

I think you have all pretty well laid out the problem. As I listened to your testimony, we get from within the medical profession itself some very different opinions. Dr. Opelka being a surgeon is in effect saying that our current system doesn't adequately compensate in the non-ambulatory environment. And then we hear, in the ambulatory environment, Dr. Arora saying there is no incentive to go in that area, and we hear well, that is the only area of the practice where you can sort of self-help with additional charges for services or testimony or whatever. And then we all want to be sympathetic to dealing with the problem that has been outlined from the AMA position and yet appropriately Ms. Kennelly points out to us if we raise those fees, that has an impact on the part B premiums and actually beyond that even into the private pay community as a whole. So you have thoroughly explored the problem that we have.

Let me briefly see if I can try to see if we can come up with some solutions to it. Ms. Super, I am very intrigued by the study that you did. I think that it is great that you have taken on a project of trying to look at that and hopefully come up with some solutions. How would you go about incentivizing palliative care, to incentivize not making the extra imaging that may or may not be necessary, without calling it something that sounds like pay-for-performance?

Ms. SUPER. Well, I thank you very much for your question, Mr. Chairman. I think if we want to look at the fee-for-service system, that there are ways we can look at the coding, programs that incentivize physicians to order procedures and tests rather than spend time with patients, and so time-sensitive codes. There have been some efforts that some physician groups have advocated and have talked about in terms of care coordination and working in terms of some partial capitation, talking about different ways that a physician could be designated as the one physician that is coordinating the care for beneficiaries, for example, that might have a certain number of chronic conditions.

If you looked at beneficiaries that had two, three or four chronic conditions which have been identified by the Congressional Budget Office—someone had said earlier scoring is an issue—as being the highest-cost beneficiaries that we have, perhaps identifying those high-cost beneficiaries that we know cost our system so much money and targeting those beneficiaries and perhaps putting them into programs and identifying some of the physicians to coordinate their care for us and looking at those types of programs.

Mr. DEAL. Dr. Cady, would that be something that has merit?

Mr. CADY. I do think we should look at programs like that. One of our concerns would be that if you compartmentalize patients, that you may be restricting care for those that need it also if you are not careful. So coordination plans need to be carefully worked

out between the team and a team effort. I think Dr. Opelka talked about a team effort, and he supports that. Any growth that is inappropriate needs to be looked at and taken care of; we agree with that.

Mr. DEAL. Dr. Opelka, it almost sounds like we are talking about having to devise maybe two different ways of compensating for medical services depending on the type of medical service that is provided because they are so different. Is that something that we should be looking at?

Mr. OPELKA. Mr. Chairman, thank you. I do believe that maybe it is more than two. In our own practices where we have complex ambulatory and hospital-based activities, we have hospital-based physician services. We have a crossover between them. We don't see solutions as one size fits all in those environments. We all know there are different forces tugging at each one of these elements of patient care.

I think we need to start with the patient and build a quality valued system and fund that quality valued system for the costs that are built into that system. We are trying to actually take the round peg and fit it in the square hole or the square into the round, and it is not happening. And we were with volume standard performance and utilization controls at one point, then gone into the SGR, and now we are at a point where we are saying this ought to be evidence-based, and I think you will find various types of evidence. It needs to be system and process developed and in a hospital-based system where you have got part A funding and part B funding all centered around one person, that patient; we need to put a system that wraps this together. That is going to be different from long-term care, chronic care, ambulatory care models, and I think working with CMS, we have opened a lot of doors with this pay-for-performance initiative. We are excited about that, and we think we ought to put our arms around this and look for a solution. If we need a 1- or 2-year window to do that and you want to set benchmarks where we have to hit benchmarks with performance to show where we are going, that is where we want to be.

Mr. DEAL. My time has expired. Maybe someone will explore that a little further.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. There is sort of a bigger question that is begged by the appearance of all of you here, and I thank you all for good presentations, and you all make sense, and you are all right in your own way. The bigger question is that this Congress, this committee, this government, this President have found a way without, I don't see, rancor among the five of you or the six of you before, but has found a way to play off doctors against seniors when you look at what has happened to Medicare premiums, in part because of this formula, premiums 6 years ago, my recollection, $46, $47, now they are $88, and I hear doctors all the time at home talking to me about their problems, their very legitimate problems, but Congress has created this pitting seniors against doctors because we do tax cuts for the wealthiest people in our country, many of them for doctors; we are in a war that costs us a billion dollars a week that the President's Secretary of State says we may be in for 10 years.

So I don't expect the AMA nor any of you to lobby Congress in opposition to the tax cuts, although I wish you would because I think we could fix a lot of this more easily, and I don't expect the AMA or other doctor groups to lobby against the Iraq war and speak out against it, although that could be your role as citizens, and I am not here to lecture you, but I look at this picture, and that is what is wrong with this picture. We haven't fixed these problems anymore than the Medicaid situation because this government doesn't have the money to do it because we do extraordinarily stupid things that have nothing to do with you but have everything to do with that bigger picture.

So enough of that, except that I would urge all of you to help us address some of those bigger problems and correct the direction that we seem to be going in that sets this situation up.

I guess I just, everybody on this panel, both parties, is very sympathetic in wanting to fix this. As Mr. Waxman says, I don't know why this Congress won't fix it permanently except for the budget issues.

I want to talk to Ms. Kennelly and ask her to give me sort of your opinion of what has happened and how we make sure that this is fixed so that this fix doesn't have the impact on premiums that it could have.

Ms. KENNELLY. Congressman Brown, I have to disagree with you about seniors pitted against doctors because I have worked with seniors since I went out in public life as a city councilwoman in Hartford, and seniors really do like their doctors.

Mr. BROWN. I am not arguing that. But this is what happens.

Ms. KENNELLY. I can remember when we wanted doctors to take assignments. You couldn't get seniors to tell a doctor to take an assignment because they thought the doctor was right. So that relationship is good. I think one of the problems is not Medicare, not Medicaid; it is the whole health system that is fractured. And that is what we really should be looking at.

And the other thing we have to look at very seriously that will affect seniors is the fact there is no cost containment in part D, and it really goes up with health inflation. And that is going to be very detrimental to seniors because so much health care now is through prescriptions. But I think the answer, we have squeezed Medicare and squeezed Medicare. We have got people going on Medicaid because private companies have dropped their health care benefits. So I have to tell you and I maybe did not feel this way in 1994, but I really think we have to look at the entire health care system if we are ever going to talk about the aging of America.

Mr. BROWN. Comment, Dr. Cady?

Mr. CADY. Thank you, Congressman Brown. I want to make something clear, and I know Ms. Kennelly is aware of this; doctors want to take care of their patients, whether they are seniors, not seniors, doesn't matter. That is what we are trained to do. That is what this young doctor was train to do. But when the reimbursement formula doesn't even cover practice costs, it is hard to keep your office open.

So what we are saying is adopt physician payment updates for 2 years, give us a chance to work with you and CMS on a perma-

nent fix for this problem, and we can also discuss in the future value-based quality issues.

We worked on this. We have the consortium at the AMA which CMS participates in. We developed something like 70 measures, 36 of them approved and many of them waiting for NQF approval. So all of those things are in the hopper. But if we don't stabilize the reimbursement situation, doctors are not going to be able to practice, some of them; some of them will retire, some of them will find a new profession; some of them will not be able to see new Medicare patients.

I am a Medicare patient. My doctor 3 months ago told me, you need an evaluation by a primary care internist. I am a procrastinator like everybody else, and they called the doctor's office first, couldn't get an appointment. I called the doctor's office myself, as a physician, could not get an appointment for 3 months. Why? Not because I was a physician, not because I was chairman of the board of the AMA, because I was a Medicare patient. So it is out there, and it has affected me, the access problem. And it can be fixed. Congress can fix this problem if you have to find the money.

As far as the seniors are concerned, we would agree, if you can find the money for that, we certainly wouldn't oppose holding the beneficiaries harmless on the issue.

Mr. DEAL. Thank the gentleman.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman, and thank you gentlemen and ladies for taking time to be here today. I just hope some good comes out of it. We often times talk about each other, that we should be more open-minded and open to new ideas and that sort of thing so when it comes to this pay-for-performance business, at first blush, I think a lot of us say, hey, that is probably virtually impossible to work well and that sort of thing, but the truth of the matter is we should be open-minded.

But having said that, in very brief responses, would you agree that, first, we ought to fix this particular problem of Medicare reimbursements before we even consider something like that. Dr. Opelka?

Mr. OPELKA. Absolutely agree with you.

Ms. ARORA. Absolutely agree.

Mr. CADY. Absolutely.

Ms. KENNELLY. Agree.

Ms. SUPER. Agree.

Mr. BILIRAKIS. That is good to hear. Regarding this subject, very quickly again, because you are here to help us, I remember a few years ago that it was a congressional trip but that included Dr. Roland from Georgia, a medical doctor, primary care physician who was in Congress at the time, and we were delegates to NATO. And the meetings were in Athens, Greece, at the time because they keep rotating around, and so we had a break, 1 day's break. And I suggested, Roy, wouldn't you like to go see where Hippocrates first started his concept of medicine, and it is on the island of Kos right near the island that my parents come from.

Anyway, the guide took us around to show us a hospital, and the remnants of that hospital are still there, and then the guy told us he never lost a patient, and then he proceeded to explain to us, of

course, he wouldn't take any patients that were really sick and so he had a perfect record.

So we go now to pay-for-performance. I guess I am using the term cherry picking when I say that. So is there a real danger of that? Hopefully, Dr. McClellan and others coming up with these ideas will take all that into consideration because I know we have hospitals in some low-income areas, hospitals that will take basically any patient and whatnot, and they are not going to have near the record a private hospital which is in a higher area would have. So, hopefully, we will take all that into consideration.

Dr. Arora, first, I want to commend you for being a primary care physician, and principally, I say that because my oldest son is an internist, as you may know, and I was telling Mr. McClellan earlier that, in all these years, he has been in a perfect position to lobby, particularly when I chaired this committee for 10 years, and he never did. He just wouldn't take advantage of the situation.

But more recently, he finally has become very verbal, and that has to do with this reimbursement business, and he says, dad, we see them all. We see all the patients. We refer everybody they take. The other day he was telling me x-rays are taken, CAT scans or whatever the case may be, and if there seems to be a little bit of a change in the treatment, has to go back to the primary care physician and what not. Then I know he hasn't told me, but I know about the house calls he makes by his patients. I know about the times he goes to the pharmacy personally and purchases pharmaceutical drugs for people and delivers them to their homes because they are elderly, and they can't get around.

So you guys are really something pretty darn special, as are all physicians obviously, but we do know there that there are bad apples in every bushel. Maybe I shouldn't use that term, and Dr. Burgess here will probably correct me, but there are doctors who take advantage of the system, are there not?

Ms. ARORA. Yes. I would first like to take your first question regarding, just to tell you a little bit about my practice environment. Many patients that I personally see have chronic medical problems, five medical problems; they are Medicare patients, on over 10 drugs, and so they are very sick, and even in our own practice, we worry that implementing pay-for-performance type of programs without adequate risk adjustment that is properly explained, we would be penalized and look like the bottom of the barrel because we are trying to work with our patients who can't understand how to take their medications and who actually may be non-compliant because they can't afford their medications.

Mr. BILIRAKIS. Why? You are not compensated for that?

Ms. ARORA. I wanted to highlight if there is a question about the need.

Mr. BILIRAKIS. I have spent a lot of time in his offices. I have seen that.

Ms. ARORA. The other thing I think all physicians are trained with the ideals of the great physicians of years ago, and we all try to do what is best for our patients. Nowhere do we ever learn that we—actually, part of medical professionalism is that we put the patient first, ahead of ourselves, and our entire medical training is really designed that way. We spend many sleepless nights in the

hospital learning about the virtues of following a patient, following patients in our clinic. And so I guess what I would say is that I can't be accountable for everybody in the system, but I know that there are lots of really good doctors out there and a lot of really good physicians that try to practice really good primary care and an environment where they just can't make it because we can't do this and also continue to try to take care of our patients at the same time we are worried every year that our salaries are going to be cut.

And I have been involved with the ACP for several years now and have had the opportunity to travel to Capitol Hill and meet with my Congressman, and the first time I learned about SGR was on one of these trips. And now I am here, I am still here a year later, 2 years later, talking about this same issue, and what I would like to see is some stability in this process so that we are not here again next year, so that we have some stability which would mean positive updates over at least 2 years, and that is just a short-term outcome. A long-term fix would be that we get rid of this SGR completely, and I know it will cost money, and I am sympathetic to the case of the seniors. Obviously, it will cost money, but I want everyone to kind of think about this as a long-term investment in the future of America's health. I mean, this is going to be dismal if we can't go see primary care physicians to coordinate care and to work on that. And it is especially important because many primary care physicians, when it is done right, it can lower the cost. And we have data that shows that, and I think it is really important that we make sure people get to primary care physicians who can actually deliver that type of care.

Mr. BILIRAKIS. Thank you, Doctor.

I apologize, Mr. Chairman, but she was on a good role there, and I think that was all we need to hear.

Mr. DEAL. She has been neglected up to this point; I didn't want to cut her off.

Ms. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman.

I want to thank each of the panelists for taking your time to come and educate us and Members of Congress.

Dr. Arora, thank you particularly for your last statement, which was right on the money.

Dr. Cady, I want to take a moment to commend you, the AMA, as a trustee of the AMA, for the statement you submitted to the Medicaid Commission. That statement, and I have it here, that statement underlined the need to protect benefits for children, pregnant women, seniors and the disabled. It highlighted the need to avoid increases in the uninsured.

And despite statements by many colleagues of mine that Medicare physician issues had no place in the reconciliation—I'm sorry, say that again because it is a bone of contention today, despite statements by my colleagues that Medicare physician issues have no place in—had no place in reconciliation, your statement made clear that physician fee cuts are integrally related to Medicaid cuts. Unfortunately, the House reconciliation package ignored all of your comments. It still contains proposals that will make Medicaid too expensive for beneficiaries, still eliminates guaranteed health care

for children that the AMA supports, and 50 percent of the savings and cost sharing will come from charging children.

The changes the majority has made are cosmetic; their only purpose being, I believe, to add to the confusion of Members of Congress just like Medicare beneficiaries are now being confused by some recent changes.

So I am going to ask that the statement by the AMA be made part of the record for our proceedings here today, and I thank you for that. I am going to turn to my former colleague.

Mr. BURGESS. Do we have a copy?

Mrs. CAPPS. I am going to be asking that it be made part of the record, and I have copies to share with our members.

[The information referred to follows:]--AMA STATEMENT HERE--

Mr. DEAL. If you would share so we can be looking at it.

Mrs. CAPPS. Surely. I want to address a question to my former colleague Barbara Kennelly. While this hearing is focused on Medicare today, many of us in Congress and many of your constituents now, too, as you advocate for both Medicare and Social Security, are concerned with what is going on with this important program to millions of our seniors, Medicaid; some of the beneficiaries of Medicaid are Medicare recipients as well.

As you know, there are a number of proposals in our bill which has been reported out of the committee and may be actually voted on this afternoon in the full House that would be very harmful to seniors. For example, increasing copayments on necessary services, allowing States to severely reduce benefits, as an example, and imposing harsh penalties on disabled and elderly who are penniless and need Medicaid's coverage of nursing care and other long-term services.

I want to ask you now, we heard the other panel members talk about the profession that is so vital in Medicare. If you could comment on the beneficiaries and their experience in this House reconciliation bill.

Ms. KENNELLY. Thank you, Congresswoman Capps. I want to commend you for putting that statement in. Dr. Cady and I spent, last month, a couple of days together on Medicaid with a group that was brought together to address these things, and I know that statement, and it is excellent.

Yes, our seniors are concerned, and we hear from them constantly. We have ten people answering the phone all day with our members and talking to them. Any increase, I know it doesn't sound like much, $3 to $5, but when you are living on an incredibly fixed income, it is something. And not only is it the amount of money that you have to worry about, they will just say, never mind, and they won't get their medicine. That is the problem.

The other thing that we hear from our members on is the whole long-term care situation and putting up the time when your assets will be looked at. I know, and I can remember when Medicaid began, I can remember when—it was really quite profound how many assets they put to their children so they could go into a home and get put on Medicaid.

That doesn't happen very much any more. Most States have made good laws so that they can keep the abuses really down to

a limited amount and to have people go into a nursing home and then have their assets begin going back 5 years, and they can't remember what those assets even were, and they are in the home, and then they are not able to pay. So those changes are very worrisome to us, and we do hear from our seniors on it.

But what you have to say about Medicaid, we do focus groups. And I want to tell you something, not too many people know about Medicaid or understand it unless you are on it or family member on it. The point is, nobody wants to be on Medicaid. They are our poorest people, most vulnerable, and we have to make every effort that we don't make their lives worse by taking away one of the few things they have, and that is health care.

Mrs. CAPPS. I yield back the balance of my time.

Thank you very much, all of you witnesses.

Mr. DEAL. Dr. Burgess.

Mr. BURGESS. I thank the Chairman.

I thank the panel for their tenacity and their enthusiasm, for being here today.

Ms. Super, you talked about the study you did going from capitated to a fee-for-service environment. Did you have a copay when you were under a capitated system? Was there an across the counter charge to get in to see the doctor, or was there no copay in the capitated system that was under study?

Ms. SUPER. I didn't study the copay system. It was mainly looking at how the physicians were paid under a multi-speciality practice group, and so it wasn't so much looking—I can't answer that question, I am sorry. It was mainly looking at how the physicians were paid.

Mr. BURGESS. As that change occurred from a capitated system, I presume that was like a staff model HMO that you were studying and then went to a fee-for-service environment, and you found that utilization went up. Do you think the utilization went up because needed services weren't being provided under the capitated system or that health care profiteers were abusing the system under a fee-for-service side?

Ms. SUPER. Well, it was a little bit of both. I would say that the conclusions of the study were that neither fee-for-service nor capitation are perfect models, and I think that what we found was that physicians respond to incentives very strongly, and that under the capitated model, there may have been some under-utilization of services; that they were not incented to see the patients as frequently, that they didn't necessarily stay as long each day, that they didn't have to meet with them as frequently. And as soon as they went to a full—they were at risk with the patients to whether or not—when the patients would come in under capitation, the physicians were at risk, and that seemed to be the indicator of what made a difference. Once the physicians went under a model where they were compensated based on the number of patients that they saw and the number of tests that they ordered, that made a complete difference on their practice patterns and so——

Mr. BURGESS. Doctors, of course, are not stupid.

Ms. SUPER. Right.

Mr. BURGESS. Now you talk about incentivizing, and I am glad to hear you use that word. In a lot of instances, that does mean paying for time.

Ms. SUPER. Exactly.

Mr. BURGESS. There are areas in our system where we don't compensate for time, and if we are going to be serious about our move to medical information technology, I know my own experience with going to a computerized prescription writing program, that it added about 1 to 2 minutes per patient. And when you are seeing 30 to 45 patients a day, you can do the math, and someone has got to pay for that 1 to 2 hours that you have added onto that doctor's day.

If I could, Dr. Arora, let me ask you, and I appreciate very much you bringing your four principles to the committee. Surely, we will study these. Several of them we are probably well on our way to doing without your advice, but at the same time I thank you for bringing them because your concerns are some of the most important because it is physicians your age. Dr. Cady and I are at the far end, but you are at the beginning of your career. And it is important that we pay particular attention to what physicians your age are thinking and what physicians your age are needing.

To your point about comprehensive strategy for developing or reversing decline in physicians going into primary care, of course, you hold a lot of those cards in your hand, and it will be your involvement, your continued involvement in the policymaking process and your development as a physician leader for your peers that will be so critical in keeping young physicians as they come up through the ranks interested in going into primary care. So I do thank you for what you have brought to the committee, and I promise you we will give that serious consideration.

In the last seconds that I have, Dr. Cady, as a general surgeon, have you yourself, do you think you have seen instances where access to care has been limited to the diminution in physician reimbursements?

Mr. CADY. Absolutely.

Mr. BURGESS. Have procedures themselves been shunned because they don't pay as well as they used to? Some doctors still see Medicare patients but not do the more complex procedures.

Mr. CADY. No, not in my own practice. That was not an issue with me as a general surgeon. If a patient needed a gall bladder out, if it was appropriate and indicated, we did it regardless. But I have seen my daughter, who is an otalaryngologist, and my son, who is an anesthesiologist, having difficulty with the Medicare reimbursement formula.

At my stage of my career, as you mentioned, this is not so much an issue with me individually, but I am concerned about her, and I am concerned about my two kids as they try to practice medicine, meet their practice costs.

The graph there, I think, is critical. To me as a surgeon, it is very simple to understand. Practice expense goes up, reimbursement goes down and the gap gets wider, and it costs more every year that we avoid fixing the SGR and replacing it with the medical economic index, like the hospitals and the other people do.

So it is a critical issue for you, and I am sensitive to the difficulty, but at the same time, I am sensitive to the patients out there that are going to have access problems.

Mr. BURGESS. One of the things I would like to mention, I know you work with AOA. You might consider working with AMA and looking into developing tools for calculating practice costs. I know that was one of the most difficult tasks that I had in my office. If someone says, how much does it cost for you to deliver a baby, it was a tough figure for me to come up with because we just don't think along those lines.

So if you can develop some of the tools for doctors to use to help young physicians know as they set up their offices, if you were going to do an electrocardiogram in your office, this is what it is going to go cost you, that way Dr. Arora will know what to charge, and not just you want to cover overhead, you want to pay her for her time.

I will yield back, Mr. Chairman. You have been very indulgent.

Mr. DEAL. Thank you. I believe we have reached the end of this very long day for all of us. We thank you. We realize the sacrifice you make of your time and your effort to get here and to be present for us to hear from you and to ask you questions, and we truly appreciate that and express our appreciation to you. And to the representatives of the organizations, please extend our appreciation.

Mr. BILIRAKIS. The one chart there, if you can call it that, the map of the United States, that is not in your written testimony.

Mr. CADY. It is a very simple map of each State. The top number is how much.

Mr. BILIRAKIS. But we don't have a copy of that.

Mr. CADY. We will get a copy of it. The top number is the amount your State of Florida will lose in 2006, and the bottom number is how much they will lose over the 2006 to 2011 period, and it is significant.

Mr. BILIRAKIS. Thank you. I already know that.

Mr. DEAL. I am sure he will make sure we get copies of those. Thanks to all of you again.

With that, this hearing is adjourned.

[Whereupon, at 3:48 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

December 23, 2005

The Honorable Edolphus Towns
Subcommittee on Health
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Re: Medicare Physician Payment

Dear Congressman Towns:

This letter is in response to the questions you sent us on December 13th. Answers to your questions are as follows:

(Q1) "Is there a cost effective alternative that does not subject physicians to spending targets?"

The Congress has a choice about a volume control policy for physician services. The existing policy—the SGR—is flawed. Because it is a national target, there is no incentive for individual physicians to control volume. Further, the SGR is inequitable because it treats all physicians and regions of the country alike regardless of their individual volume-influencing behavior. Yet another problem is that the SGR treats all volume increases the same, whether they are desirable or not.

Given the SGR's flaws, the Commission's preference is to directly target policy solutions to the source of inappropriate volume increases. We recognize, however, that the Congress may wish to retain some budget mechanism linked to volume. In our March 2005 Report to the Congress, we presented potential ideas for volume control methods that encourage more collaborative and cost effective delivery of physician services in accordance with clinical standards of care. These ideas include:

- creating one or more alternate pools based on membership in organized groups of physicians,
- dividing the United States into regions and adjust the annual conversion factor based on changes in the volume of services provided in each region,
- setting targets based on the performance of hospital medical staffs, and
- adjusting fees differentially by service or types of service.

All of these ideas raise many questions about design, implementation, and policy. MedPAC has not endorsed any of these approaches, but we will explore them further if the Congress is interested in investigating them.

Alternatively, if the Congress decides that a volume control mechanism is not appropriate, several ideas might be worth exploring. One idea, used by the private sector, is using quality pay for performance and measuring resource use together -- where resource use explicitly takes into account the volume of services for which a physician is

responsible. A second idea being developed by the private sector is to create high performance networks of physicians who provide high quality at a lower cost and create incentives for beneficiaries to use them. A third idea we are monitoring is being studied by CMS in a demonstration that holds physician groups responsible for both Part A and Part B spending and quality, and rewards or penalizes them based upon the outcomes.

(Q2) "If the SGR is calculated without the price of Part B drugs, what impact will this have on the payment system and the public health of Medicare beneficiaries?"

The Commission cannot quantify the effects of excluding Part B drugs from the SGR calculations. The Congressional Budget Office and the Office of the Actuary at CMS are in a much better position to do so. In addition, the Government Accountability Office issued a report in October 2004 titled "Medicare physician payments: Concerns about spending target system prompt interest in considering reforms." This report addressed alternatives to current policy that included omitting Part B drugs from the SGR calculations. We note, however, that such a change in policy would reduce the budget score for alternatives to the SGR. Nonetheless, doing so would only change the budget score and would not change total spending. The factors influencing spending, including growth in the volume of services, would continue.

If we can be of further assistance, please do not hesitate to contact MedPAC's Executive Director Mark Miller at (202) 220-3700.

Sincerely,

Glenn M. Hackbarth, J.D.
Chairman

CC: The Honorable Nathan Deal

Questions for the Record
From a Hearing Before the
Subcommittee on Health
Of the
Committee on Energy & Commerce
"Medicare Physician Payment: How to Build a More Efficient Payment System"
November 17, 2005

Questions from Rep. Edolphus Towns

Question 1

What safeguards are in place to ensure that improved efficiency does not cause beneficiaries to lose the option to access health care from their physicians of choice?

Answer 1

Under the Physician Voluntary Reporting Program (PVRP), physicians are asked to voluntarily report on certain actions they take that have been scientifically proven to promote better outcomes. The program is not intended, nor structured in any way to limit access to physicians. The program is meant to provide physicians with information about the quality of the services they provide to Medicare beneficiaries so that they can then improve the quality of their services. These measures are evidence-based and were developed with input from a variety of health care experts and other stakeholders in a broad comment process. Participants included the National Quality Forum (NQF), the Ambulatory Care Quality Alliance, the AMA Physician Consortium for Quality Improvement, the National Committee for Quality Assurance (NCQA) and RAND. To ensure the measures do lead to higher quality, CMS relied heavily on measures that had either completed or were close to completing the NQF's review process because the NQF is a primary consensus-development body for health care quality measures,

The quality measures being used are almost exclusively about processes (e.g. did a physician administer an appropriately timed antibiotic to a patient, prior to undergoing surgery). However, there is a limitation with how much one can measure with process measures alone. We also need to move forward with outcome measures in order to obtain a complete picture of the patients experience in the healthcare system.

Be assured that we are moving carefully and with full collaboration of the physician community with all of these measures. For outcome measures, we want to make sure that physicians are not penalized if they have a patient who is non-compliant. A physician may do all they can for the patient, and the patient can still fail to adhere to the medical advice and the direction of the treating physician. The physician should not be penalized for this choice of the patient. Likewise, we need to make sure that outcome measures are risk adjusted to take into account the various stages of the illness that physicians are presented with. We believe that by continuing to work collaboratively with physicians on these measures while staying focused on evidence-based guidelines, we can advance a

system that increasingly rewards physicians for providing the right care at the right time; support prevention and ongoing care for the chronically ill; reward both better performance and physicians who improve; and provide both physicians and patients with the tools and information necessary to ensure high-quality, appropriate care.

Question 2

Also, what benchmarks are in place to ensure that beneficiaries will not be denied needed care?

Answer 2

This pilot program is based on reporting on quality, not paying based on quality, to assure that all providers can respond by improving quality rather than selecting patients. The pilot includes participation by a broad range of physicians to assure that the program works as intended across different specialties and settings. The PVRP is an important step in establishing a quality-based payment system for physician services in Medicare. It will provide us with the needed data and experience to help establish benchmarks required for a more widespread quality-based system.

As we move forward with this project and others, we are working to ensure that we do not create barriers to physicians in treating their patients. To accomplish this, the measures and systems we are using are designed to be accepted by physicians and reliable for patients. There are many factors needed to assure this reliability, including measures based on evidence, simplified data collection, relevance to physicians and patients, and fair reflection of physicians' patient population to assure that we do not experience inappropriate patient selection or de-selection effects. Our current collaborative efforts with physicians, organizations that represent Medicare beneficiaries and other payors is helping us create an environment for all these key elements to be addressed.

Statement

of the

American Medical Association

to the

Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

RE: Medicare Physician Payment: How to Build a More Efficient Payment System

Presented by: Duane M. Cady, MD

November 17, 2005

Division of Legislative Counsel
202 789-7426

Statement

of the

American Medical Association

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Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

RE: Medicare Physician Payment: How to Build a More Efficient Payment System

Presented by: Duane M. Cady, MD

November 17, 2005

The American Medical Association (AMA) appreciates the opportunity to provide our views today regarding the urgent need for Congressional action to replace steep Medicare physician pay cuts with positive updates for at least the next two years, giving Congress and the Administration time to enact a permanent solution to the fatally flawed Medicare physician payment formula. Pending physician pay cuts will affect nearly one million physicians and other health care professionals whose Medicare payment rates are determined by the Medicare physician fee schedule.

Physicians have been working with Congress over the last several years to achieve a solution to the Medicare physician payment formula. A permanent solution to this problem is critical for maintaining access to and quality of care for Medicare patients. In fact, in 2004, the Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan, MD,

underscored to Congress the agency's "concern about making sure that Medicare payments to physicians are adequate and encourage better care, because physician decisions can have such a critical impact on all Medicare costs and on patient health." That statement still rings true today. Indeed, there is widespread agreement – from many in Congress (both sides of the aisle) and the Medicare Payment Advisory Commission (MedPAC) – that the physician payment formula should be scrapped altogether. Further, Congress and CMS agree that an adequate payment structure for physicians is vital for maintaining a strong foundation under which Medicare can properly provide quality health care for our nation's seniors and disabled citizens. Yet, here we are today, with 44 calendar days until a 4.4% Medicare physician pay cut goes in effect. Congress must act now, or the foundation upon which the Medicare program is built will crumble.

CONGRESSIONAL ACTION NEEDED THIS YEAR TO STOP MEDICARE PHYSICIAN PAY CUTS

CMS recently confirmed that Medicare physician payments will be cut by 4.4%, effective January 1, 2006. This will be the first in a series of cuts projected over the next six years by the Medicare Trustees, with cumulative cuts of 26% from 2006 through 2011. Congress must act this year to stop the pending cuts and provide positive payment updates for at least 2006 and 2007. This will help preserve access to health care services for seniors and persons with disabilities while Congress and the Administration jointly work to enact a permanent fix to the current Medicare physician payment formula.

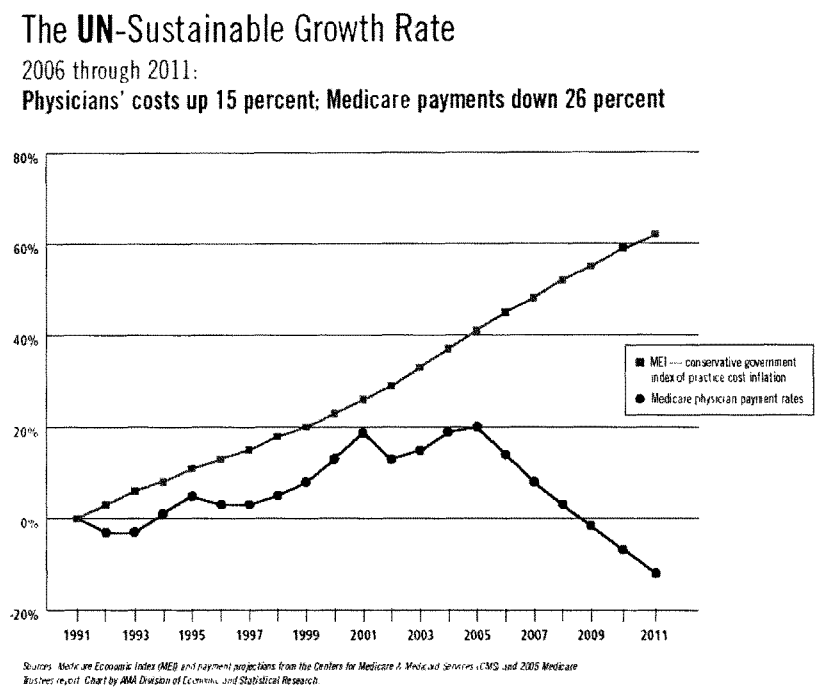
FUNDAMENTAL PROBLEMS WITH THE FATALLY FLAWED MEDICARE PHYSICIAN PAYMENT FORMULA: THE SGR

A fatally flawed Medicare physician payment update formula – called the sustainable growth rate (the SGR) – is responsible for the projected cuts. Under the SGR, payment updates are tied to GDP growth, which factors in neither patients' health care needs nor physicians' practice costs. Physicians are penalized with pay cuts when Medicare spending on physicians' services exceeds SGR spending targets that are based on GDP growth, but make no allowance for government policies and other factors that increase utilization of services.

Because of these fundamental defects, the SGR led to a negative 5.4% update in 2002, and additional reductions in 2003 through 2005 were averted only after Congress intervened and replaced projected steep negative updates with positive updates of 1.6% in 2003 and 1.5% in each of 2004 and 2005. We greatly appreciate these short-term reprieves. Even with these increases, however, Medicare physician payment updates during these years were only about half of the rate of inflation of medical practice costs. To make matters worse, if the 2006 cut is imposed, average physician payment rates will actually be less in 2006 than they were in 2001 (in real terms, not adjusted for inflation). Further, a 4.4% cut in January 2006, would mean that from 2002-06, payment rates will have fallen 16% behind the government's index of inflation in physicians' practice cost.

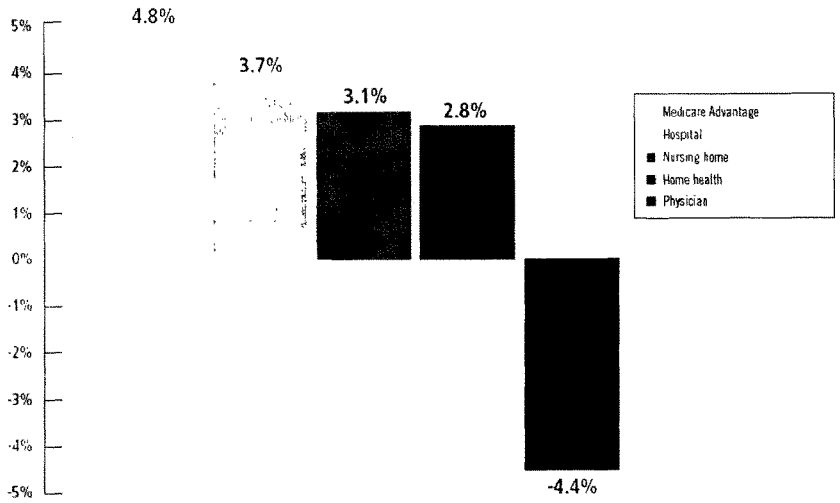
As shown by the graph below, these reductions come at a time when, even by Medicare's own conservative estimate, physician practice costs are expected to rise by an additional 15% from 2006-11 (with Medicare physician payments decreasing by 26%). The vast majority of

physician practices are small businesses, and the steep losses that are yielded by what is ironically called the "sustainable growth rate," would be unsustainable for any business, especially small businesses such as physician office practices.



Only physicians and health professionals face updates of 7% below the annual increase in their practice costs. Hospitals and long-term care providers are slated for updates that fully keep pace with their market basket increases, and Medicare Advantage plans will see average updates of 4.8% in 2006, as illustrated in the bar graph below. Medicare physician payments must be re-structured to ensure access for fee-for-service patients as well.

Projected 2006 Medicare payment updates



Sources: Projected updates based upon best available information from the Centers for Medicare & Medicaid Services as of November 2005.

ACCESS PROBLEMS FOR MEDICARE BENEFICIARIES UNDER THE CURRENT MEDICARE SGR PHYSICIAN PAYMENT FORMULA

Physicians simply cannot absorb the pending draconian payment cuts. In fact, a recent AMA survey indicates that if the cuts begin January 1, 2006:

- More than a third of physicians (38%) would decrease the number of new Medicare patients they accept;
- More than half of physicians (54%) plan to defer information technology purchases;

- A majority of physicians (53%) would be less likely to participate in a Medicare Advantage plan; and
- One-third (34%) of physicians whose practice serves rural patients would discontinue their rural outreach services.

A physician access crisis is looming for Medicare patients. More than 20 states each face cuts in Medicare funding of more than one billion dollars from 2006-2011. The MMA promised important new benefits for patients. An adequate payment structure for physicians' services must be in place in order for the government to deliver on its promise of these important benefits.

Yesterday, Medicare patients began enrolling for the new Medicare drug benefit that will become effective January 1, 2006. **Physicians are the foundation of our nation's health care system, and Medicare patients' access to physicians' services is imperative for the success of the new prescription drug benefit.** Continual cuts put such access at risk. Indeed, there are already signs that access to care is deteriorating. A MedPAC survey found that 22% of patients already have some problems finding a primary care physician and 27% report delays getting an appointment.

The physician cuts that threaten to destabilize the Medicare program will also create a ripple effect across other programs. Indeed, these cuts jeopardize access to medical care for millions of our active duty military family members and military retirees because their TRICARE insurance ties its payment rates to Medicare. The Military Officers Association of America

(MOAA) recently sent a letter to Congress urging Congressional action to avert the 4.4% cut because it will "significantly damage" military beneficiaries' access to health care services. MOAA stated that "[w]ith our nation at war, Congress should make a particular effort not to reduce health care access for those who bear and have borne such disproportionate sacrifices in protecting our country."

MEDICARE QUALITY OF CARE INITIATIVES DEPEND ON ADEQUATE PHYSICIAN PAYMENT STRUCUTRE

An adequate Medicare physician payment structure is also imperative for Medicare quality of care initiatives. There is a growing consensus that greater physician adoption of information technology is vital to improvements in quality of care. Unless physicians receive positive payment updates, however, these investments will not be possible.

Further, inclusion of value-based purchasing (or pay-for-performance) provisions as part of any final budget reconciliation bill, without a long-term solution to the SGR, will only compound the looming access problem and make future SGR reforms more expensive. Value-based measures will lead to higher volume of physicians' services. Under the SGR formula, more services will result in more cuts. **Value-based purchasing and the SGR formula are incompatible. The SGR formula needs to be repealed in order for value-based purchasing proposals to succeed.**

PERMANENT SOLUTION TO THE SGR IS NEEDED TO PROTECT PATIENT ACCESS AND QUALITY OF CARE

The Medicare physician payment problem continues to exist because, as discussed above, it is inherently flawed and has led to deep cuts that were not projected when the formula was implemented in 1997. While we greatly appreciate the short-term reprieves achieved by Congress and the Administration in recent years, these temporary fixes have led to even deeper and longer sustained cuts because Congress recouped the cost of temporarily blocking the severe cuts in physician payments in the out-years. Without a long-term solution, repeated Congressional intervention will be required to block payment cuts that jeopardize continued access to high quality care for the elderly and disabled. A one-year fix would provide a temporary respite and lead to another struggle to deal with this problem early next year. **Thus, at least a two-year fix is urgently needed this year to allow time for a permanent solution to the SGR.**

Some government officials have cited the SGR formula as a method for restraining the growth of Medicare physicians' services. Yet, there are many reasons for such growth, and there are no studies documenting systematic inappropriate care. Without valid studies, it is impossible to determine what volume growth is appropriate or inappropriate. Earlier this year, for example, Medicare officials announced that spending on Part A services is decreasing. This suggests that, as technological innovations advance, services are shifting from Part A to Part B, leading to appropriate volume growth on the Part B side. If there is a problem with volume growth regarding a particular type of medical service, the AMA looks forward to working

with Congress and the Administration to address it, rather than retaining a formula that penalizes both patients and physicians for growth that may not be inappropriate at all.

ADMINISTRATIVE ACTION NEEDED TO ASSIST CONGRESS IN REPLACING THE SGR

CMS Administrator McClellan recently stated that "the current system of paying physicians is simply not sustainable." We agree and urge the Subcommittee to continue pressing CMS to use its authority to take administrative action to help Congress avert physician pay cuts and ensure that a stable, reliable Medicare physician payment formula is in place for Medicare patients.

Despite their protestations, the AMA firmly believes that CMS has the authority to remove the costs of drugs, back to the base period, from the calculation of the SGR. Because this would significantly reduce the cost of legislation and allow Congress to address the looming Medicare pay cuts more easily, CMS should take this step as soon as possible. Indeed, CMS told Congress earlier this year that removing drugs prospectively is worth about $36 billion in lowered costs, while removing them from the base-year forward reduces $111 billion from the cost of an ultimate fix.

Drug expenditures are continuing to grow at a very rapid pace. Over the past 5 to 10 years, drug companies have revolutionized the treatment of cancer and many autoimmune diseases through the development of a new family of biopharmaceuticals that mimic compounds found within the body. Such achievements do not come without a price. For example, in 2004 alone, six oncology drugs received FDA approval or expanded approval, and two others

received approval in 2003. As Dr. McClellan noted in testimony earlier this year, spending for one recently-developed drug, Pegrilgrastim (Neulastra) totaled $518 million last year, more than double the 2003 total. This drug strengthens the immune systems of cancer patients receiving chemotherapy, thereby improving and extending the lives of many and potentially reducing hospital costs in the process.

Growth rates for drug spending dwarf those of the physician services the SGR was intended to include. Between the SGR's 1996 base year and 2004, the number of drugs included in the SGR pool rose from 363 to 445. Spending on physician-administered drugs over the same time period rose from $1.8 billion to $8.6 billion, an increase of 358% per beneficiary compared to an increase of only 61% per beneficiary for actual physicians' services. As a result, drugs are consuming an ever-increasing share of SGR dollars, nearly tripling from 3.7% of total SGR spending in 1996 to 9.8% in 2004.

It is not equitable or realistic to finance the cost of innovative drug therapies through cuts in payments to physicians and other health care professionals. CMS must act now to remove these costs form calculations of the SGR. The longer CMS waits to make this policy change, the more costly it will be for the government to do so.

The AMA appreciates the opportunity to provide our views to the Subcommittee on these important matters. We look forward to working with the Congress and the Administration to: (i) stop the pending Medicare cuts; (ii) provide at least two years of

positive Medicare physician payment updates beginning in 2006; and (iii) defer implementation of value-based purchasing proposals until the SGR is repealed and replaced with a formula that does not unfairly penalize physicians for volume increases. These measures will assist the Medicare program in providing broad-based access and quality of care for seniors, persons with disabilities, and military beneficiaries.