MEDICARE PAYMENTS TO PHYSICIANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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U.S. HOUSE OF REPRESENTATIVES

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CONTENTS

	Page
Advisory of February 3, 2005, announcing the hearing	2

WITNESSES

U.S. Government Accountability Office, Bruce Steinwald, Director, Health Care, Economic and Payment Issues	5
Medicare Payment Advisory Commission, Glenn M. Hackbarth, Chairman	16

American Medical Association, Nancy Nielsen	39
American Urological Association, William F. Gee	58
Medicare Rights Center, Robert M. Hayes	62
Partners Community HealthCare, Inc., Thomas H. Lee	48

SUBMISSIONS FOR THE RECORD

American Academy of Family Physicians, Wendy Gaitwood, statement	71
American Association for Geriatric Psychiatry, Bethesda, MD, Stephanie Reed, statement	75
American College of Radiology, Josh Cooper, statement	76
American Physical Therapy Association, Alexandria, VA, Justin Moore, statement	80
Coalition for Patient-Centered Imaging, statement	84
Critical Care Cardiology, Inc., Chula Vista, CA, Vimal Indravadan Nanavati, letter	86
Ethical Health Partnerships, Winter Park, FL, Dawn Lipthrott, statement	88
Healthcare Information and Management Systems Society, Chicago, IL, H. Stephen Lieber, statement	93
Managed Care Advocacy Program, Toledo, OH, Elizabeth A. Flournoy, letter	95
Medical Group Management Association, William F. Jessee, statement	96
Medtronic, Inc., Minneapolis, Minnesota, Arthur D. Collins, Jr., letter	97
National Coalition for Quality Diagnostic Imaging Services, Houston, TX, statement	98
Renal Physicians Association, James Weiss, statement	101

MEDICARE PAYMENTS TO PHYSICIANS

THURSDAY, FEBRUARY 10, 2005

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 03, 2005
HL–1

CONTACT: (202) 225–3943

Johnson Announces Hearing on Medicare Payments to Physicians

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on Medicare payments to physicians. **The hearing will take place on Thursday, February 10, 2005, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witnesses only. Witnesses will include Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission (MedPAC), A. Bruce Steinwald from the U.S. Government Accountability Office (GAO), and representatives from groups affected by Medicare's payment policies. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Annual updates to Medicare's reimbursement for physicians and other providers paid under the physician fee schedule are determined by a formula set in law known as the sustainable growth rate (SGR). This formula sets a target for growth in Medicare expenditures for physician services based on growth in the gross domestic product. This target is also adjusted for volume growth and other factors. If Medicare expenditures exceed the target, Medicare payment rates to physicians are reduced. If Medicare expenditures are less than the target, payment rates are increased.

Projections prepared by the Office of the Actuary for the Centers for Medicare & Medicaid Services, reported in the 2004 Annual Report of the Medicare Trustees, indicate that Medicare will reduce payment rates to physicians by approximately 5 percent annually for 7 years, beginning in January 2006. Physician payment rates would decline more than 31 percent from 2005 to 2012, while costs of providing services would increase by 19 percent over the same period.

In announcing the hearing, Chairman Johnson stated, "The current Medicare payment system for physicians is unsustainable. We cannot allow Medicare's payments to doctors to fall through the floor while the cost of providing care continues to rise. Physicians are essential to the Medicare program and without their participation our seniors will lose access to high-quality care. This hearing will offer the Subcommittee an opportunity to explore alternative payment systems such as paying for quality and efficiency."

FOCUS OF THE HEARING:

The hearing will focus on identifying problems with the physician payment formula and exploring potential solutions. The GAO will present findings from its recent report on physician payments. The MedPAC will review its recommendations for physician payment reform, including tying payment to quality of care and resource use, and implementing measures to reduce the volume and increase the quality of certain services. The second panel will provide input from affected parties, including testimony from witnesses with practical experience in systems that promote quality and efficiency.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*109th Congress*" from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=17*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Thursday, February 24, 2005. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

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

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

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

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

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

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

Chairman JOHNSON. Good morning, everyone. It is a pleasure to welcome you to the first hearing of the Subcommittee on Health and especially to welcome the new Members on both sides of the aisle that have joined us for this session's work. We also have today Congressman Cardin and Congressman Gingrey sitting in with us, as long as they are able, and I welcome them as well. Although our surroundings in this room have changed considerably with paint and carpeting, we do find ourselves today facing a very old problem, Medicare reimbursements to physicians. Unfortunately, I do not believe that the old formula used to update physician reimbursement rates can be fixed with a coat of paint or a tweak here or a tweak there. We need to fundamentally rethink

how we pay our doctors. The Office of the Actuary for the Centers of Medicare & Medicaid Services (CMS) projects that Medicare under current law will reduce physician payment rates and other Medicare providers paid under the physician fees schedule by approximately 5 percent each year for the next 7 years, beginning in January of 2006, unless we change the law.

If these reductions occur, payment rates would drop by almost one-third while costs of practicing medicine will rise by almost one-fifth. That is a swing of 50 percent. If we do not reform the sustainable growth rate (SGR) payment formula, physicians will have a disincentive to participate in Medicare, and the result will be that seniors will have reduced access to physician services. Let's face it, the so-called formula is unsustainable. We tried to fix this irrational payment formula the last two Congresses. We worked with the Administration to make sure that the formula accounted for 1 million beneficiaries in fee-for-service Medicare who were going to their doctors and receiving care who had not been counted previously. We urged the Administration to change the way they measured productivity. This change was made.

Finally, in the Medicare Modernization Act (MMA, P.L. 108–173), we replaced a single year's measure of economic growth with a 10-year rolling average to smooth out projected expenditure calculations and to reduce fluctuation and payment updates. Despite these changes, the payment system is still broken. It is time to fundamentally reform how Medicare pays physicians. The current system generates no incentives for high performance, because the best and the worst providers receive the same reimbursement. The current system rewards providers for delivering more services, not for managing care and delivering better outcomes. It is time to make health care safer and more accountable and to reward providers who deliver quality care by using resources efficiently and effectively. In the MMA, we challenged hospitals to report on 10 quality indicators to be eligible to receive a full Medicare payment update. It is now time for physicians to come forward with quality indicators that can drive reimbursements up in recognition of physicians' commitment to quality care.

On our first panel today, we will hear from Bruce Steinwald of the U.S. Government Accountability Office (GAO), which last fall released a report on the problems with the spending target system used to set physician reimbursements in Medicare. We will also hear from Glenn Hackbarth, the Chairman of the Medicare Payment Advisory Commission (MedPAC), which has recommended replacing the current payment system and offered some insights on how we might incorporate paying for quality and efficiency in Medicare. Witnesses on our second panel will share perspectives from the provider and beneficiary viewpoints on how the current payment system works and how it might be modified to better serve Medicare beneficiaries, providers and taxpayers. I now invite my colleague, Mr. Stark, to make his opening statement.

Mr. STARK. Thank you, Madam Chairman, and I appreciate your calling this hearing today. Yes, our system was made worse over the past couple of years by Congress, mostly by saying—by putting it off and saying we will deal with it tomorrow, which is arriving. We should have tackled this issue 3 years ago when we

had a sensible solution in sight. Instead, we did MMA. It made the system worse. If we begin linking payments and quality to extract value from the system, we are going down a road which I am not sure we are prepared to do. The present payment system was put into place with the cooperation and agreement of most physicians in the country. What is not mentioned is that from the year 2001 until 2005, the actual services payments exceeded what the physician should have gotten. They have gotten more than they were entitled to under the law for almost 5 years.

Now, if you are going to follow the formula, it dips down a little and goes below SGR for a period of time starting at around 2006 until 2012. In about an equal amount, and nobody likes that, and nobody likes to remember that they got overpaid last year, and so to make it even they get underpaid this year. That is not a popular position. I am not sure it is politically sustainable. I do want to suggest that the formula was put into place with the cooperation of the physician community in an effort to find a way that could be adjusted from time to time and changed and negotiated. Unfortunately, we did not do that. We diddled with the system, and I think that we should be very careful about what we do and just say we have to raise rates. I would also like to focus our discussion somewhat today. We talk about rates. To put it in more plebeian terms, we are talking about a piece-rate business.

So, we are talking about the rate per procedure. We are not talking about physicians' incomes, which physicians do not like to talk about very much, because they have been going up rather substantially, and their gross Medicare payments have been going up rather substantially, which either means they are cheating on their time for playing golf and working harder, or they may be more productive and be able to do more procedures in the same amount of time, in which case we should be able to lower the rate per procedure if they become more efficient. I think we have to look at both sides of that formula, and I look forward to hearing the witnesses' testimony. Thank you for having the hearing.

Chairman JOHNSON. Thank you very much. Now, I would like to begin with Mr. Steinwald of GAO.

STATEMENT OF BRUCE STEINWALD, DIRECTOR, HEALTH CARE, ECONOMIC AND PAYMENT ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Mr. STEINWALD. Thank you, Madam Chairman, Mr. Stark, Members of the Subcommittee. I am pleased to be here today to discuss with you the system that is used to annually update fees paid to physicians under the Medicare program. As you noted, the SGR system is calling for several years of reductions in physician fees beginning in 2006. How and why this happened, and what options are available for change, will be the focus of my remarks today. I believe the key to understanding the growth in Medicare expenditures for physician services lies in understanding the trends and service volume and intensity. Volume refers to the average number of services performed per beneficiary, and intensity refers to the costliness and complexity of those services. For example, if we have more magnetic resonance imaging (MRIs) and fewer X-rays from one year to the next, that is an intensity increase, be-

cause MRIs are more expensive than X-rays. However, if we had more MRIs and X-rays from one year to the next, we have both an intensity and a volume increase. That is, in fact, what we have experienced.

Please direct your attention to the screen, which shows the trends in volume and intensity in physician services per Medicare beneficiary that is holding the number of beneficiaries constant from 1980 through 2003. This appears on page 4 as Figure 1 in the written statement. The chart presents national averages, and therefore masks considerable variation across physician specialties, geographic areas and Medicare beneficiaries. As the chart shows, volume and intensity growth during the 1980s and early 1990s was substantial. During these years, efforts to control spending growth by the Congress focused on limiting fee increases, and they were largely unsuccessful in controlling expenditures. In 1992, the chart-based system of setting fees was replaced by a Medicare fee schedule and, with it, a target system for controlling spending for physician services was also installed. As you can see, for several years afterward, volume and intensity were moderated, but then began to trend upward again in the year 2000. Largely because of this upward trend, in 2002, the SGR system called for a fee decrease for the first time ever, and only through congressional action were fee cuts averted in 2003, 2004 and 2005. Without additional action, fee cuts will return in 2006.

The reason for projected fee cuts are twofold. First is that volume intensity spending growth is projected to exceed the SGR allowance for such growth. This allowance is the average annual growth rate of the national economy or Gross Domestic Product, which is projected to be slightly higher than 2 percent a year for the foreseeable future. The second reason is that the SGR system will need to recoup the overpayments made in 2004 and 2005, when the system's negative updates were averted by the MMA in 2003. As Mr. Stark noted, essentially, the MMA mandated fee update simply put off the requirements of SGR to balance spending with the targets rather than changing the targets. We at GAO recognize that multiple years of negative updates presents a difficult situation for physicians, for the Congress and potentially for Medicare beneficiaries. As you know, the MMA asked us to examine options for modifying and improving, and/or improving, the SGR system.

I would like to call your attention to the screen, which displays table 1 on page 11 of my written statement. The table shows a sample of options that seek to address the SGR problems. I would note that our October 2004 report examines these options and several additional options in some detail. In general, however, we found that the choices for change cluster around two broad approaches. One approach, which has been recommended by MedPAC, would end the use of spending targets and replace them with more focused efforts to control spending. The other approach would retain spending targets, but modify the current SGR system to address its shortcomings. Eliminating the targets would make it easier to stabilize fee updates; whereas retaining targets with modifications would retain the mechanism that automatically applies fiscal breaks whenever spending for physician services grows too fast. In the interest of time, I will not explain the different op-

tions in detail. I will be happy to answer questions about any of them, except to note that they vary substantially in their effect on physician fees and spending. I might also add that the options vary in their effects on beneficiary out-of-pocket co-payment as well.

Either of the two broad approaches could be implemented in a way that would likely generate positive fee updates, and each could be accompanied by separate more focused efforts to moderate volume and intensity growth. However, because multiple years of projected 5-percent fee cuts are incorporated in Medicare's budget baseline, almost any change to the SGR system is likely to increase program spending considerably. Overall, we are mindful of the serious financial challenges facing the Medicare program, the need to design policies that help ensure the long term sustainability and affordability of the program. We at GAO look forward to working with the Subcommittee and others in Congress on this complex issue. Madam Chairman, this concludes my prepared statement. I would be happy to answer any questions you or any other Subcommittee Members may have.

[The prepared statement of Mr. Steinwald follows:]

Statement of Bruce Steinwald, Director, Health Care, Economic and Payment Issues, U.S. Government Accountability Office

Madam Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss the sustainable growth rate (SGR) system that Medicare uses to update physician fees and moderate the growth in spending for physician services. A brief look at the updates resulting from the SGR system since it was enacted by Congress puts current concerns in context. From 1999—the first year that the SGR system was used to update Medicare's physician fees—through 2001, annual fee increases ranged from 2.3 percent to 5.5 percent. However, in 2002 the SGR system reduced physician fees by nearly 5 percent. Fee declines in subsequent years were averted only by new legislation that modified or temporarily overrode the SGR system. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) specified a minimum update of 1.5 percent for both 2004 and 2005.[1] Absent additional administrative or legislative action, however, the SGR system is projected to reduce fees by about 5 percent per year for several years beginning in 2006. These projected declines have raised policymakers' concerns about the appropriateness of the SGR system for updating physician fees and about physicians' continued participation in the Medicare program. At the same time, there are concerns about Medicare spending growth and the long-term fiscal sustainability of the program.

My comments today are intended to describe the issues that Medicare faces in annually updating physician fees and potential approaches for addressing those issues. Specifically, I will discuss (1) how the SGR system is designed to moderate the growth in spending for physician services, (2) why physician fees are projected to decline under the SGR system, and (3) options for revising or replacing the SGR system and their implications for physician fee updates and Medicare spending. My testimony today is based on the findings contained in our October 2004 report on this subject.[2] This work was performed between January 2004 through September 2004 according to generally accepted government auditing standards.

In summary, the SGR system is designed to apply financial brakes whenever spending for physician services exceeds predefined spending targets. It does this by reducing physician fees or limiting their annual increase. Historically, efforts that limited fees but did not set spending targets failed to moderate spending growth. Increases in the number of services delivered to each beneficiary—known as volume—and the complexity or costliness of those services—known as intensity—caused continued increases in spending. The SGR system allows for some volume and intensity spending growth, but if such growth exceeds the average growth in the national economy, as measured by the gross domestic product (GDP) per capita,

[1] Pub. L. No. 108–173, § 601(a)(1), 117 Stat. 2067, 2300.

[2] GAO, *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms*, GAO–05–85 (Washington, D.C.: Oct. 8, 2004).

fee updates are reduced. There are two principal reasons why physician fees are projected to decline under the SGR system beginning in 2006. One reason is that projected spending growth attributable to volume and intensity increases exceeds the SGR allowance for such growth. The MMA is also partly responsible because it increased the update for 2004 and 2005—thus increasing spending—but did not raise the spending targets for those years. The SGR system, which is designed to keep spending in line with its targets, must reduce fees beginning in 2006 to offset the excess spending attributable to both volume and intensity increases and this MMA provision. In general, proposals to reform Medicare's method for updating physician fees would either (1) eliminate spending targets and establish new considerations for the annual fee updates or (2) retain spending targets, but modify certain aspects of the current system. Either approach could be complemented by focused efforts to moderate volume and intensity growth directly.

Background

Although the current focus of concern is largely on the potential for several years of declining physician fees, the historic challenge for Medicare has been to find ways to moderate the rapid growth in spending for physician services. Before 1992, the fees that Medicare paid for those services were largely based on physicians' historical charges.[3] Spending for physician services grew rapidly in the 1980s, at a rate that the Secretary of Health and Human Services (HHS) characterized as out of control. Although Congress froze fees or limited fee increases, spending continued to rise because of increases in the volume and intensity of physician services. From 1980 through 1991, for example, Medicare spending per beneficiary for physician services grew at an average annual rate of 11.6 percent.

The ineffectiveness of fee controls alone led Congress to reform the way that Medicare set physician fees. The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989)[4] established both a national fee schedule and a system of spending targets,[5] which first affected physician fees in 1992.[6] From 1992 through 1997, annual spending growth for physician services was far lower than the previous decade. The decline in spending growth was the result in large part of slower volume and intensity growth. (See fig. 1.) Over time, Medicare's spending target system has been revised and renamed. The SGR system, Medicare's current system for updating physician fees, was established in the Balanced Budget Act of 1997 (BBA) and was first used to adjust fees in 1999.[7]

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[3] Medicare paid physicians on the basis of "reasonable charge," defined as the lowest of the physician's actual charge, the customary charge (the amount the physician usually charged for the service), or the prevailing charge (based on comparable physicians' customary charges).

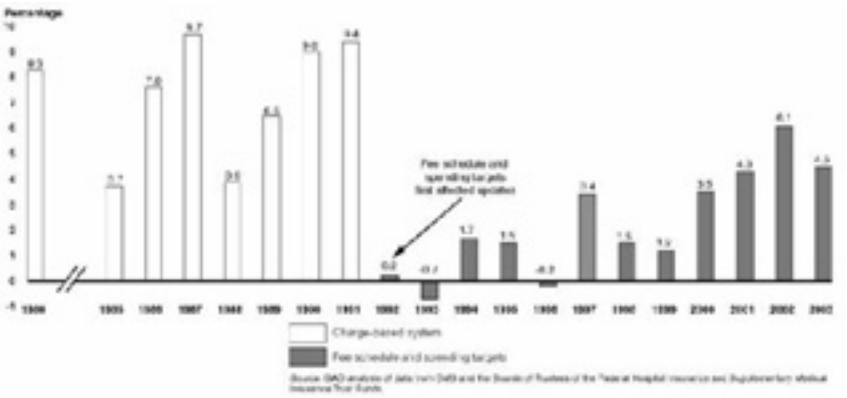
[4] See Pub. L. No. 101–239, § 6102, 103 Stat. 2106, 2169–89.

[5] Medicare sets fees for more than 7,000 physician services based on the resources required to provide each service, adjusted for differences in the costs of providing services across geographic areas.

[6] The first system of spending growth targets, known as the Medicare Volume Performance Standard (MVPS), was in effect from 1992 through 1997. In 1998, the SGR system of spending targets replaced MVPS.

[7] See Pub. L. No. 105–33, § 4503, 111 Stat. 251, 433–34. BBA set a specific fee update for 1998. See BBA, § 4505, 111 Stat. 435–39.

Figure 1: Growth in Volume and Intensity of Medicare Physician Services per Beneficiary, 1980–2003



Notes: Data are for beneficiaries in the traditional fee-for-service (FFS) program only. Data for end stage renal disease patients are not included. From 1980 through 1992, volume and intensity of service changes are based on Medicare outlays for all physician services. From 1993 through 2003, volume and intensity of service changes are based on Medicare outlays for physician services covered by the fee schedule.

Following the implementation of the fee schedule and spending targets in 1992, through 1999, average annual growth in volume and intensity of service use per beneficiary fell to 1.1 percent. More recently volume and intensity growth has trended upward, rising at an average annual rate of about 5 percent from 2000 through 2003. Although this average annual rate of growth remains substantially below that experienced before spending targets were introduced, the recent increases in volume and intensity growth are a reminder that inflationary pressures continue to challenge efforts to moderate growth in physician expenditures.

SGR System Designed to Limit or Reduce Physician Fee Updates in Response to Excess Growth in Volume and Intensity

The SGR system establishes spending targets to moderate physician services spending increases caused by excess growth in volume and intensity. SGR's spending targets do not cap expenditures for physician services. Instead, spending in excess of the target triggers a reduced fee update or a fee cut. In this way, the SGR system applies financial brakes to physician services spending and thus serves as an automatic budgetary control device. In addition, reduced fee updates signal physicians collectively and Congress that spending due to volume and intensity has increased more than allowed.

To apply the SGR system, every year the Centers for Medicare & Medicaid Services (CMS) follows a statutory formula to estimate the allowed rate of increase in spending for physician services and uses that rate to construct the spending target for the following calendar year.[8] The sustainable growth rate is the product of the estimated percentage change in (1) input prices for physician services; [9,10] (2) the average number of Medicare beneficiaries in the traditional fee-for-service (FFS) program; (3) national economic output, as measured by real (inflation-adjusted) GDP per capita; and (4) expected expenditures for physician services resulting from changes in laws or regulations. SGR spending targets are cumulative. That is, the sum of all physician services spending since 1996 is compared to the sum of all annual targets since the same year to determine whether spending has fallen short

[8] This allowed rate is the sustainable growth rate from which the SGR system derives its name. We use the abbreviation SGR when referring to the system and the full term of "sustainable growth rate" when referring to the allowed rate of increase.

[9] CMS calculates changes in physician input prices based on the growth in the costs of providing physician services as measured by the Medicare Economic Index, growth in the costs of providing laboratory tests as measured by the consumer price index for urban consumers, and growth in the cost of Medicare Part B prescription drugs included in SGR spending.

[10] Under the SGR and MVPS systems, the Secretary of Health and Human Services defined physician services to include "services and supplies incident to physicians' services," such as laboratory tests and most Part B prescription drugs.

of, equaled, or exceeded the SGR targets. The use of cumulative targets means, for example, that if actual spending has exceeded the SGR system targets, fee updates in future years must be lowered sufficiently both to offset the accumulated excess spending and to slow expected spending for the coming year.

Under SGR, spending per beneficiary adjusted for the estimated underlying cost of providing physician services is allowed to grow at the same rate that the national economy grows over time on a per-capita basis—currently projected to be slightly more than 2 percent annually. If volume and intensity grow faster, the annual increase in physician fees will be less than the estimated increase in the cost of providing services. Conversely, if volume and intensity grow more slowly than 2 percent annually, the SGR system permits physicians to benefit from fee increases that exceed the increased cost of providing services. To reduce the effect of business cycles on physician fees, MMA modified the SGR system to require that economic growth be measured as the 10-year moving average change in real per capita GDP. This measure is projected to range from 2.1 percent to 2.5 percent during the 2005 through 2014 period.

When the SGR system was established, GDP growth was seen as a benchmark that would allow for affordable increases in volume and intensity. In its 1995 annual report to Congress, the Physician Payment Review Commission stated that limiting real expenditure growth to 1 or 2 percentage points above GDP would be a "realistic and affordable goal."[11] Ultimately, BBA specified the growth rate of GDP alone. This limit was an indicator of what the 105th Congress thought the nation could afford to spend on volume and intensity increases.

If cumulative spending on physician services is in line with SGR's target, the physician fee schedule update for the next calendar year is set equal to the estimated increase in the average cost of providing physician services as measured by the Medicare Economic Index (MEI). If cumulative spending exceeds the target, the fee update will be less than the change in MEI or may even be negative. If cumulative spending falls short of the target, the update will exceed the change in MEI. The SGR system places bounds on the extent to which fee updates can deviate from MEI. In general, with an MEI of about 2 percent, the largest allowable fee decrease would be about 5 percent and the largest fee increase would be about 5 percent.

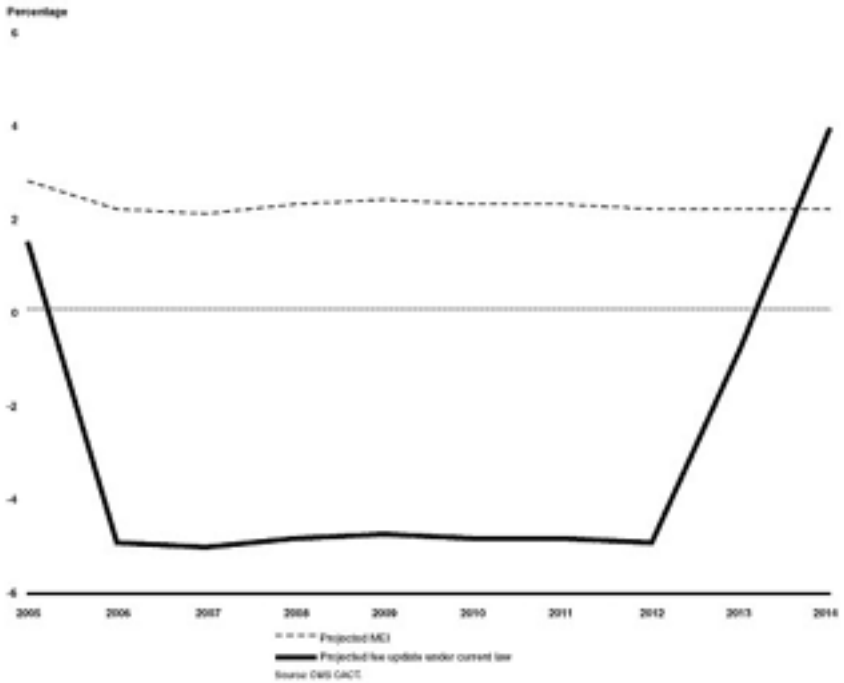
Continued Volume and Intensity Growth and Legislated Fee Updates Contribute to Projected Decline in Physician Fees

The 2004 Medicare Trustees Report announced that the projected physician fee update would be about negative 5 percent for 7 consecutive years beginning in 2006; the result is a cumulative reduction in physician fees of more than 31 percent from 2005 to 2012, while physicians' costs of providing services, as measured by MEI, are projected to rise by 19 percent.[12] According to projections made by CMS Office of the Actuary (OACT) in July 2004, maximum fee reductions will be in effect from 2006 through 2012, while fee updates will be positive in 2014. (See fig. 2.) There are two principal reasons for the projected fee declines: increases in volume and intensity that exceed the SGR's allowance—partly as a result of spending for Part B prescription drugs—and the minimum fee updates for 2004 and 2005 specified by MMA.

[11] Physician Payment Review Commission, *1995 Annual Report to Congress* (Washington, D.C.: 1995).

[12] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: Mar. 23, 2004).

Figure 2: Projected MEI and Fee Update under Current Law



Note: Projections are as of July 2004.

Volume and Intensity Growing Rapidly, Partly as a Result of Included Spending For Outpatient Drugs

Recent growth in spending due to volume and intensity increases has been larger than SGR targets allow, resulting in excess spending that must be recouped through reduced fee updates. In general, the SGR system allows physician fee updates to equal or exceed the MEI as long as spending growth due to volume and intensity increases is no higher than the average growth in real GDP per capita—about 2.3 percent annually. However, in July 2004, CMS OACT projected that the volume and intensity of physician services paid for under the physician fee schedule would grow by 3 percent per year. To offset the resulting excess spending, the SGR system will have to reduce future physician fee updates.

Additional downward pressure on physician fees arises from the growth in spending for other Medicare services that are included in the SGR system, but that are not paid for under the physician fee schedule. Such services include laboratory tests and many Part B outpatient prescription drugs that physicians provide to patients.[13] Because physicians influence the volume of services they provide directly—that is, fee schedule services—as well as these other services, defined by the Secretary of HHS as "incident to" physician services, expenditures for both types of services were included when spending targets were introduced. In July 2004, CMS OACT projected that SGR-covered Part B drug expenditures would grow more rapidly than other physician service expenditures, thus increasing the likelihood that future spending would exceed SGR system targets. To the extent that spending for SGR Part B drugs and other "incident to" services grows larger as a share of overall SGR spending, additional pressure is put on fee adjustments to offset excess spending and bring overall SGR spending in line with the system's targets. This occurs

[13] Most of the Part B drugs that Medicare covers fall into three categories: those typically provided in a physician office setting (such as chemotherapy drugs), those administered through a durable medical equipment item (such as a respiratory drug given in conjunction with a nebulizer), and those that are patient-administered and covered explicitly by statute (such as certain immunosuppressives).

because the SGR system attempts to moderate spending only through the fee schedule, even when the excess spending is caused by expenditures for "incident to" services, such as Part B drugs, which are not paid for under the fee schedule.

MMA's Minimum Updates For 2004 and 2005 Contribute to Future Physician Fee Cuts

The MMA averted fee reductions projected for 2004 and 2005 by specifying an update to physician fees of no less than 1.5 percent for those 2 years. The MMA increases replaced SGR system fee reductions of 4.5 percent in 2004 and 3.3 percent in 2005 and thus will result in additional aggregate spending. Because MMA did not make corresponding revisions to the SGR system's spending targets, the SGR system must offset the additional spending by reducing fees beginning in 2006.

An examination of the SGR fee update that would have gone into effect in 2005, absent the MMA minimum updates, illustrates the impact of the system's cumulative spending targets. To begin with, actual expenditures under the SGR system in 2004 are estimated to be $84.9 billion, whereas target expenditures for 2004 were $77.1 billion. As a result, SGR's 2005 fee updates would have needed to offset the $7.8 billion deficit from excess spending in 2004 plus the accumulated excess spending of $5.9 billion from previous years to realign expected spending with target spending. Because the SGR system is designed to offset accumulated excess spending over a period of years, the deficit for 2004 and preceding years reduces fee updates for multiple years.

Alternatives for Updating Physician Fees Would Eliminate Spending Targets or Revise Current SGR System

The projected sustained period of declining physician fees and the potential for beneficiaries' access to physician services to be disrupted have heightened interest in alternatives for the current SGR system. In general, potential alternatives cluster around two approaches. One approach would end the use of spending targets as a method for updating physician fees and encouraging fiscal discipline. The other approach would retain spending targets but modify the current SGR system to address perceived shortcomings. These modifications include such options as removing the prescription drug expenditures that are currently counted in the SGR system; resetting the targets and not requiring the system to recoup previous excess spending; and raising the allowance for increased spending due to volume and intensity growth.

Alternatives to the SGR system would increase fees and thus aggregate spending—both government outlays and beneficiary cost sharing, including Part B premiums, for physician services relative to projected spending under current law.[14,15] (See table 1.) While seeking to pay physicians appropriately, it is important to consider how modifications or alterations to the SGR system would affect the long-term sustainability and affordability of the Medicare program.

[14] The Part B premium amount is adjusted each year so that expected premium revenues equal 25 percent of expected Part B spending. Beneficiaries must pay coinsurance—usually 20 percent—for most Part B services.

[15] See GAO–05–85 for more information about these alternatives.

Table 1: Projected Effect on Fee Updates and Physician Services Spending under Current Law and Selected Potential Options for the SGR System, 2006 to 2014

Options	Minimum fee update	Years with negative fee update	Maximum fee update	Cumulative expenditures increase relative to current law
Current law	−5.0%	8	+3.9%	—
Eliminate spending targets	+2.1%	0	+2.4%	22%
Modify spending targets				
Set allowable growth to GDP+1 percent	−5.0%	6	+5.3%	4%
Reset spending base for SGR targets	−2.3%	6	+2.2%	13%
Remove Part B drugs	−5.0%	5	+5.3%	5%
Combine all three modifications	+2.2%	0	+2.8%	23%

Source: CMS OACT.

Eliminate Spending Targets, Base Fee Updates on Physician Cost Increases

In several reports to Congress, the Medicare Payment Advisory Commission (MedPAC) has recommended eliminating the SGR system of spending targets and replacing it with an approach that would base annual fee updates on changes in the cost of efficiently providing care as measured by MEI.[16,17] Under this approach, efforts to control aggregate spending would be separate from the mechanism used to update fees. The advantage of eliminating spending targets would be greater fee update stability. According to CMS OACT simulations, such an approach would likely produce fee updates that ranged from 2.1 percent to 2.4 percent over the period from 2006 through 2014. (See table 1.) However, Medicare spending for physician services would rise, resulting in cumulative expenditures that are 22 percent greater over a 10-year period than under current law, based on CMS OACT estimates. Although MedPAC's recommended update approach would limit annual increases in the price Medicare pays for each service, the approach does not contain an explicit mechanism for constraining aggregate spending resulting from increases in the volume and intensity of services physicians provide. In 2004 testimony, MedPAC stated that fee updates for physician services should not be automatic, but should be informed by changes in beneficiaries' access to services, the quality of services provided, the appropriateness of cost increases, and other factors, similar to those that MedPAC takes into consideration when considering updates for other providers.[18]

Retain Spending Targets, Modify Current SGR System

Another approach for addressing the perceived shortcoming of the current SGR system would retain spending targets but modify one or more elements of the system. The key distinction of this approach, in contrast to basing updates on MEI, is that fiscal controls designed to moderate spending would continue to be integral to the system used to update fees. Although spending for physician services would likely also rise under this approach, the advantage of retaining spending targets is that the fee update system would automatically work to moderate spending if volume and intensity growth began to increase above allowable rates. The SGR system

[16] See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2001, 2002, 2003, and 2004).

[17] MedPAC suggested that other adjustments to the update might be necessary, for example, to ensure overall payment adequacy, correct for previous MEI forecast errors, and to address other factors.

[18] Medicare Payment Advisory Commission, *Payment for Physician Services in the Medicare Program*, testimony before the Subcommittee on Health, House Committee on Energy and Commerce (May 5, 2004).

could be modified in a number of ways: for example, by raising the allowance for increased spending due to volume and intensity growth; resetting the base for the spending targets and not requiring the system to recoup previous excess spending; or removing the prescription drug expenditures that are currently counted in the SGR system.

Increase Allowance for Volume and Intensity Growth

The current SGR system's allowance for volume and intensity growth could be increased, through congressional action, by some factor above the percentage change in real GDP per capita. As stated earlier, the current SGR system's allowance for volume and intensity growth is approximately 2.3 percent per year—the 10-year moving average in real GDP per capita—while CMS OACT projected that volume and intensity growth would be more than 3 percent per year. To offset the increased spending associated with the higher volume and intensity growth, the SGR system will reduce updates below the increase in MEI. According to CMS OACT simulations, increasing the allowance for volume and intensity growth to GDP plus 1 percentage point would likely produce positive fee updates beginning in 2012—2 years earlier than is projected under current law.[19] Because fee updates would be on average greater than under current law during the 10-year period from 2005 through 2014, Medicare spending for physician services would rise. CMS OACT estimated that cumulative expenditures over the 10-year period would increase by 4 percent more than under current law.[20] (See table 1.)

Reset Spending Base for Future SGR System Targets

In 2002, we testified that physician spending targets and fees may need to be adjusted periodically as health needs change, technology improves, or healthcare markets evolve.[21] Such adjustments could involve specifying a new base year from which to set future targets. Currently, the SGR system uses spending from 1996, trended forward by the sustainable growth rate computed for each year, to determine allowable spending.

MMA avoided fee declines in 2004 and in 2005 by stipulating a minimum update of 1.5 percent in each of those 2 years, but the law did not similarly adjust the spending targets to account for the additional spending that would result from the minimum update. Consequently, under the SGR system the additional MMA spending and other accumulated excess spending will have to be recouped through fee reductions beginning in 2006. If the resulting negative fee updates are considered inappropriately low, one solution would be, through congressional action, to use actual spending from a recent year as a basis for setting future SGR system targets and forgiving the accumulated excess spending attributable to MMA and other factors. The effect of this action would be to increase future updates and, as with other alternatives presented here, overall spending.

According to CMS OACT simulations, forgiving the accumulated excess spending as of 2005—that is, resetting the cumulative spending target so that it equals cumulative actual spending—would raise fees in 2006. However, because volume and intensity growth is projected to exceed the SGR system's allowance for such growth, negative updates would return beginning in 2008 and continue through 2013. Resulting cumulative spending over the 10-year period from 2005 through 2014 would be 13 percent higher than is projected under current law. (See table 1.)

Remove Prescription Drugs from the SGR System

The Secretary of HHS could, under current authority, consider excluding Part B drugs from the definition of services furnished incident to physician services for purposes of the SGR system. Expenditures for these drugs have been growing rapidly, which, in turn, has put downward pressure on the fees paid to Medicare physicians. However, according to CMS OACT simulations, removing Part B drugs from the SGR system beginning in 2005 would not prevent several years of fee declines and would not decrease the volatility in the updates. Fees would decline by about 5 percent per year from 2006 through 2010. There would be positive updates beginning in 2011—3 years earlier than is projected under current law. (See table 1.) CMS OACT estimated that removing Part B drugs from the SGR system would result in

[19] We use GDP plus 1 percentage point as the allowance for volume and intensity growth for illustrative purposes only.

[20] In May 2004 testimony, CBO estimated that this option would raise net federal mandatory outlays by about $35 billion over the 2008–2014 period. Congressional Budget Office, *Medicare's Physician Fee Schedule*, testimony before the Subcommittee on Health, House Committee on Energy and Commerce (May 5, 2004).

[21] GAO, *Medicare Physician Payments: Spending Targets Encourage Fiscal Discipline, Modifications Could Stabilize Fees*, GAO–02–441T (Washington, D.C.: Feb. 14, 2002).

cumulative spending over the 10-year period from 2005 through 2014 that is 5 percent higher than is projected under current law.[22]

Combine Multiple Spending Target Modifications

Together Congress and CMS could implement several modifications to the SGR system, for example, by increasing the allowance for volume and intensity growth to GDP plus 1 percentage point, resetting the spending base for future SGR targets, and removing prescription drugs. According to CMS OACT simulations, this combination of options would result in positive updates ranging from 2.2 percent to 2.8 percent for the 2006–2014 period. CMS OACT projected that the combined options would increase aggregate spending by 23 percent over the 10-year period. (See table 1.)

Concluding Observations

Medicare faces the challenge of moderating the growth in spending for physician services while ensuring that physicians are paid fairly so that beneficiaries have appropriate access to their services. Concerns have been raised that access to physician services could eventually be compromised if the SGR system is left unchanged and the projected fee cuts become a reality. These concerns have prompted policymakers to consider two broad approaches for updating physician fees. The first approach—eliminating targets—emphasizes fee stability while the second approach—retaining and modifying targets—includes an automatic fiscal brake. Either of the two approaches could be implemented in a way that would likely generate positive fee updates and each could be accompanied by separate, focused efforts to moderate volume and intensity growth. Because multiple years of projected 5 percent fee cuts are incorporated in Medicare's budgeting baseline, almost any change to the SGR system is likely to increase program spending above the baseline. As policymakers consider options for updating physician fees, it is important to be mindful of the serious financial challenges facing Medicare and the need to design policies that help ensure the long-term sustainability and affordability of the program. We look forward to working with the Subcommittee and others in Congress as policymakers seek to moderate program spending growth while ensuring appropriate physician payments.

Madam Chairman, this concludes my prepared statement. I will be happy to answer questions you or the other Subcommittee Members may have.

Medicare Physician Payments
Considerations for Reforming the Sustainable Growth Rate System

Concerns were raised about the system Medicare uses to determine annual changes to physician fees—the sustainable growth rate (SGR) system—when it reduced physician fees by almost 5 percent in 2002. Subsequent administrative and legislative actions modified or overrode the SGR system to avert fee declines in 2003, 2004, and 2005. However, projected fee reductions for 2006 to 2012 have raised new concerns about the SGR system. Policymakers question the appropriateness of the SGR system for updating physician fees and its effect on physicians' continued participation in the Medicare program if fees are permitted to decline. At the same time, there are concerns about the impact of increased spending on the long-term fiscal sustainability of Medicare.

GAO was asked to discuss the SGR system. Specifically, this statement addresses the following: (1) how the SGR system is designed to moderate the growth in spending for physician services, (2) why physician fees are projected to decline under the SGR system, and (3) options for revising or replacing the SGR system and their implications for physician fee updates and Medicare spending. This statement is based on GAO's most recent report on the SGR system, *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms* (GAO–05–85).

To moderate Medicare spending for physician services, the SGR system sets spending targets and adjusts physician fees based on the extent to which actual

[22] In May 2004 testimony, CBO estimated that this option would raise net federal mandatory outlays by about $15 billion through 2014. Congressional Budget Office, *Medicare's Physician Fee Schedule*, testimony before the Subcommittee on Health, House Committee on Energy and Commerce (May 5, 2004).

spending aligns with specified targets. If growth in the number of services provided to each beneficiary—referred to as volume—and in the average complexity and costliness of services—referred to as intensity—is high enough, spending will exceed the SGR target. While the SGR system allows for some volume and intensity spending growth, this allowance is limited. If such growth exceeds the average growth in the national economy, as measured by the gross domestic product per capita, fee updates are set lower than inflation in the cost of operating a medical practice. A large gap between spending and the target may result in fee reductions. There are two principal reasons why physician fees are projected to decline under the SGR system beginning in 2006. One problem is that projected volume and intensity spending growth exceeds the SGR allowance for such growth. Second, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) increased the update for 2004 and 2005—thus increasing spending—but did not raise the spending targets for those years. The SGR system, which is designed to keep spending in line with its targets, must reduce fees beginning in 2006 to offset excess spending attributable to both volume and intensity growth and the MMA provision. In general, proposals to reform Medicare's method for updating physician fees would either (1) eliminate spending targets and establish new considerations for the annual fee updates or (2) retain spending targets, but modify certain aspects of the current system. The first approach emphasizes stable and positive fee updates, while the second approach automatically applies financial brakes whenever spending for physician services exceeds predefined spending targets. Either approach could be complemented by focused efforts to moderate volume and intensity growth directly. As policymakers consider options for updating physician fees, it is important to be mindful of the serious financial challenges facing Medicare and the need to design policies that help ensure the long-term sustainability and affordability of the program.

Chairman JOHNSON. Thank you, Mr. Steinwald. Mr. Hackbarth from MedPAC. Thank you for being with us this morning.

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

Mr. HACKBARTH. Thank you, Chairman Johnson and Congressman Stark.

Mr. STARK. Microphone.

Mr. HACKBARTH. Is that better? Thank you, and I appreciate the opportunity to report on MedPAC's recommendations. Our March report, soon to be published, will include recommendations, not just on the SGR, but on pay-for-performance for physicians, resource measurement—that is developing tools that allow us to assess physician performance—and imaging services. Let me begin by being explicit about the premise that is beneath my—supports my testimony, and that is that the U.S. healthcare system is a very technologically advanced healthcare system which, at its best, works wonders for Medicare beneficiaries, indeed the whole population. It does not, however, provide consistently high-quality service. By high quality, I mean service that is consistent with evidence-based guidelines for care and avoids errors in the provision of care. While physicians as a group are extraordinarily dedicated professionals—and I have had the privilege as Chief Executive Officer (CEO) of a large group to experience that firsthand—not all physicians are equal in terms of their performance. Some physicians perform better than others on quality of care, patient satisfaction and deficiency. Of these—these are not just MedPAC's conclusions or my personal conclusions. They are the conclusions of years of research and of esteemed bodies like the Institute of Medicine.

The conclusion that MedPAC draws from these findings is that policies, like the SGR system, that treat all physicians as though they performed equally are inequitable. Even more important than that, they fail to create appropriate incentives to improve performance and invest in systems that would aid in better provision of health care. As a result, we think a better approach is a more targeted approach, one that establishes explicit performance standards and rewards physicians accordingly while also establishing incentives to invest in quality-enhancing systems. We believe that a latter approach develops analytic tools to help individual physicians as well as the Medicare program, better understand how their practice compares to their peers on both quality and efficiency. We believe a better approach focuses on areas of rapid growth and expenditures, like imaging, to ensure that we are buying care that is appropriate, of high quality and safe for Medicare beneficiaries.

We recognize this targeted approach is not an easy approach by any stretch. Unlike the SGR, it is not automatic. It requires specific judgments about what we want and what we do not want in the provision of medical care, about what is good and what is bad. It requires investment in developing systems, analytic tools, administrative processes. It also, frankly, requires taking some calculated risks. Any complicated endeavor of this sort, mistakes will be made, some misjudgments will be made that we will have to recognize and address and improve over time. Despite these challenges, which are very real, we strongly believe, unanimously believe, on the Commission that it is the best course for Medicare to begin targeting our efforts to improve quality and reduce cost. That is the course that is in the best interest of the program, the best interest of Medicare beneficiaries, and ultimately for the U.S. healthcare system. Thank you very much.

[The prepared statement of Mr. Hackbarth follows:]

Statement of Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission

Chairman Johnson, Congressman Stark, 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 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 service volume. The sustainable growth rate (SGR) system was meant to control the volume of physician services and hence total expenditures for physician services by setting the update (change in unit payment for the year) for physician services. The SGR is based on changes in: the number of beneficiaries in the Medicare fee-for-service program; input prices; law and regulation; and gross domestic product (GDP). The GDP, the measure of goods and services produced in the United States, is used as a benchmark of how much growth in volume society can afford. The basic SGR mechanism is to compare actual spending to target spending and adjust the update when there is a mismatch.

The SGR approach has three basic problems.

- 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, negative updates would provide a budget control but in so doing would produce fees that in the long run could threaten beneficiaries' access.
- 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 SGR formula has produced updates that in some years have been too high and in others too low. MedPAC has consistently raised concerns about the SGR—when it has set updates both above and below the change in input prices. The current projection, according to the trustees of the Medicare trust funds, is that annual updates of negative five percent will occur for seven 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.

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. At the same time, the growth in the volume of physician services should be addressed directly. Volume and volume growth differs across geographic areas and by service and ultimately is the result of individual physician's practice decisions. Is all the care being provided necessary? Dartmouth researchers and others have shown that often high quality care is not correlated with more services. We know the private sector is taking steps to control volume in services such as imaging with very high growth rates. Volume growth must be addressed by determining its root causes and specifying 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.

In this testimony we will first review how the SGR came about and explain the problems with it. Then we will discuss our recommendations. First, a year-to-year evaluation of payment adequacy to determine the update. Second, approaches that would allow Medicare to differentiate among providers when making payments as a way to reduce inappropriate volume of services and improve the quality of care. Currently, Medicare pays providers the same regardless of their quality or use of resources. We recommend 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, the Commission recommends that providers who perform imaging studies and physicians who interpret them meet quality standards as a condition of Medicare payment. Further, the Commission recommends measuring physicians' use of Medicare resources when serving beneficiaries and providing information about practice patterns confidentially to physicians. This recognizes the unique role of physicians—who order tests, imaging studies, surgery, drugs—as gatekeepers of the healthcare system. These are all important steps to improve quality for beneficiaries and to lay the groundwork for obtaining better value in the Medicare program.

Historical concerns about physician payment

The Congress established the fee schedule that sets Medicare's payments for physician services as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA89). As a replacement for the so-called customary, prevailing, and reasonable (CPR) payment 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 CPR-method payment rates by geographic area, that could not be explained by differences in practice costs.

A third element of the OBRA89 reforms is central to our testimony today. The legislation 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.

Because of physicians' unique role in the healthcare system, the hope was that the VPS would give them a collective incentive to control the volume of services. Physicians order tests, imaging studies, surgery, drugs, and otherwise serve as gatekeepers of the healthcare system. In addition, the unit of payment in the fee schedule is quite small—over 7,000 discrete services.

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 as part of the Balanced Budget Act of 1997. Under the SGR, the expenditure target is not a function of historical growth in the volume of services. Instead, the SGR target is based on growth in real GDP per capita and other factors—inflation in physicians' practice costs, changes in enrollment in fee-for-service Medicare, and changes in spending due to law and regulation. As noted, the real GDP factor was included in the SGR to link the expenditure target to growth in the national economy. This linkage was thought appropriate because volume growth for physician services is theoretically as unlimited as the demand for health care. Congress decided to link growth to GDP as a benchmark of what the U.S. economy could afford.

The problem with the current update system

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 nationally 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.

Compounding the problem with the conceptual basis of the system, the SGR system has produced volatile updates. 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 unexpected large reduction in 2002 of 5.4 percent. This volatility illustrates the problem of trying to control spending with an update formula.

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.

A different approach to updating payments

To address these problems, 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. Replacing the SGR system could allow updates more consistent with efficiency and quality care and would also uncouple payment updates from spending control. If total spending for physician services needs to be controlled, it is necessary to look not only at adjusting payment updates, but at controlling volume growth directly—as discussed in the next section.

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 Medicare might need to exercise budget restraints and MedPAC's analysis would serve as one input to Congress's decisionmaking process.

For example, we use this approach in our recommendation on the physician payment update in our March report to the Congress. Our assessment is 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, are 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. In the fall of 2004, MedPAC found that among beneficiaries looking for a new doctor, 88 percent reported little or no problems obtaining a new primary care physician. Access to specialists was even better—94 percent reported little or no problems. Further, Medicare beneficiaries and privately insured individuals age 55–64 report very similar experiences accessing physicians. Indeed, Medicare beneficiaries' reported as good as or better access than their privately insured counterparts. (These findings are consistent with earlier work done by the Center for Studying Health Systems Change.) A large national survey found that among office-based physicians who commonly saw Medicare patients, 94 percent were accepting new Medicare patients in 2003. This figure is up 1 percentage point from 2002.

We have also found that the supply 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. In consideration of expected growth in physicians' costs and our payment adequacy analysis, the Commission recommends that payments for physician services be updated by the projected change in input prices, less an adjustment of 0.8 percent for productivity growth.

This update should be thought of in the context of the entire package of our physician payment recommendations. The update, coupled with pay for performance and our imaging recommendations discussed below, will provide an adequate increase in physician payment overall while starting to reward better quality and dampen growth in a rapidly growing service. Over the next few years, as quality performance is rewarded, as physicians are made aware of their practice patterns and increase efficiency, and as specific volume problems are targeted, Medicare can improve the value of the physician services it buys.

A different approach to controlling volume

If payment rates are adequate and updated to account for changes in efficient physicians' cost, the remaining issue is controlling volume, which is important for both beneficiaries and taxpayers. For beneficiaries, increases in volume lead to higher out-of-pocket costs—co-payments, the Medicare Part B premium, and any premiums they pay for supplemental coverage. For taxpayers, increases in volume lead to higher Part B expenditures supported with the general revenues of the Treasury. The MMA has established a trigger for legislative action if general revenues exceed 45 percent of total outlays for the Medicare program.

For beneficiaries, 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, and 17.3 percent in 2005.

Volume growth also has implications for the federal budget. The Committee is aware of the growth of Medicare relative to the nation's output of goods and services as discussed in the Medicare trustees report. Increases in Medicare spending per beneficiary is an important reason for that growth, cited by the Congressional Budget Office and the General Accounting Office among others.

However, some of the root causes of volume growth may be amenable to policy action and some 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. Among broad categories of services, growth in volume per beneficiary ranged from about 15 percent to almost 45 percent, based on our analysis of data comparing 2003 with 1999 (Figure 1). Within these broad categories, growth rates were higher for services which researchers have characterized as discretionary (e.g., imaging and diagnostic tests). In imaging, for example, growth rates were over 15 percent a year for such services as magnetic resonance imaging, computed tomography, and nuclear medicine.

In addition, 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 (e.g. Wennberg and Fisher) have reached several conclusions about such findings:

- Differences in volume among geographic areas is primarily due to greater use of discretionary services sensitive to the supply of physicians and hospital resources.

- On measures of quality, care is often worse 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, suggesting patients may be delaying entry into the healthcare system because of patient discomfort with the level of specialization.

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

In our March report to the Congress we make several recommendations that taken together will help control volume and increase quality of Medicare physician services. Our basic approach is to differentiate among physicians and pay those who provide high quality services in a resource efficient way more, and pay those who do not, less—or in some cases not at all. 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.

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 a variety of demonstration projects, such as the group practice demonstration, aimed at tying payment to quality. 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. CMS's prior quality investments provide a foundation for initiatives tying payment to quality and encouraging the diffusion of information technology.

However, for the most part, Medicare, the largest single payer in the system, still pays its healthcare 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. The incentives of this system are neutral or negative toward improving the quality of care.

To begin to address these issues, the Congress should 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 over time a broader set of measures.

IT measures should describe evidence-based quality- or safety-enhancing functions performed with the help of IT. Functions might include, for example, tracking patients with diabetes and sending them reminders about preventive services, or providing educational support for patients with chronic illnesses. This approach focuses the incentive on quality-improving activities, rather than on the tool used. It also allows providers to achieve performance in the early stages without necessarily investing in IT, although it would be easier if they did so. The potential additional payment may also increase the return on IT investments.

Because physicians play a central role in directing patient care, their adoption and use of IT should be a part of physician pay-for-performance initiatives from the start. Physician use of electronic health records promises to lead to better care management, reduced errors, improved efficiency, and can facilitate reporting of meaningful quality indicators that may not otherwise be available. However, few providers use IT for clinical (as opposed to administrative) functions perhaps because it is difficult to demonstrate an adequate return on investment.

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.

Process measures for physicians, such as monitoring and maintaining glucose levels for diabetics, should be added to the pay-for-performance program as they become 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 healthcare 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; that is if they provided fewer diagnostic services, used fewer subspecialists, referred patients less frequently to hospitals and intensive care units (ICUs), and did fewer minor procedures.

MedPAC recommends that Medicare measure physicians' resource use over time, and feed back the results to physicians. Physicians would then be able to assess their practice styles, evaluate whether they tend to use more resources than either their peers or what evidence-based research (when available) recommends, and revise their practice style as appropriate. 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 use the results in payment, for example as a component of a pay-for-performance program.

Although comprehensively measuring resource use and quality may be difficult, we must ask ourselves what the cost is of doing nothing. 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. This recommendation would 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 (Figure 1). This increase has been driven by technological innovations that have improved physicians' ability to diagnose disease and made it more feasible to provide imaging procedures in physician offices. Other factors include:

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

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, create an urgent need for Medicare to develop 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 services provided by physicians operating within the scope of practice defined by the state in which they are licensed. The Commission concludes that requiring standards is warranted because of the growth of imaging studies provided in physician offices and the lack of comprehensive standards for this setting. 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, CMS should through administrative action:

- 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
- strengthen the rules that restrict physician investment in imaging centers to which they refer patients.

CMS should improve their coding edits that detect improper imaging claims, such as claims for unbundled and mutually exclusive services. Medicare also should discount payments for multiple imaging studies of the same modality that are performed on contiguous body parts. Medicare payments should reflect the efficiencies that are often gained when studies are performed in tandem.

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, IT, measuring resource use, and reform of payments for imaging service—can help Medicare beneficiaries receive high-quality, appropriate services while also controlling volume growth. Although the Commission's preference is to address issues of inappropriate volume increases directly as discussed in the previous section on imaging, we recognize that the Congress may wish to have some form of limit on aggregate volume as well; but it needs to be one that will more closely match physician's incentives to their individual performance. In our March report to the Congress, we will discuss potential ideas for creating incentives for more effective volume control methods that encourage more collaborative and cost effective delivery of physician services in accordance with clinical standards of care.

Chairman JOHNSON. I thank the witnesses for joining us this morning and for the work you have done over the last number of months in preparation for our tackling this issue. There are two things, two brief questions that I want to ask about, the functioning of current law. I do thank MedPAC for the recommendations in regard to imaging, which I will not pursue in this hearing. The law explicitly requires that we adjust the target for any impact on physician visits that law or regulation has imposed. Those words of law and regulation have been very imperfect instruments, and we are going to hear later in this hearing testimony about things that have affected the number of physician visits, and are the direct consequence of policy changes adopted by either the Congress or the Administration, and yet were not included and were not considered in setting the target.

Then there are nongovernmental things. For instance, advertising drugs. If it is a prescription drug, your doctor has to prescribe it. So, advertising drugs has resulted in a lot of physician visits that drive that volume up, that force that snapback in reimbursements, when actually that physician visit was not necessary, except that person wanted to evaluate the drug they heard advertised on television that morning in regard to their health. So, the adjustment that is implied in the law that will take place is inadequate, because a lot of new visits and volume issues are driven by forces outside law and regulations and our own policy initiatives. So, I would like you to comment on that factor. Also, not in the SGR formula, but in the target setting, we take into account the cost of drugs, at least those drugs, Part B drugs, administered by the physicians, and that cost—as that cost has gone up, that has dictated cuts in physician payments in a way that is, in my estimation, totally irrational. So, I would like you to comment on those two aspects of the formula that are part of what is driving the appearance that we are spending a lot more money on physician services. Either one of you, in whatever order you want to go.

Mr. STEINWALD. Okay. I will start, Mrs. Johnson. With regard to the elements that enter into the setting of the SGR targets, I mentioned one of them, the allowance for growth above inflation is gross domestic product. Then there is the—what is called the Medicare economic index that measures inflation in running a medical practice. There is also the size of the fee-for-service beneficiary population, which tends to fluctuate from year to year. In addition, the

Secretary has the authority to adjust the targets for changes in law and regulation that could affect spending for physician services. We have said at GAO that we think that CMS could be more transparent in how it makes those adjustments, makes it more of a public process. Other than that, we have not commented on whether we believe they have been deficient in their adjustment for law and regulation changes. With regard to Part B drugs, one of the options that we did outline in our report to you and in our testimony today, was the removal of Part B drugs from calculating the formula. In the past, Part B drug spending has inflated faster than the cost of physician services. The effect of having Part B drugs into the target-setting process has been to impose additional downward pressure on physician fee updates over time.

Mr. HACKBARTH. For one of our reports, our mandated reports—and forgive me for not being able to remember which one—we were asked to look at the process that the CMS actuaries used to adjust for changes in law and regulation. We did not look at specific estimates, but we looked at the process. Based on that, and based on my own experience at CMS as deputy administrator, I have a lot of sympathy for the difficulty of the task the actuaries are asked to do. Often making an estimate of how these things will affect cost trends is exceedingly difficult. There simply is not sound evidence on which to base an estimate. So, in cases where they do not have sound evidence, they will not make an estimate in the first instance, but will assume as an initial assumption, no effect. Then they will go back and look at the actual performance, and as I understand the framework, they are permitted to go back and retrospectively make some adjustments. All in all, we think that that process that they use is a reasonable one, although we would agree with what GAO says about the need for greater transparency in the process.

With regard to the point you made, Chairman Johnson, about a variety of societal factors, affecting the growth rate in services, whether it is direct advertising to consumers or technological changes, and the initial structure of the SGR, the purpose of the GDP element and formula was to provide an allowance for increased volume and intensity of service due to those sorts of factors. So, that is the piece of the formula that is to address changes that go on in the healthcare system or even in beneficiary preferences. The issue becomes, under the formula, whether it is a sufficient allowance to take into account those factors. At the end of the day, as you well know, it is MedPAC's judgment that trying to tinker with a formula of this sort, that applies across the board, affects all physicians without regard to their individual performance and provides no incentive to alter patterns of practice. It is just not a good thing to be doing. It is going to create inequity. It is not going to move the system in the proper direction. We need a much more targeted approach to do that.

Chairman JOHNSON. Thank you. There are other factors like national coverage decisions, local coverage decisions that affect this, and they are beyond the control of the physician, so I think tinkering, you would have to tinker with an awful lot of parts of it. So, thank you both for your comments. I think it is also germane that, with regard to Part B services, we have now distinguished be-

tween drug price and physician cost and reformed that entire service. I think that gives us some indication of how we might go forward in translating that into this formula. Mr. Stark.

Mr. STARK. Thank you, Madam Chair. Mr. Steinwald, Mr. Hackbarth, thank you both for your work. Do you know, Mr. Steinwald, off the top of your head, or would it be easy to find out, in your chart, which is on page 11, you list the cumulative expenditure increase relative to current laws as percentages. Would you be able to quantify that, put a number to those percentages, do you know?

Mr. STEINWALD. I personally would not.

Mr. STARK. Okay.

Mr. STEINWALD. The actuaries in CBO and in——

Mr. STARK. I think that is important in the measure. I just wanted to make a couple of comments and ask you each question. It is the case that the spending for physician services by Medicare has grown at the average rate of about 6 percent a year since 1997. By the end of 2002, we had exceeded our target by $17 billion, and I think CBO is not sure today. It says that, in the next few years, the target would have grown by another $10 billion. So, that while we cut the rates, the aggregate amount paid—and I may add that we did not add a whole lot of Medicare beneficiaries over that period of time, so that basically, I think, it could be said that the aggregate payment of these physicians went up comfortably.

Now, I wanted to ask Glenn if you know—there have been two suggestions coming out of the—what is called the physician community. One has been to eliminate the SGR. The CBO, I understand, says that would cost us about $135 billion over 10. So, there is one juicy bit of money. Or, retroactively, take the prescription drug formula out of the growth formula, and that would cost us about, let us see, $119 billion over 10. I am hearing, and I wondered if those are correct. I wondered if you could comment on either the affordability or wisdom of either option, or, Mr. Steinwald—I mean, there are several suggestions out here, and I want to see if either of you or both of you could pinpoint the one you like best and how much you think it would cost.

Mr. HACKBARTH. Yes. Well, the price tag associated with any of these changes in physician payment is obviously driven by the SGR baseline. From our perspective, the baseline itself is unrealistic. It is detached from reality. The Medicare trustees in their most recent report said that the updates that this baseline envisions are unrealistically low. I daresay nobody expects that we are going to repeatedly cut physician fees 5 percent and more year after year after year. So, we are in a very difficult position where the baseline is not realistic, and it results in any constructive positive change having a very, very large price tag. From our perspective, that is one of the worst aspects of SGR. It has become a barrier to sound, prudent policy. We have not taken a position on proposals to remove drugs, for example, retrospectively, going back to the beginning of the SGR system. We see those as proposals that do not deal directly with policy, that is how much we should pay physicians. The real issue is about scoring, how can we alter this baseline with the minimum score, and we do not think that it is

appropriate for MedPAC to be dealing in what are essentially scoring issues.

Mr. STARK. Well, you touch on that. Do you have statistics that it might be interesting if—I know your staff does not have anything else to do—but the payment rates per procedure that Medicare pays and what Blue Cross or other indemnity payers, it has not always been lower, as I understand it.

Mr. HACKBARTH. Well, in fact, it is one of the measures that we look at in assessing payment adequacy. As you look across the country, in fact, Medicare pays on average less than private payers. Actually, the Medicare payment has gone up recently, compared to private payment, but is still below on average. There is a lot of variation in that across the country. In some cities, Medicare is a comparatively good payer. In other cities, it pays quite a bit less.

Mr. STARK. Yes, that is what I was going to say. There are some areas where it pays more, I understand.

Mr. HACKBARTH. There are, in fact.

Mr. STARK. Do you adjust that—if I could just finish, Madam Chair, then I will shut up. Because there are not many payers for folks over 65 other than Medicare?

Mr. HACKBARTH. Right.

Mr. STARK. You adjust, in other words, when you say private insurance pays often more, but does private insurance for the same procedure?

Mr. HACKBARTH. Well, private insurance is not determined on the age of the patient; it is based on the procedure of the type of office visit, and so there is not an age difference.

Mr. STARK. Thank you.

Mr. STEINWALD. Mr. Stark.

Mr. STARK. Yes, go ahead.

Mr. STEINWALD. You asked about outpatient prescription drugs, and Glenn touched on it briefly. As I said, one of our options for you is to remove outpatient prescription drugs from the calculation of the target, but that was forward-looking. We have done a little bit of looking about whether the CMS has the authority to remove them retroactively, or retrospectively. If you will recall in 2003, they did adjust the targets in order to achieve a positive update for 2003. It seems to us that the same facts and circumstances would permit them if they wished to do a retroactive adjustment of targets, but that would be up to CMS.

Mr. STARK. Madam Chair, if I could just yield at this point, because I would like to make a comment here that I think is important. There is a little bit here of territorial dispute. If the Administration, as I understand it, goes—makes these adjustments, it comes basically out of their budget, if you will.

Chairman JOHNSON. Yes.

Mr. STARK. If we do it legislatively, it comes out of ours. Therefore, there has always been a little tension between—they would say to us, you guys legislate.

Chairman JOHNSON. That certainly is correct.

Mr. STARK. Well, you do it on our side of the budget requirement, and if we say, CMS, you have the authority to do it, it comes out of theirs. I just point that out as there is—that is a little bit of back and forth.

Chairman JOHNSON. We are keenly aware of it. We have written—exchanged correspondence on this subject quite extensively.

Mr. STARK. I understand that.

Chairman JOHNSON. However, I think the legislative action that the Congress took in the last session in the MMA strengthens our case considerably. Mr. Ramstad—excuse me, Mr. Johnson of Texas, excuse me, my mistake.

Mr. JOHNSON. Thank you, Madam Chair.

Chairman JOHNSON. I saw Johnson and skipped over him.

Mr. JOHNSON. Mr. Hackbarth, I know you all were possibly considering pay for performance. I think it is a priority of CMS based on quality outcomes. As you said, medical imaging costs in Part B have experienced pretty good growth, and it makes sense as doctors are more frequently putting imaging machines in their own offices as opposed to handing their patients off across town to the hospital. In my mind, that provides great continuity of care as long as the imaging is up to par. So, your recommendation to implement standards of quality for imaging services in Part B makes sense to me. Kodak's Health Imaging Division is in my district, and they are innovative, as you know, working on translating technology into better care for patients. They would probably welcome a chance to set themselves apart. A few publications have noted the worth of less invasive therapies that are available because of medical imaging. In fact, the New England Journal of Medicine has called imaging one of the most important developments in the past 1,000 years, right up there with anesthesia, which anyone who has ever had surgery thinks is pretty good. It seems to me that Medicare could save money by avoiding longer hospital stays for patients and the patients benefit from an easier recovery. I am wondering if you know of any credible studies that have been done to analyze the cost of performing medical imaging versus the actual and potential savings that imaging might offer to private and public health programs. If not, do you think that Congress ought to direct GAO or the U.S. Department of Health and Human Services (HHS) to action in this area before we take up legislation?

Mr. HACKBARTH. MedPAC agrees that medical imaging, advances in medical imaging are tremendous advances in medical care, often can both improve quality and reduce cost, to the extent, for example, that they—the imaging avoids unnecessary surgery, et cetera. So, not only are we in favor of the advancement in imaging—personally, I stand and wonder, looking at some of the equipment and what can be done. Now, having said that——

Mr. JOHNSON. There is a machine right behind you, I can see right through you.

Mr. HACKBARTH. That is what I was afraid of. Now, having said that, we do have some concerns, because there are a number of forces coming together here that changed the environment substantially. One is the advanced technology—and it is not only better, but it is also getting smaller and lower cost, which is making it feasible, for example, for physicians to purchase it and move it out of hospitals and large imaging centers.

Mr. JOHNSON. We need to cover their costs.

Mr. HACKBARTH. That is clearly an issue. As it moves out, that creates some issues. As things move out of institutional structures,

like hospitals, where there are systems of oversight, into settings where there is less oversight, we need to be very vigilant about the quality of care provided and the safety of care provided, and that is the reason that we have made the recommendations that you referred to that Medicare needs to step up its efforts to assure both quality and safety as things migrate out of institutional settings. Right now, we have got a patchwork system aimed at quality and safety, and we think it needs to be much more systemic and organized, and that there are precedents for it. For example, a mammography screening, some years ago, a system was instituted to assure quality and safety for patients. We think some of those models could be applied more broadly in imaging. Now, with regard to your specific question about how much is saved, I am sure that there is research on that, that is not research that we have reviewed specifically. Frankly, we are willing to assume that, in many cases, it does save money, but it does not follow from that, that in every case, it saves money. So, what we would need is a system that, as I said at the outset, can more accurately discriminate between what is good, improving quality, reducing costs, from unnecessary, low quality and perhaps unsafe. You cannot generalize; you have got to go in and be very discriminating in your tools.

Mr. JOHNSON. Thank you so much. You all keep up the good work. Thank you, Madam Chairwoman.

Chairman JOHNSON. Thank you. Congressman Lewis.

Mr. LEWIS. Thank you very much, Madam Chair, for holding this hearing. I want to thank the two of you for being here this morning. Mr. Steinwald, I would like to know from you, are there possible fixes you talk about in your statement, what can CMS do under its current regulatory authority and which require statutory action on the part of those of us on this Committee or on the part of Congress?

Mr. STEINWALD. Yes, sir. To the best of my knowledge, of the options that we outlined, the only one that CMS has authority to implement on its own, relates to outpatient prescription drugs. We are fairly certain they have the authority to do it prospectively, remove the drugs from spending from setting the SGR targets. We are uncertain about whether they have the authority to do it retrospectively. We think that they might, but that would be a determination. I am sure they would be very careful to come up with. All of the other ones that we have outlined in our report in October and our testimony today would require legislative action.

Mr. LEWIS. Thank you very much. The Chair—and I believe you, Mr. Hackbarth, made reference to all of the media, especially television adds, some mornings and the evening, we see the television saturated with ads from pharmaceuticals. Do you have any evidence that customers or patients are saying to their doctor, "Doctor, I saw such and such a thing on television, why don't you try that? Why don't you prescribe it for me?"

Mr. HACKBARTH. I am sure that there is research out there. I have not reviewed it. MedPAC has not reviewed it. Anecdotally, working with physicians, I have heard physicians talk about the impact that the advertising has on the relationships with patients and their expectations, but that is just anecdotal.

Mr. LEWIS. You do not have any evidence that patients or the relatives of patients sort of converge on the doctors and say, "I am convinced because of this ad." With all this pressure from these ads, spending hundreds, thousands, millions of dollars, somebody has got to use some of this medicine.

Mr. HACKBARTH. Well, I would assume that the advertisers believe that it has an impact. Maybe they are the best words, they would not be spending all of this money unless they thought that it caused patients to go to their physicians and urge the physician to prescribe the medicine. They are doing it because they expect an impact. There may be academic research on the issue. I am not aware of it. MedPAC has not looked at it. Anecdotally, I have heard from physicians that it affects the dynamics of their interactions with patients, but that is all I have right now, Mr. Lewis.

Mr. LEWIS. Mr. Steinwald, would you have any reading on this?

Mr. STEINWALD. No, sir, I have nothing.

Mr. LEWIS. Wouldn't that be an interesting study for someone to conduct?

Mr. STEINWALD. Well, it might be, although advertising has been around now for some years. As Glenn pointed out earlier, there is an allowance in the update system for increased spending, that is increased volume and intensity of services, beyond the cost of the increase in the medical practice. That increase is set at the growth of GDP. It might be your judgment or anyone else's that that is too low of an allowance, and one of the options we presented to you was to increase that allowance to above GDP growth. That would accommodate just the kind of trend that you are talking about that leads to more services being prescribed.

Mr. LEWIS. Well, with something that is driving this increase in growth, delivery of health care; it is not just the fees for doctors, hospitals. What about drugs?

Mr. HACKBARTH. There are a number of different drivers of the increase. The one most often discussed is just technological change. The things that we can do for patients is ever-expanding, because of scientific advances. Often, although not always, the advancements, at least initially, cost more. A typical pattern that we see is a new technology and a new approach will become available, and it is applied to a small group of patients initially, and then over time as it is refined, improved, the pool of patients expands and the service, for example, is provided to patients that have higher levels of risk. So, there is the initial cost of the new technology and expanding diffusion of the technology across the patient population. That is one of the single most important drivers of the rate of increase in healthcare costs, not just for Medicare, but for society at the large. There are other factors. For example, direct consumer advertising alters patients perspectives. There are a lot of factors. Technology, broadly described, is probably the single most important.

Mr. STEINWALD. I would like to add to that a little bit. In support of something that Glenn said early in his statement, just because we see these increases, and they may be driven by technology and other drivers, it does not indicate that all of it is necessary and of high value to Medicare beneficiaries. We have some evidence, especially in the variability with which elective surgery

procedures, for example, are performed around the country, that leads us to believe that at least some of the utilization and some of the utilization increase we observe is not really necessary or of benefit to Medicare's beneficiaries. This leads us to further believe that there are opportunities to achieve savings in the program and, at the same time, provide beneficiaries with the services that they really need.

Mr. LEWIS. Thank you, very much. Thank you, Madam Chair.

Mr. HACKBARTH. Chairman Johnson, could I just add one point on this, because I really think this goes to the heart of the challenge facing Medicare and the healthcare system. One piece of evidence of the sort that Bruce was talking about is research done by Jack Wennberg and Elliott Fisher at Dartmouth, looking specifically at the care provided by academic medical centers, the jewels of our healthcare systems, the leaders in innovation. They looked at the patterns of care in academic medical centers for Medicare beneficiaries with some common medical problems. What they found was enormous variation, as Bruce describes, in the volume and intensity of service provided to Medicare beneficiaries. These are renowned institutions that each of you would instantly recognize. So, they vary greatly in what they do to patients with common problems. The quality of the result is not related to the cost. In fact, often, the highest-cost institutions that provide the most intense service have lower quality results. So, what we need is a system that—no, technology is not bad; technology is great. It does wonderful things, but it is not always great. It is not always appropriate, and we need to start to have systems that can make judgments about what is good and necessary and beneficial and what is not. Across the board approaches will not work.

Chairman JOHNSON. Thank you for that clarification. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Madam Chairwoman, for convening this important hearing. Thank you, gentlemen, for your participation and important testimony here today. Mr. Hackbarth, I am sure you know that CMS recently announced that 10 large physician groups will participate in the first pay-for-performance initiative. The demonstration project will allow physician groups to show that improving care in a proactive, coordinated way saves money. I was certainly grateful to see that Park Nicollet in my home district of Minnesota was selected to be part of this important demonstration. As both of you gentlemen know, I am sure, Minnesota has a history of delivering high quality care efficiently, but we have been penalized for this in various Medicare systems. The biggest culprit—our biggest nemesis is the AAPCC formula for managed care that rewards, really, high cost and inefficiency. A State like Minnesota, that has a history of lower costs and high quality, we are penalized for that cost deficiency. The formula is unfair. It is inequitable and unjust, to put it kindly, and I certainly believe that pay-for-performance paradigm in Medicare has great potential to improve outcomes for Medicare patients and reduce overall costs. My question for you, Mr. Hackbarth, is whether or not the CMS demonstration project matches the outlines of your recommendations for updates based on a pay-for-performance?

Mr. HACKBARTH. Yes, in general terms, it certainly does. We are very excited about that demonstration and think that it has a lot of promise. In fact, one of our commissioners is the CEO of one of the groups involved, so we have learned a lot about it from him. What is unique about the demonstration and particularly exciting is that it will base the performance payments on both quality and efficiency in the provision of services and brings the two things, which, from our perspective are the ultimate goal to finding value, a combination of high quality and efficiency. Then the other thing that it does that we are especially excited about, is that it combines Parts A and B. We have this—from the perspective of the healthcare world, this artificial distinction between A and B, and it comes to be a barrier in improving performance, because it is an artificial line. Sometimes the things that will save money and improve quality span that artificial A–B line, and this demonstration is going to leap over it. So, there is a lot about the demonstration that we think is really promising. Having said that, we do not think that Medicare needs to stop, not do pay-for-performance at all until this demonstration project is complete. We believe that there are steps that can be taken for physicians and other providers that will begin moving the process forward, link payments to quality, and then down the roadway, we can take the lessons from this demonstration and take this to a larger step in the future.

Mr. RAMSTAD. Well, your testimony and your response is very refreshing. For the first time since I have been here, 15 years, I am sensing a paradigm shift. Sometimes changing Medicare is a little bit like moving a glacier. On both counts, your responses showed some promise. It is really hard for me to continue explaining to the seniors in Minnesota when they go to Florida or they go to California, without dividing the panel among States here, but the inequities in the AAPCC formula. There is no way that those inequities can be rationalized or justified. So, when you talk about a pay for performance paradigm in Medicare and you talk about, as you did, combining A and B, those are very positive signs. I applaud you for that progress. Let's continue to work together in a pragmatic way and make these necessary changes to improve Medicare for everyone. Thank you, Madam Chairman.

Chairman JOHNSON. Thank you very much. I would like to recognize Mr. Doggett.

Mr. DOGGETT. Thank you, Madam Chairman. Thank you, gentlemen, for your testimony. Let me direct my questions to Mr. Hackbarth, but I welcome anything you would want to add, Mr. Steinwald. I represent the poorest county in America, trails even the Mississippi delta, Starr County down on the border, and the poorest metropolitan statistical area, the area around McAllen and Mission, Texas. I have a number of physicians there who rely on Medicare, Medicaid, children's health insurance program for their high-paying folks; and the poor folks are the ones that don't qualify relatively for those programs. When you talk in your testimony about the inequities in the current payment system because they treat all physicians and regions of the country alike, how are the changes that you are contemplating likely to affect an area like

that and physicians who practice there in that kind of practice setting?

Mr. HACKBARTH. There are a couple of different approaches to this. One is that, over the course of a number of years, we have looked at the payment rules, the payment system, how the formulas work to try to assure that they pay providers in rural areas, in smaller communities, equitably. Going back a number of years now, we have made recommendations, for example, in the hospital payment system, many of which were included in MMA, that address what we saw to be inequities in the payment formulas. They have increased payment to rural healthcare providers of various types, both hospitals and physicians. The results of those changes are not yet in. Some of them are relatively new, but we think some very important steps have been taken toward payment equity. With regard to pay for performance, our goal there is to have evidence-based standards of care that wouldn't be different for a rural beneficiary or an urban beneficiary. This is what good medicine requires. So, to the extent that rural providers do very well, and we have reason to believe that many can do very well on those quality scores, they will get additional payment reflective of the quality of their practice. On the other hand, if they perform poorly, then they will lose money. That really ought not be an urban/rural thing. That ought to be a standard about what constitutes appropriate quality.

Mr. DOGGETT. How do we measure the quality of their practice?

Mr. HACKBARTH. For a physician specifically, we recommend basically a two-step process. The first step is to begin adjusting payment based on a physician's or a physician group's ability to produce and use specific types of information that are important in providing quality of care. For example, the ability to identify patients with chronic illness and provide appropriate care, track what they need, follow up on abnormal results and the like. It is the information capability. Good medical practice has to be based on good information. So, what we envision under some projects out there that have already specified information standards, we would say, to the extent that a physician collects and uses this sort of information, they ought to get additional payment and they ought to be rewarded for that.

Mr. DOGGETT. They won't be penalized because they have a higher percentage of people who are poor and sick?

Mr. HACKBARTH. No, no. The second step we envision is that we would begin instituting specific measures based on clinical standards, how you care for a diabetic patient or a patient with congestive heart failure. That would be based on evidence-based guidelines of practice. What we urge the Congress to do and the Secretary of HHS to do is to say to the physician community, that is where we are headed and we want to engage with you, the profession, and the specialty societies in developing those measures so that at a point in the not too distant future we have got a broad set of clinical performance measures to apply to physician practice. We believe that is eminently doable, given the research that exists, so long as there is a collaborative process between the department and the physician community.

Mr. DOGGETT. Just one other thing about the pay for performance system. I think generally they aren't designed to control volume. How do you recommend that we control volume if we move away from the SGR and toward a more market-based-like update?

Mr. HACKBARTH. We think that pay for performance can make sure that we get the right volume. One of the problems I have with the SGR is all volume is the same. It is undifferentiated. So, we want the right volume. There are some areas of underuse of service where we want to increase the utilization. That is a critical point. Some other tools that we think ought to be developed include what we refer to as resource measurement. The first step for a physician to improve his or her practice is to understand how their practice compares to evidence-based standards of care and their peers. We can through the Medicare program, begin helping physicians understand how their practice compares. When I am talking about their practice, I don't mean just how many office visits but how they care for episodes of care, for patients with particular clinical problems. What we propose is that CMS invest in developing that capability and then feed the information back to physicians on a confidential basis at first and say, this is how you compare with your peers in caring for a patient with, say, congestive heart failure. That is the first step to changing patterns of care in a constructive way, letting people know how they do, how it compares to their peers and to evidence-based standards.

Mr. DOGGETT. Thank you. Thank you, Madam Chair.

Chairman JOHNSON. I thank the gentleman. It was an excellent question. I hope you will be able to stay to the end of the panel, because we do have people who have direct experience with that, and we will be looking very deeply into exactly those issues. Mr. English.

Mr. ENGLISH. Mr. Hackbarth, I am going to follow on my last colleague's question. Given that MedPAC has consistently urged us to sever the link between the fee update and volume controls and has recommended replacing the SGR system with an update based on changes in the cost of providing services, would you please describe for us in maybe a little more detail the volume control approaches favored by MedPAC and what kind of concrete impact can you suggest this would have on the system?

Mr. HACKBARTH. The general approaches that we are recommending in this report are pay for performance, what I just described as resource measurement, and then looking at high growth areas like imaging and apply the resource measurement tools there, changing some of the coding edits that Medicare uses and applies to claims. So, they are very targeted approaches that we are talking about. Will these things, these specific recommendations—pay for performance, resource measurement, imaging—immediately alter the trend, the growth in volume and intensity? We think yes. They are not going to solve the problem, and more needs to be done in the future. Those are very constructive, targeted steps that we believe will have a much better effect on the system than the across-the-board SGR approach.

Mr. ENGLISH. Okay. As I look at the proposed changes for the payment system specifically to reward providers for delivering quality care, I wonder if you could clarify. The intent of these

changes is not simply to raise quality or efficiency in isolation but, as I understand it, rather to incentivize increases in quality tied to gains in efficiency. These two must be, I would think, achieved together. Are you confident your proposals will be able to do that?

Mr. HACKBARTH. Ultimately, as you say, what we want to do is put together in a single set of measures both quality and efficiency measures. As I said to Mr. Ramstad, that is one of the exciting things about the new demonstration project, is that it is an effort to do that. We have to walk there. We can't begin at that point. We think we have to buildup, build the capabilities. So, right now, what we are talking about is having the efficiency and quality measures separate. Right now, what we are missing most is the quality measurement. We want to begin rewarding high quality over time and start to build an integrated set of efficiency and quality measures. One of the things that we want to change, and we haven't touched on this, is when we start rewarding quality of care, we start changing, I think, how physicians think about their practice, in particular with regard to things like clinical information systems. Right now, the system rewards volume, the system rewards technological sophistication, and so people invest in things that will allow them to increase their volume and do fancy new procedures that they get paid a lot for. If we start paying for quality, then they say, well, what I am investing I want to invest in things that will help me perform well on quality, like computerized medical records or order entry systems and the like. Once we start to expand those tools and have them in widespread use, I think we will see not only significant gains in quality but also in the efficiency of the system.

Mr. ENGLISH. That is a marvelous blueprint to operate off of, Mr. Hackbarth. I, frankly, used to be a city finance officer. I have a passing familiarity with performance measurement systems and their potential but also their limitations. I guess my own feeling is, on something like this dealing with services that are so sophisticated, I am wondering in the long run how easy it is going to be to apply a performance measurement system in the way that you are suggesting here. I will look forward to examining your proposal in greater detail, and here I think the devil really is in the details. I thank you, Madam Chairman.

Chairman JOHNSON. I thank the gentleman. Mr. Thompson, welcome to the Committee. I also welcome the other new Members.

Mr. THOMPSON. Thank you very much, Madam Chair. Thank you for holding today's hearing. Thank you both for being here today. Mr. Hackbarth, if I could ask you, the reimbursement rates, are they having any effect in regard to physician shortages within the Medicare populations?

Mr. HACKBARTH. With regard to access to care for Medicare beneficiaries?

Mr. THOMPSON. Right.

Mr. HACKBARTH. We see no evidence of widespread access problems. We look at a variety of different measures—what beneficiaries say about their own access to care, what physicians say about their willingness to accept new Medicare patients. As we discussed earlier, we look at the relationship between Medicare fees and private fees. In looking at all those different types of measures,

we find that Medicare beneficiaries continue on a national basis to have very good access to care from the beneficiary's perspective—that is what they say—and in fact a higher level of satisfaction with access than the privately insured population. Having said that, there are specific communities within the United States where it may be a problem finding a physician. For example, if you are a Medicare beneficiary that is newly moved into a community, finding a primary care physician can in some isolated places be a problem, but, on a national basis, we do not see access problems.

Mr. THOMPSON. Do you suspect that if this issue is not dealt with and dealt with quickly that that will become a problem?

Mr. HACKBARTH. If by that you mean if the——

Mr. THOMPSON. Will there be more people moving into areas where they won't be able to find a doctor?

Mr. HACKBARTH. If we were to have a succession of 5 percentage point cuts in the Medicare rates, I think it would be quite likely that we would begin to see widespread access problems.

Mr. STEINWALD. I would certainly agree with that. I would point out, though, that we have researched this issue, too, and we also don't find an access problem. We did some research looking at trends in utilization and the percentage of Medicare beneficiaries receiving services over the 2000 to 2002 period and we found in every State those measures of utilization increased, and that includes the one year in which there was about a 5 percent fee cut in Medicare. There was still an increase in services and an increase in the proportion of beneficiaries served.

Mr. HACKBARTH. The other thing on access is that, in the communities where there are some problems, it is not necessarily solely because of Medicare payment rates. They often tend to be very rapidly growing communities where the population is already perhaps outstripping the supply of physicians and then the Medicare payment issue comes in on top of that. Access is affected by non-Medicare issues as well.

Mr. THOMPSON. Mr. Steinwald, if I could return to an issue that Mr. Lewis brought up earlier and that is prospectively dealing with the out-of-hospital drugs or retroactively dealing with those. It is my understanding that if we do it prospectively that we are going to see 5 percent cuts through 2010. As we know, Congress hasn't been real receptive to allowing this to happen. I think it was your number, $120 billion over 10 years, if we do it retroactively?

Mr. STEINWALD. No, sir, that is not mine. I think that is——

Mr. THOMPSON. CBO?

Mr. STEINWALD. Yes, it is a CBO estimate; and that is, actually, I think the estimate of the 10-year cost of repealing SGR and replacing it with an inflation-based update.

Mr. THOMPSON. Do you have any knowledge of knowing what it will cost for Congress to continue to move up from the minus 5 to baseline the physician reimbursement cost?

Mr. STEINWALD. At GAO we don't do budget estimates. As you work with various options, I am sure you will be asking CBO to cost them out for you. What I have provided you in the table that I referred to earlier is an indication of the relative costliness of the different options in percentage terms. So, you can at least gauge of the different options, what relative impact they will have on

spending and how they would be scored. The actual scoring will have to be done by the CBO.

Mr. THOMPSON. I am just trying to get an idea. Does it pay to fix it now or kick the can down the road?

Mr. STEINWALD. I think it is certainly timely and wise to start to address this problem. We don't have any experience with the consequences of multiple-year negative fee updates, but I think everyone—and I alluded to a single year when there appeared to be no access problems, but multiyear, as many years as we are talking about now, I think we would all agree there would have to be serious consequences for both doctors and beneficiaries, and so I would urge you to start to think about that in the short term.

Mr. HACKBARTH. Mr. Thompson, could I just address that quickly? We are at the threshold of an important change here. In years past, the Congress has been able to do a 1- or 2-year override of the SGR rates and have the 10-year cost be basically zero because the system assumes that the SGR mechanism will take that money back in future years. So, there is an initial cost, but in the long run it comes to a zero. However, that is about to change. There are restrictions in the SGR on how much it can take back in any given year. We are now approaching the point where, even over the 10-year horizon, you can't take back all of the money from a year-to-year increase. So, even 1-year changes will start to have a positive 10-year budget score attached to them.

Mr. THOMPSON. Thank you. Thank you, Madam Chair.

Chairman JOHNSON. Mr. Hulshof.

Mr. HULSHOF. Thank you, Madam Chairman. Let me say I am excited to be on the Subcommittee, and I appreciate this opportunity. This has been a prominent issue back home in Missouri, and so I am excited to be on the Subcommittee to help create a solution to that and look forward to that. Mr. Hackbarth, I am intrigued by the idea of pay for performance, because, again, during my tenure on the full Committee, in visiting with healthcare providers across the board, whether it is home health, hospice, hospitals, doctors, acute care providers, it seems that medical care in this country for our senior citizens population is driven by where the money is, where reimbursements are, and so this idea of actually focusing on patient care is an intriguing one. Missouri has also been recently designated by CMS to have one of these demonstration projects. It is not in my congressional district, it is in my colleague Roy Blunt's district in Springfield, Missouri. You have addressed this a bit insofar as that particular area which is more heavily populated than my own congressional district. My colleague from Texas talked about a concern that, in a more rural setting, if you have a higher senior citizen population or if you have higher rates of obesity or other factors, making sure that we don't create another AAPCC type of disparity between large urban settings and those rural areas. You addressed that a little bit.

Since we have a vote on and I want to make sure that I adhere to my time limits, coming up behind you, maybe in front of the microphone where you sit in the next panel, Dr. Nancy Nielsen, who represents the American Medical Association, and so let me give you what I believe she is going to tell us through her testimony and then give you a chance to respond to it. Dr. Nielsen says

that initiatives that provide financial incentives for quality care improvements should not be undertaken by Medicare until the physician payment update formula has been replaced with a system that ensures a stable economic environment for treating patients. I think, as she indicates in the paragraphs that follow that statement, the concern is that doctors out there, because of the uncertainty, because of the constant threat of cuts in reimbursements, that a lot of doctors or a lot of small practices have not made the investment in technology. A lot of these are a very expensive type of—converting to different types of systems, and so if we move in this direction of pay for performance, do we need to actually have a new payment structure in place and then talk about pay for performance, or can we do this in tandem? What is your opinion about that?

Mr. HACKBARTH. We are in favor of changing the payment formula. We have been for a long time, both, incidentally, when it was in providing for updates which were much higher than the increase in input cost as well as more recently when it has been saying the update should be much lower. That is a change that we think is urgent and ought to happen as soon as possible. We don't think that Congress, even if it can't change the entire formula, ought to allow 5 percent cuts to go into effect. I think our position on that is very clear. With equal urgency, however, we think the system needs to begin moving in a measured, thoughtful way toward pay for performance and begin rewarding the many, many physicians who are providing very high-quality care, support investments in future provision of high-quality care. Those two things are equally important and urgent from our perspective.

Mr. HULSHOF. In the interest of time, Madam Chair, I yield back so my colleague from Illinois can inquire before our vote.

Chairman JOHNSON. Thank you very much. For the Members, we will reconvene at 20 minutes of 12 so that we can hear hopefully the next panel before noon. Those of you that can stay for questioning, that will be wonderful, but it is very important to hear both together, particularly from the point of view of technology, which we haven't had a chance to discuss here much. Mr. Emanuel, welcome to the Committee.

Mr. EMANUEL. Thank you very much. I look forward to serving on the Committee. I thank the other Members, and I thank my colleague from Missouri. When you are the ninth questioner, you feel somewhat like Mo Udall's comment, "Anything that needs to be asked has been asked, it just hasn't been asked by everybody that needs to ask it." Let me associate myself, though, with Congressman English's questions earlier about the volume cap. That was something I wanted to talk about. Maybe—in the interest of time, I am more than willing to take this answer to the question in writing because, obviously, some of us have to get to a vote; and rather than be anxious about the vote and hearing what you have to say, I am more than willing to take this in written form. The one area that I would like to talk about—maybe we can do it later; if not, just in writing. If you do make a major change to the physician payment, what is the strategy and the approach to ensuring that the beneficiaries both on copays and premiums don't also receive a major change? Can we hold them harmless or limit the damage

to the beneficiary from a payment, either in the copay and the premium together? That would be an area, if we had more time, I would like to explore. I want to thank you again. I am more than willing to take that question in writing and further associate myself with what Congressman English talked about in the sense of the volume cap and the ability to control costs. Thank you very much.

Chairman JOHNSON. Thank you. Would either of you like to comment on that? We have about 7 minutes left. If you want to comment a couple of minutes, you can.

Mr. HACKBARTH. Let me begin by noting that it is very important to keep in mind the impact on beneficiaries of any of these changes. Because the way the system works, to the extent that physician fees increase, there is an increase in beneficiary co-payments and there is an increase in the Part B premium. Since 7 May, it also means that we move closer to the 45 percent limit on the piece of the program financed through general revenues. So, we have to be mindful of all of those effects. We have not looked at specific proposals for giving beneficiaries the increase, and so I just don't have any MedPAC recommendation on that. The other side of the coin, though, is that we need to assure access to care for Medicare beneficiaries; and if we don't have fees that appropriately reflect the cost, as we have discussed earlier, there is a real threat to their access. So, it is a balancing act, as it has been since the beginning of the program. Nobody has more to gain, from our perspective, through pay for performance than the Medicare beneficiaries. So, we need to be mindful, but we need to move ahead on the fronts that we have described.

Mr. STEINWALD. I agree with what Glenn said. You had asked would it be possible to hold the beneficiary harmless if these were increased. I think the simple answer to that is, not within current law on how co-payments and premiums are calculated. On the other hand, if we are talking about averting fee declines, the impact on beneficiary co-payments of fee declines should be a declining co-payment. If fees were allowed to increase or remain constant, the impact on beneficiaries should be slight. The impact on premiums, however, might be greater because volume and intensity increases spending and premiums are based on spending, not on fees.

Chairman JOHNSON. We should note, though, that the impact on the beneficiaries is variable, that the low-income beneficiaries have their premiums and co-payments paid by the government.

Mr. EMANUEL. If I may, if we had more time, and again because I am conscious of the vote, one of the questions as a follow-up on that is for low-income—obviously, it is true for everyone but for low-incomes especially—both the premium and the copay will hit a level that is different for other people, where you somewhat—if I hear your answer correctly—access—we are kind of putting it in the front of the queue as opposed to both on the payment side—either the copay or the premium. I think actually beneficiaries are somewhat affected on those two areas differently. You are weighing that and saying for everybody, blanketly, access is the primary area. I think actually people get affected based on income and geography differently. That is just for another time.

Chairman JOHNSON. Thank you. I thank the panel very much for your good work and your good answers. We will reconvene in 10 minutes.

[Recess.]

Sometimes votes take a little longer than you think they are going to take, but we are looking forward to the testimony of our second panel. If I may, let me just start with Dr. Nielsen from the American Medical Association.

STATEMENT OF NANCY NIELSEN, M.D., AMERICAN MEDICAL ASSOCIATION

Dr. NIELSEN. Thank you, Chairman Johnson. I am a member of the board of trustees of the American Medical Association and speaker of the house of the AMA. I am also a practicing internist in Buffalo, New York. The AMA would like to express appreciation to you, Chairman Johnson, to Ranking Member Stark and to each Member of the Subcommittee for your hard work and leadership in addressing the Medicare payment update problem. You are going to hear the same themes repeated that you heard in the first panel. The Medicare payment formula relating to physicians is flawed and permanently broken. It would have led to steep cuts in recent years unless there had been repeated congressional and Administration intervention. Additional cuts of 31 percent are expected beginning in January of 2006 through 2013. These cuts present a serious threat, as you heard described in the earlier panel. Congress and the Administration must act now to replace the current physician payment formula, as MedPAC has recommended. MedPAC also recommended a 2.7 percent physician payment update for 2006. There are a number of problems with the current payment formula.

First, under a spending target system called the SGR, which applies only to physicians, annual payment updates are tied to GDP. The GDP is only a measure of growth in the overall economy. The medical needs of Medicare patients do not wane when the American economy slows. Second, GDP does not take into account health status, the aging of the Medicare population, technological innovations or changes in the practice of medicine; and, third, physicians are penalized across the board when arbitrary spending targets are exceeded. Here is the inequity. Failure to meet these targets results in large part from government policies and medical innovations that expand Medicare services. The Administration has the authority to take action to help ease the payment update problem and lead the way for congressional intervention. We certainly appreciate the efforts of this Subcommittee to encourage the Administration to take a critical first step toward solving the payment update problem, and we urge the Subcommittee to continue to press CMS to do so by removing physician-administered drugs from the SGR. CMS has the authority to remove drugs going back to the beginning of SGR, as described in a legal memo attached to our written testimony drafted by Terry Coleman, a former chief counsel and deputy administrator of HCFA. When CMS calculates the SGR spending target each year, it compares actual Medicare spending on physician services to target spending. In calculating the SGR, CMS includes the costs of physician-administered drugs, clearly not a physician service. The inclusion of drugs in the SGR makes it ex-

tremely likely that overall spending on physician services will exceed the spending target, thus triggering the physician pay cuts that jeopardize access.

CMS defines and can revise the definition of physician services to exclude drugs. CMS can then recalculate actual or target spending, excluding the cost of the drugs, back to 1996–1997, the base period of the SGR. This would not involve adjusting physician payments for any previous year, however. The law also requires CMS, when calculating the SGR, to reflect increases in physician spending due to changes in law and regulation, but CMS does not include spending changes due to national coverage decisions. This further compounds the problem. Finally, we are interested in working with the Subcommittee and the Administration on quality improvement policies. I hope in the question and answer period we will have the opportunity to talk about some of the things that we have done as well in that regard. We will be hard-pressed to make investment in information technology if these planned cuts go into effect; and, therefore, it is critical to replace the flawed formula to allow quality improvement initiatives to flourish. Thank you for the opportunity to appear before you today.

[The prepared statement of Dr. Nielsen follows:]

Statement of Nancy Nielsen, M.D., American Medical Association

Chairman Johnson, Ranking Member Stark and Members of the Subcommittee, the American Medical Association (AMA) appreciates the opportunity to provide our views today regarding Medicare payments to physicians.

The AMA would like to commend you, Madam Chairman, and each Member of the Subcommittee, for all of your hard work and leadership in recognizing the fundamental problems inherent in the Medicare physician payment update formula. We deeply appreciate enactment of provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), as well as your unrelenting support for the regulatory relief provisions that were included in the MMA.

Today, the AMA especially applauds your commitment to developing a long-term solution to the current flawed physician payment formula. As you know, the flaws in the Medicare physician payment formula led to a 5.4% payment cut in 2002, and additional cuts in 2003 through 2005 were averted only after Congress intervened. These short-term congressional interventions will expire next year, however, and the Medicare Trustees have projected that physicians and other health professionals face pay cuts totaling 31% over the next eight years. Payments for cataract surgery, for example, will fall from an average of $684 in 2005 to an average of $469 in 2013.

These reductions are not cuts in the rate of increase, but are actual cuts in the amount paid for each service, resulting in a reduction in physician payment rates of nearly a third. They come at a time when even by Medicare's own conservative estimate, physician practice costs are expected to rise by 19% and when many physicians face far larger increases due to the skyrocketing cost of medical liability insurance. They also follow more than a decade of Medicare cost constraints that held payment increases to 18% between 1991 through 2005 despite the government's conclusion that practice costs had increased by 40% over the same time period. Physicians simply cannot absorb these draconian payment cuts and, unless Congress acts, it is difficult to see how they can avoid discontinuing or limiting the provision of services to Medicare patients.

A physician access crisis is looming for Medicare patients. While the MMA has made significant strides in improving the overall system for Medicare beneficiaries, including broad-scale improvements for care furnished to patients in rural areas as well as important new benefits, these critical improvements must be supported by an adequate payment structure for physicians' services. There are already some signs that access is deteriorating, including a 2.5% reduction in the number of new patient visits per enrollee in 2003, as reflected in claims data for that year. Physicians are the foundation of our nation's healthcare system, and continual cuts (or even the threat of repeated cuts) put Medicare patient access to physicians' services (as well as drugs and other services they prescribe) at risk and threaten to destabilize the Medicare program and create a ripple effect across other programs, as

well. Indeed, Medicare 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.

Congress and the Administration must take immediate action to replace the SGR with a system that keeps pace with increases in the cost of practicing medicine. While we greatly appreciate the short-term reprieves achieved by Congress and the Administration in recent years, a long-term solution is needed now. Indeed, the 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 action to implement a long-term solution now, repeated congressional intervention will be required to block payment cuts that jeopardize continued access to high quality care for the elderly and disabled.

The AMA is happy to have the opportunity today to address problems with the physician payment formula, and looks forward to working with the Subcommittee and Congress to ensure implementation of a new payment update that keeps pace with increases in the cost of practicing medicine.

THE SUSTAINABLE GROWTH RATE SYSTEM

Medicare pays for services provided by physicians and numerous other healthcare professionals on the basis of a payment formula that is updated annually in accordance with a target rate of growth, called the sustainable growth rate (SGR). Under the SGR, enacted by the Balanced Budget Act of 1997 (BBA), the Centers for Medicare and Medicaid Services (CMS) establishes allowed expenditures for physicians' services based on certain factors set forth in the law: (i) inflation, (ii) fee-for-service enrollment, (iii) real per capita gross domestic product (GDP), and (iv) laws and regulations. CMS then compares allowed expenditures to actual expenditures. If actual expenditures exceed allowed expenditures in a particular year, then physician payments are reduced in the subsequent year. Conversely, if allowed expenditures are less than actual expenditures, physician payments increase.

PROBLEMS UNDER THE SUSTAINABLE GROWTH RATE SYSTEM

The flawed SGR system has led to payment volatility and substantial patient access concerns requiring congressional intervention to avoid erosion of beneficiary access to care.

The vast majority of physician practices are small businesses, and, as such, do not have the economic and other necessary resources to absorb sustained losses or the steep payment fluctuations that have occurred under the SGR system. Further, the unpredictability of the SGR system makes it difficult for physician office practices, as small businesses, to project revenue into the future and make the necessary business and financial decisions needed to operate a sound business over time. It is nearly impossible for physician practices to plan ahead since SGR estimates for future years (which are based on numerous factors that are impossible to predict) are completely unreliable, in addition to being quite grim. When these small medical practices experienced the 5.4 percent Medicare cut in 2002, physicians and non-physician practitioners were left with very few alternatives for maintaining a financially sound practice without limiting their Medicare patients' access in some way.

It took strong efforts by Congress, in particular by this Subcommittee, in addition to similar efforts by the Senate, the Administration and CMS to avoid another SGR-triggered pay cut in 2004 and 2005. While we greatly appreciate this effort, we do not believe Congress and the Administration (nor patients, physicians and other healthcare professionals) should have to struggle with the ill effects of such a system, year after year.

The Medicare Payment Advisory Commission (MedPAC) has recommended in the past that the SGR be replaced with a system where updates are based on an assessment of increases in practice costs, adequacy of payment rates, and beneficiaries' access to care, and we agree. In addition, we expect MedPAC, in its March Report to Congress, to recommend that Congress should increase 2006 payments for physician services by the projected change in input prices, less a productivity adjustment of 0.8 percent, resulting in a projected update of 2.7%. The AMA agrees with these MedPAC recommendations.

There are several fundamental problems with the SGR formula:

1. Payment updates under the SGR formula are tied to the gross domestic product, which bears little relationship to patients' healthcare needs or physicians' practice costs;
2. The SGR formula is highly dependent on projections that in effect require CMS to predict the unpredictable; and

3. Physicians are penalized with lower payments when utilization of services exceeds the SGR spending target, yet, the factors driving these increases are often beyond physicians' control (as further discussed below under "Administrative Action Needed.")

Problems with the Payment Formula Due to GDP

GDP Does Not Accurately Measure Health Care Needs

The SGR permits utilization of physicians' services per beneficiary to increase by only as much as GDP. The problem with this "relationship" is that GDP growth does not track the healthcare needs of Medicare beneficiaries. For example, when a slowed economy results in a decreased GDP, the medical needs of Medicare patients remain constant, or even increase, despite the economic downturn. Yet, physicians and numerous other health professionals, whose Medicare payments are tied to the physician fee schedule and who are doing their best to provide need services, are penalized with lower payments because of a slowly growing economy, resulting in the decreased GDP. Further, GDP does not take into account the aging of the Medicare population, technological innovations or changes in the practice of medicine.

Historically, healthcare costs have greatly exceeded GDP. Yet, the SGR is the only payment formula in Medicare tied to that index. In contrast, payments for hospitals, skilled nursing facilities and home health, for example, are all tied to their inflationary pressures.

Technological Innovations Are Not Reflected in the Formula

The United States' population is aging and new technologies are making it possible to perform more complicated procedures on patients who are older and more frail than in the past. The Congressional Budget Office has said that recent Medicare volume increases are due to "increased enrollment, development and diffusion of new medical technology" and "legislative and administrative" program expansions. The SGR system's artificial cap on spending growth ignores such medical advances when it limits target utilization growth to GDP growth.

Both Congress and the Administration have demonstrated their interest in fostering advances in medical technology and making these advances available to Medicare beneficiaries through FDA modernization, increases in the National Institutes of Health budget, and efforts to improve Medicare's coverage policy decision process.

The only way for technological innovations in medical care to really take root and improve standards of care is for physicians to invest in those technologies and incorporate them into their regular clinical practice. The invention of a new medical device cannot, in and of itself, improve health care—physicians must take the time to learn about the equipment, practice using it, train their staff, integrate it into their diagnosis and treatment plans and invest significant capital in it. Although the Medicare hospital payment system allows an adjustment for technological innovations, the physician payment system does not do so. The physician payment system is the only fee structure of Medicare that is held to GDP, and no other Medicare payment system faces as stringent a growth standard.

Government efforts to foster technological innovations could be seriously undermined as physicians now face disincentives to invest in new medical technologies or to provide them to Medicare beneficiaries.

Site-of-Service Shifts Are Not Considered in the Formula

Another concern that is not taken into account in the SGR formula is the effect of the shift in care from hospital inpatient settings to outpatient sites for certain medical procedures, such as imaging services. As MedPAC has pointed out in the past, hospitals have reduced the cost of inpatient care by reducing lengths-of-stay and decreasing staff. Indeed, it has been a goal by Congress and the Bush Administration to utilize more physician services through disease management and prevention initiatives in order to avoid expensive hospitalizations and nursing home admissions. Technological innovations have also made it possible to treat many services that once required hospitalization in physicians offices instead. Much of this shift—such as the replacement of surgical procedures with drug treatments that must be monitored by office-based physicians—cannot be accurately measured. MedPAC, however, has documented a shift for certain imaging procedures and some private payers have acknowledged that they have encouraged this trend because it saves money for both the government and patients. While this trend has led to treatment of increasingly complex cases in physicians' offices, the increased use and intensity that results is not recognized in the SGR formula.

Beneficiary Characteristics Are Not Reflected in the Formula

A related factor that also is unrecognized in the SGR formula is changes over time in the characteristics of patients enrolling in the fee-for-service program. For example, increases in patients diagnosed with, or having complications due to such diseases as obesity, diabetes and end stage renal disease, require greater utilization of physicians' services. Yet, these types of changes in beneficiary characteristics are not reflected in the SGR.

Inability to Predict Payment Updates under the SGR

Instead of making payments more predictable for physicians and budgets more predictable for policymakers, use of the SGR has had the opposite effect. Future updates are dependent on forecasts of (i) GDP, (ii) how many beneficiaries will choose Medicare Advantage versus fee-for-service Medicare, (iii) the rate of medical practice cost inflation each year, (iv) the rate of utilization growth each year, and (v) spending changes that will occur as a result of legislative and regulatory changes, such as expanded coverage for preventive services.

Provisions in the MMA have reduced the volatility of GDP predictions, and fluctuations in the MEI generally are somewhat limited. It is still very difficult, however, to predict other factors in the SGR. As a result, policymakers cannot predict the impact of Medicare physician services on overall Medicare spending and medical practices cannot predict their revenue streams for the short- or long-term. Estimates of payment updates initially are based on incomplete data and such estimates can fluctuate significantly as more data becomes available. For example, in March of 2001, CMS projected that physician payments would fall slightly by about −0.1 percent in 2002. CMS noted that this projection was based on very early information and could change before a final update was announced in January 2002. In fact, those estimates did change, and Medicare payments to physicians and other healthcare professionals were cut by 5.4 percent in 2002.

ADMINISTRATIVE ACTION NEEDED TO CORRECT SGR IMPLEMENTATION PROBLEMS

Apart from the inherent problems in the physician payment formula, there are other problems with implementation of the SGR that seriously threaten patient access and inequitably affect payment updates due to factors that are beyond physicians' control. The Administration has the authority to take additional action to help ease these implementation problems and lead the way for congressional intervention. We strongly urge the Subcommittee to continue to press CMS to use its administrative authority to address and resolve the following issues in the proposed Medicare physician payment rule for 2006:

1. *Remove Medicare-covered, physician-administered drugs and biologics from the physician payment formula, retroactive to 1996*

CMS Authority to Remove Drugs from the SGR

As discussed above, Medicare payments to physicians are reduced when actual Medicare spending for physicians' services exceeds a pre-determined spending target (the SGR). When CMS calculates actual spending on physicians' services, it includes the costs of Medicare-covered prescription drugs administered in physicians' offices. Although the physician's administration of the drug is clearly a physician service that by statute must be included in the pool, the drugs themselves are not "physicians' services" and drugs are not paid under the Medicare physician fee schedule. Thus, it is inconsistent to include drugs in the calculation of expenditures in the SGR methodology. In fact, in an interim final rule issued in December 2002 (on the application of inherent reasonableness to Medicare Part B services), CMS chose to exclude drugs from the definition of "physicians' services." To include drugs as a "physicians' service" for certain purposes, but not for others, is inconsistent and inequitable. Indeed, this policy has been questioned by many legislators, including Subcommittee Chairman Johnson and Committee Chairman Thomas, who have repeatedly requested that CMS remove drugs from the SGR baseline. In addition, more than 240 House Members and more than 70 Senators have signed various letters asking CMS to take this action.

Nothing in the statute requires Part B drugs to be included in the SGR formula. It has simply been a CMS decision to include drugs and CMS could easily make a different decision to exclude drugs, while still effectively implementing the statute written by Congress. CMS has stated it has the legal authority to revise the definition of services, although CMS has not yet stated whether it has the authority to implement a revised definition of physicians' services that would allow drugs to be

fully removed from computation of actual and allowed expenditures back to the SGR base period. Any change in the definition of physicians services to remove drugs would not affect the SGR itself—only the actual and allowed expenditure amounts.

We believe that CMS has the authority to fully remove drugs from the definition of physician services back to the SGR base period. First, if CMS adopts a revised definition of physician services that excludes drugs, it can recalculate actual expenditures back to the base period using that revised definition. Nothing in the statute limits how CMS is to calculate actual expenditures or limits CMS' ability to revise its previous calculations of actual expenditures. CMS has previously revised its calculations of actual expenditures based on the omission of codes and on additional claims data. Thus, CMS has implicitly taken the position that previously announced actual expenditure amounts can be recalculated. Accordingly, CMS can recalculate actual expenditure amounts for each year back to the base period using the revised definition. Recalculating the base period actual expenditures will also, by definition, recalculate the base period allowed expenditures since the statute sets the base period allowed expenditures equal to the base period actual expenditures. This approach would fully remove drugs from the SGR methodology for purposes of determining payments in future years.

A second, supporting approach is based on the statutory language defining allowed expenditures. If CMS wants to remove drugs from the calculation of actual expenditures, it would presumably want to remove drugs from the calculation of allowed expenditures as well so that the same definition applies on both sides of the equation. To remove drugs from allowed expenditures for next year, however, requires recalculating last year's allowed expenditures using the revised definition, since the statute defines next year's allowed expenditures as last year's allowed expenditures increased by the SGR. Thus, revising a previous year's allowed expenditure amount is inherent in any implementation of a revised definition of physicians' services. Under the statute, the allowed expenditures should be revised back to the base period, since each year's amount is calculated by reference to the previous year's.

In short, there is a firm legal basis for recalculating both the actual and allowed expenditures using a revised definition of physicians' services back to the SGR base period. The result is that drugs would be fully removed from the SGR methodology.

This recalculation would not involve recalculating the allowed or actual expenditures for purposes of determining payment amounts in a prior year. The recalculation would affect only payment amounts in future years. Revising calculations for a past year for the purpose of setting future years' payment amounts is not impermissible retroactive rulemaking. It is similar, for example, to the recalculation of graduate medical education costs in a base year for purposes of setting future payment amounts. That recalculation was approved by the Supreme Court.

CMS Should Remove Drugs from the SGR

In the past, some CMS officials have argued that including drugs in the SGR was necessary to counter-balance incentives for over-utilization in the drug reimbursement system. The AMA does not accept this premise. Certainly physicians are not administering chemotherapy drugs to patients who do not have cancer. Even if such incentives existed, however, they were surely eliminated by the reductions in payment for these drugs under the MMA. Thus, we urge the Subcommittee to reiterate the request that CMS reconsider its current policy in light of the changes made in the MMA. Pharmaceutical companies, not physicians, control the cost of drugs. Further, pharmaceutical companies and United States policy, not physicians, control the introduction of new drugs into the marketplace.

A new physician payment formula that reflects the cost of practicing medicine is desperately needed, but current budget deficit projections will make it extremely difficult for Congress to take the steps that are needed to implement such a formula. The Administration must reduce the price tag and help pave the way for an appropriate long-term solution by removing drugs from the SGR pool, retroactive to 1996. In fact, CMS actuaries recently announced that, in accordance with current estimates, removing drugs form the SGR would trigger a 3.7 percent update in 2006. Even more fundamentally, removing Part B drugs from the SGR formula would nearly eliminate all of the impending cuts to physicians—every 5% cut for 7 consecutive years would be wiped out by taking this one simple action.

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. The lives of millions of disabled and elderly Americans have been extended and improved as a result. But such

achievements do not come without a price. Drug costs of $1,000 to $2,000 per patient per month are common and annual per patient costs were found to average $71,600 a year in one study.

Further, between the SGR's 1996 base year and 2003, the number of drugs included in the SGR pool rose from 363 to 430. Spending on physician-administered drugs over the same time period rose from $1.8 billion to $7.7 billion, an increase of 318% per beneficiary compared to an increase of only 46% per beneficiary for actual physicians' services. As a result, drugs have consumed an ever-increasing share of SGR dollars and have gone from 3.7% of the total in 1996 to 9.8% in 2003.

This lopsided growth lowers the SGR target for real physicians' services, and, according to the Congressional Budget Office, annual growth in the real target for physicians' services will be almost a half percentage point lower than it would be if drugs and lab tests were not counted in the SGR. As 10-year average GDP growth is only about 2%, even a half percent increase makes a big difference. Thus, including the costs of drugs in the SGR pool significantly increases the odds that Medicare spending on "physicians' services" will exceed the SGR target. Ironically, however, Medicare physician pay cuts (resulting from application of the SGR spending target) apply only to actual physicians' services, and not to physician-administered drugs, which are significant drivers of the payment cuts.

Although growth in drug expenditures appears to have slowed somewhat in 2004, Medicare actuaries predict that drug spending growth will continue to significantly outpace spending on physicians' services for years to come. This is a realistic assumption. In 2003, MedPAC reported that there are 650 new drugs in the pipeline and that a large number of these drugs are likely to require administration by physicians. In addition, an October 2003 report in the *American Journal of Managed Care* identified 102 unique biopharmaceuticals in late development and predicted that nearly 60% of these will be administered in ambulatory settings. While about a third of the total are cancer drugs, the majority are for other illnesses and some 22 medical specialties are likely to be involved in their prescribing and administration.

The development of these life-altering drugs has been encouraged by various federal policies including expanded funding for the National Institutes of Health and streamlining of the drug approval process. To its credit, the Administration has made acceleration of the pace of drug development one of its goals and has adopted a number of policies that spur such development. Last June, for example, CMS and the National Cancer Institute announced a collaborative effort to improve the process for bringing new anti-cancer drugs to patients. In July, the Food and Drug Administration announced that it will create a new oncology office to further facilitate the approval process for these drugs. In August, CMS launched a new Council on Technology and Innovation that Administrator McClellan announced is intended to ensure that Medicare "beneficiaries have access to valuable new medical innovations as quickly and efficiently as possible." The AMA shares and applauds these goals. However, it is not equitable or realistic to finance the cost of these drugs through cuts in payments to physicians.

It is simply bad public policy to penalize physician payments when certain physicians prescribe needed life-saving drugs. Yet, the current formula creates disincentives to prescribe these drugs by cutting all physicians' pay when certain physicians prescribe Part B drugs.

Accordingly, we recommend that the Subcommittee continue to urge CMS to remove drugs from the SGR pool, retroactive to 1996. With payment cuts slated to begin in 2006, it is critical for the Administration to act as soon as possible.

2. *Ensure that government-induced increases in spending on physicians' services are accurately reflected in the SGR target*

As discussed above, the government encourages greater use of physician services through legislative actions, as well as a host of other regulatory decisions. These initiatives clearly are good for patients and, in theory, their impact on physician spending is recognized in the SGR target. In practice, however, many have either been ignored or undercounted in the target.

Effective January 1, 2005, CMS is implementing the following new or expanded Medicare benefits, some of which have been mandated by the MMA: (i) initial preventive physician examinations; (ii) diabetes screening tests; (iii) cardiovascular screening blood tests, including coverage of tests for cholesterol and other lipid or triglycerides levels, and other screening tests for other indications associated with cardiovascular disease or an elevated risk for that disease; (iv) coverage of routine costs of Category A clinical trials; and (v) additional ESRD codes on the list of telehealth services. In addition, the new outpatient prescription drug benefit enacted

under the MMA will significantly expand expenditures for physician services because beneficiaries who previously could not afford to purchase drugs will visit physicians to get prescriptions and will be monitored for the effect of the drugs.

As a result of implementing a new Medicare benefit or expanding access to existing Medicare services, the above-mentioned provisions will increase Medicare spending on physicians' services. Such increased spending will occur due to the fact that new or increased benefits will trigger physician office visits, which, in turn, may trigger an array of other medically necessary services, including laboratory tests, to monitor or treat chronic conditions that might have otherwise gone undetected and untreated, including surgery for acute conditions.

Although CMS has stated that the costs of these new services are included in the calculation of the SGR target for 2005, CMS has not provided details of how these estimates were calculated, and certain questions remain. CMS reportedly does consider multiple year impacts and cost of related services, but the agency has not provided any itemized descriptions of how the agency determined estimated costs. Without these details it is impossible to judge the accuracy of CMS' law and regulation allowances.

In summary, CMS should adequately reflect, in the SGR target, physician spending increases due to such initiatives as the following: (i) legislative mandates, e.g., new preventive screening benefits and the new prescription drug benefit; (ii) CMS coverage expansions for new procedures and technology; (iii) government "good health" policies, such as efforts to reduce healthcare disparities, streamlining drug approvals, fighting diabetes, improving women's health; and (iv) federal "quality initiatives," which tend to increase the use of physician services to save money elsewhere in the system.

3. *Ensure that the SGR fully reflects the impact on physician spending due to national coverage decisions*

When establishing the SGR spending target for physicians' services, the law requires that impact on spending, due to changes in laws and regulations, be taken into account. The AMA believes that any changes in national Medicare coverage policy that are adopted by CMS pursuant to a formal *or informal* rulemaking, such as a Program Memorandum or a national Medicare coverage policy decision, constitute a regulatory change as contemplated by the SGR law, and must also be taken into account for purposes of the spending target.

CMS' authority to make any regulatory change is derived from law—whether it is a law specifically authorizing Medicare coverage of a new service or a law that provides the Secretary of HHS with general rulemaking authority. Thus, any new coverage initiative is a direct implementation, by regulation, of a law. This is exactly what the SGR requires be taken into account—increases in spending due to "changes in law and regulations."

When the impact of regulatory changes for purposes of the SGR is not properly taken into account, physicians are forced to finance the cost of new benefits and other program changes through cuts in their payments. Not only is this precluded by the law, it is extremely inequitable and ultimately adversely impacts beneficiary access to important services.

HHS and CMS actively promote utilization of newly-covered Medicare services through press releases and other public announcements. For example, the Secretary of HHS released a 2002 report highlighting the importance of medical innovations and new technology, especially new drugs, in helping seniors live longer and healthier lives. Further, another HHS release regarding Medicare coverage of sacral nerve treatment for urinary incontinence stated, "[u]rinary incontinence affects approximately 13 million adults in the United States, with nearly half of nursing home residents having some degree of incontinence. It is twice as prevalent in women as it is in men, and costs more than $15 billion per year, including both direct treatment of the disease and nursing home costs." The Secretary made a similar announcement when Medicare expanded its coverage of lymphadema pumps, stating, "[i]t's important to make effective technologies available to Medicare beneficiaries when it helps them the most. This coverage decision simplifies Medicare policy to allow older Americans who need these pumps to get them more quickly and easily."

CMS also recently announced expanded Medicare coverage of implantable cardioverter defibrillators, as well as expanded coverage for diagnostic tests and chemotherapy treatment for cancer patients, as well as for carotid artery stenting, cochlear implants, pet scans for Alzheimers disease and use of photodynamic therapy to treat macular degeneration. While not every coverage decision significantly increases Medicare spending, taken together, even those with marginal impact do contribute to increased use of physician services. In addition, a number of coverage

expansions since the advent of the SGR are expected to have a major impact on spending. The recent expansion of coverage for implantable defibrillators is expected to make this device available to some 500,000 people, with CMS anticipating that 25,000 will receive the device in the first year alone. A decision last spring to expand the use of photodynamic therapy for treatment of macular degeneration is conservatively estimated by the National Opinion Research Center (NORC) to increase expenditures by more than $300 million a year and could boost spending by more than twice that amount if used by all the Medicare beneficiaries who might be eligible.

While the AMA strongly supports Medicare beneficiary access to these important services, physicians and other practitioners should not have to finance the costs resulting from the attendant increased utilization. Accordingly, CMS should ensure that the impact on utilization and spending resulting from all national coverage decisions is taken into account for purposes of the SGR spending target.

4. *Rebasing of the Medicare Economic Index*

The Medicare Economic Index (MEI) is a measure of medical inflation, and is a factor used by CMS to update Medicare payments to physicians each year. The AMA appreciates and agrees with CMS' recent initiative to revise weights in the Medicare Economic Index (MEI) to reflect more current data and changes in the cost of practicing medicine. This initiative, however, does not address the broader problem that the MEI only measures changes in the prices for specific physician practice inputs, but there has been no effort to look at the inputs themselves and ensure that the market basket for which price changes are being measured is still the appropriate market basket.

Inputs to the MEI are vastly different now than when the MEI was first developed in the early 1970s, and thus additional inputs are needed to ensure that the current MEI adequately measures the costs of practicing medicine. For example, physicians must comply with an array of government-imposed regulatory requirements, including those relating to fraud and abuse, billing errors, quality monitoring and improvement, patient safety, and interpreter services for patients with limited English proficiency. To ensure compliance with these initiatives, physicians have had to hire additional office staff to handle these additional responsibilities. Indeed, a Project Hope survey conducted for MedPAC in early 2002 found that "half of all physicians reported that their practice had hired additional billing and administrative staff in the past year, and more than 80% indicated that the practice had increased the training given to staff regarding billing and insurance matters."

CMS should include in the MEI any additional inputs that are needed to ensure that the MEI adequately measures the costs of practicing medicine.

FINANCIAL INCENTIVES FOR IMPROVED QUALITY OF CARE

Last week, CMS announced new initiatives to pay healthcare providers for the quality of care they provide to Medicare patients, and stated that the Administration is committed to rewarding innovative approaches to get better patient outcomes at lower costs. The AMA is also committed to quality improvement and we strongly support innovative efforts across the nation to provide safe and effective care to our patients. We do not believe, however, that initiatives that provide financial incentives for quality care improvements should be undertaken by Medicare until the physician payment update formula has been replaced with a system that ensures a stable economic environment for treating Medicare patients.

With projected Medicare payment cuts of more than 30 percent between 2006 and 2012, many physician practices are heavily focused on simply keeping their doors open to patients. In addition, due to recent cuts and the expectation of more to come in 2006 and subsequent years, many physicians have already been forced to delay investment in maintaining and improving office facilities, staff and equipment. Others have had to cover overhead by seeing more patients and shortening the time of each patient visit.

Participation in successful quality improvement initiatives requires significant financial investment in expensive new information technology or increased human resources. It is difficult to fathom how physician office practices will be able to make such a financial investment in light of current struggles to absorb past and projected steep Medicare pay cuts. Additional funding to implement quality improvement initiatives in physicians offices would be critical for a successful outcome.

The AMA also has strong concerns about any quality improvement initiatives that would seek to maintain budget neutrality by improving payments to some physicians while reducing payments to others that are already in financial jeopardy and unable to commit needed financial and/or human resources to participate in the ini-

tiative. To further complicate matters, effective and appropriate quality measures vary among specialties and some—such as patient tracking—that are most easily implemented may not be relevant for all specialties. Thus, the feasibility of participating in a quality improvement program may vary significantly among medical specialties, and it is not clear that all specialties would have a realistic opportunity to compete for quality-related payments.

Finally, the AMA urges the Subcommittee to consider that while quality improvement initiatives could eventually improve quality and accrue overall savings to the healthcare system, these programs in the early years likely would increase utilization of physician services. For example, during his May 11, 2004 appearance before the House Ways and Means Health Subcommittee, CMS Administrator, Dr. Mark McClellan, suggested that one of the agency's quality improvement projects, the Chronic Care Improvement Project, "may actually increase the amount of (patient-physician) contact through appropriate office visits with physicians." Additional care and patient visits to achieve improved quality, while applauded, would cause Medicare spending on physician services to exceed the SGR spending target, thereby triggering still more Medicare physician pay cuts and compounding the problems physician practices are experiencing due to already strained office budgets.

The AMA thus urges the Subcommittee to ensure that a reliable, positive Medicare physician payment formula is in place before implementing comprehensive quality improvement programs. Expecting physicians to make investments in new information technology and participate in quality improvement initiatives before there is a solution to the payment update problem defies logic. Quality improvement initiatives can flourish only if payment cuts are permanently eliminated and replaced with at least modest updates.

We appreciate the opportunity to provide our views, and look forward to working with the Subcommittee, Congress and the Administration to ensure an adequate and reliable Medicare physician payment system that keeps pace with the cost of practicing medicine.

Chairman JOHNSON. Thank you very much. Dr. Lee.

STATEMENT OF THOMAS H. LEE, M.D., CHIEF EXECUTIVE OFFICER, PARTNERS COMMUNITY HEALTHCARE, INC., AND NETWORK PRESIDENT, PARTNERS HEALTHCARE SYSTEM, INC., BOSTON, MASSACHUSETTS

Dr. LEE. Thank you very much, Chairman Johnson. I want to thank you and the Subcommittee for the opportunity to testify today on pay for performance. I also am a practicing physician, and I am the network president for a large provider system in Massachusetts with a strong commitment to quality but also with practical experience with pay for performance over the last 4 years. I want to make three main points today. The first is that pay for performance works. It really does drive improvements in quality and efficiency, or at least it can. The second point I want to make is that these improvements don't occur because someone has dangled a few dollars in front of physicians to try to work harder or be smarter, but it comes from promoting the adoption of systems that can actually improve care. Thirdly, I will make some comments on how Bridges to Excellence might be a model that can be extended for applying pay for performance to the large majority of U.S. physicians that are not tightly tied to any integrated delivery system.

Partners is an integrated delivery system in eastern Massachusetts that was founded by Mass General Hospital and Brigham and Women's Hospital. We have about 2,000 some physicians in the community as well as another 2,000 are at academic medical centers, and we have pay for performance contracts now covering about 500,000 primary care lives and about 500,000 specialty refer-

ral patients beyond them. So, we have 10 percent or more of our payments under these contracts tied up in reaching incentives in efficiency and quality on both the hospital side and the doctor side. It is about $90 million in 2005 that is contingent upon reaching these goals. As I summarized in my written testimony, most of our contracts have about half of this withhold tied to achieving efficiency targets, in-patient utilization, pharmacy utilization, radiology utilization. The other half is pretty much split between clinical quality reliability measures like diabetes care and the adoption of infrastructure, systems like electronic medical records and computerized order entry in the hospitals.

The written testimony has some details on our performance but, to summarize quickly, it has driven us to adopt systems and do much better on both efficiency and quality. For example, in pharmacy, our rate of rise last year was 5 percent, and nationally it was 9 percent or more. On the quality side, on virtually all the measures that are in our contracts, we are better than the 90th percentile nationally. The key message is not to boast about our performance here but is to emphasize that we believe it has worked and we believe it has worked because we have adopted systems that make our care more reliable. The example that I would like to give is about imaging, because that is obviously a topic that is the fastest rising in health care and one of the most difficult. None of us want to go in and have doctors ratchet back and not do an MRI because they are just trying to save money. What we have done, because we have incentives in our contracts to moderate the rate of rise in radiology, is put in place a web-based system so that our doctors have to order all their x-rays through it and use clinical data to assess the appropriateness of tests.

When tests are inappropriate or possibly inappropriate—and that is about 15 percent of the tests that go through our system—the doctor gets feedback right away, and most of the time our physicians change what they do. When they don't, they have to interact with a colleague about it, not outside our system but inside our system. These kinds of systems work best when they are integrated with electronic medical records. That, of course, is a theme many of us have on our minds today. I think you all know that the business case for adopting these records is challenging, particularly for these small practices. $25,000 cost per year per doctor, that is a typical and even conservative first-year cost. The incentives in our contracts fall far short of this figure, but if Medicare were to use incentives in this way, it would really strengthen the business case. Bridges to Excellence might be a model that can be used for the many physicians who will not be in contracts that reward pay for performance—that have a pay for performance model.

I know that many of you are familiar with this, and there is a CMS demonstration project that may be beginning soon with that model. General Electric, working with providers, including us, uses a Six Sigma product design process to identify systems that they would expect would improve efficiency and quality, electronic but also humanware systems; and I can go into them more if we want during the question and answer period. Just to wrap up, let me just say that the Bridges program is voluntary. Physicians who want the rewards apply, undergo a survey administered by NCQA

and then get the rewards of up to $50 per member per year based upon the number of members they have. In summary, my colleagues and I believe that pay for performance can drive improvement and it does so by the adoption of systems. We think that while organized systems are probably better positioned to deliver on the pay for performance, for the great majority of physicians who are not in organized systems, models like Bridges may be a good way to go. Thanks very much.

[The prepared statement of Dr. Lee follows:]

Statement of Thomas H. Lee, M.D., Chief Executive Officer, Partners Community HealthCare, Inc., and Network President, Partners HealthCare System, Inc., Boston, Massachusetts

I would like to thank Chairman Johnson and the Members of the Subcommittee on Health of the Ways and Means Committee for the opportunity to testify on the potential impact of pay-for-performance incentives on efficiency and quality for the Medicare program. I am invited to testify as a physician leader of a large provider system with a strong commitment to quality and with practical experience with pay for performance over the last four years. Based on this experience, I will discuss three points:

- Pay-for-performance works. I will provide data demonstrating that relatively modest incentives focused on well-defined, achievable targets can be successful in driving improvement in efficiency and quality.
- Adoption of systems (electronic and otherwise) that improve efficiency and quality should be an explicit focus of pay-for-performance programs. I will describe early progress toward the re-engineering of care through systems such as computerized prescribing and test ordering, which we believe to be critical to our current and future success under pay for performance.
- Finally, I will turn to thoughts on measures that may be applicable to both primary care and specialist physicians should Medicare seek to implement pay-for-performance incentives in the near future.

Background

These comments are drawn from three types of experience. First, I am Network President for Partners Healthcare System, an integrated delivery system in Eastern Massachusetts that includes two major teaching hospitals (Brigham and Women's Hospital and Massachusetts General Hospital), four community hospitals, and a large physician network with about 1,100 primary care physicians and 4,000 specialists. About half of the physicians in our Network are self-employed community-based physicians, usually in small 1–2 physician practices that are affiliated with Partners through our network, Partners Community Healthcare, Inc. (PCHI). We currently have three major pay-for-performance contracts that cover the care of more than 500,000 primary care patients and a comparable number of referral patients to our specialists.

The second role that informs these comments has come from the participation in the design and implementation of Bridges to Excellence, a program led by General Electric and other major employers such as UPS, Raytheon, Ford Motor Company. Bridges to Excellence is a program through which employers provide incentives to physician practices that adopt systems likely to reduce errors of all three types (over-use, mis-use, and under-use). This program has been implemented in several marketplaces in the U.S., and has influenced the design of a forthcoming CMS demonstration project. It is relevant to this discussion because it can be applied to both primary care and specialist physicians, and because it can be applied to physicians who are not members of an organized delivery system.

Finally, I am a practicing internist and cardiologist, and have cared for patients under fee for service, capitation, and pay for performance contracts.

Impact of Pay for Performance

Our integrated delivery system has worked with the three major commercial managed care health plans in the Eastern Massachusetts marketplace since 2000 to develop pay for performance contracting as a successor to budget-based risk (capitation). As noted above, we currently have more than 500,000 primary care patients and a comparable number of referral patients to specialists whose care is covered by such contracts. Approximately $90 million in withhold is at stake based upon our

ability to achieve efficiency and quality targets. This amount constitutes 10% or more of the fees for our physicians and payments to our hospitals for these patients.

Table 1 summarizes the targets for improvement in efficiency, clinical quality, and error-reducing information infrastructure in our contracts. While the exact criteria for return of withhold vary from contract to contract, these targets require improving current performance, or beating actual or expected regional trends—that is, withhold return cannot be achieved by maintaining the status quo. We and the health plans have had little difficulty coming to agreement on which areas lend themselves to improvement and are meaningful. The health plans in our marketplace understand that consistency in these criteria across contracts increases the chances that providers will be able to invest in systems needed to achieve improvement.

The proportion of the withhold that is tied to achieving the specific goals varies, but, in general, about half of the incentive is focused on the efficiency-related targets, with the remainder divided between clinical quality goals and investment in information infrastructure expected to reduce all three types of errors. Targets for return of hospital withhold and physician withhold overlap, but vary somewhat. For example, both hospital and physician withholds have the same targets for reducing hospital admissions, but hospital quality incentives focus on Joint Commission on Accreditation of Healthcare Organizations (JCAHO) inpatient care measures, while physician withhold is tied to National Committee on Quality Assurance (NCQA) HEDIS (Health Plan Employer Data and Information Set) measures (e.g., mammography and PAP smear rates).

Note that in our most recent contracts (described as "Version 2.0"), the measures have evolved, so that the pharmacy target excludes drugs for which utilization should not be decreased (e.g., cholesterol-reducing agents), and radiology has been added as a major target for improved efficiency.

Table 1. Withhold Targets in Prior and Current PCHI Pay For Performance Contracts

	2001–2003 (Version 1.0)	2004–2008 (Version 2.0)
Efficiency	**Facility use:** Inpatient medical-surgical days/1000 members **Pharmacy:** Percent of prescriptions written for generic medications	**Facility use:** Weighted [1] medical surgical admissions/1000 **Pharmacy:** Target for pharmacy trend after exclusion of classes of agents for which utilization should be increased or is predominantly driven by clinical factors [2] **Radiology:** Rates of use of MRI/CT/nuclear cardiology tests/1000 members
Clinical Quality	**HEDIS measures:** Diabetes, asthma, Chlamydia screening **Patient safety:** [3] Anticoagulation monitoring frequency	**Physicians:** HEDIS measures for Diabetes, asthma, Chlamydia screening **Hospitals:** JCAHO measures; Leapfrog reporting
"Error reducing" infrastructure		**Physicians:** Adoption of electronic medical records **Hospitals:** Implementation of computerized physician order entry

[1] Admissions to academic medical centers are counted more heavily than admissions to community hospitals.

[2] Examples of classes of excluded agents: statins, diabetes therapies, chemotherapy, HIV therapies.

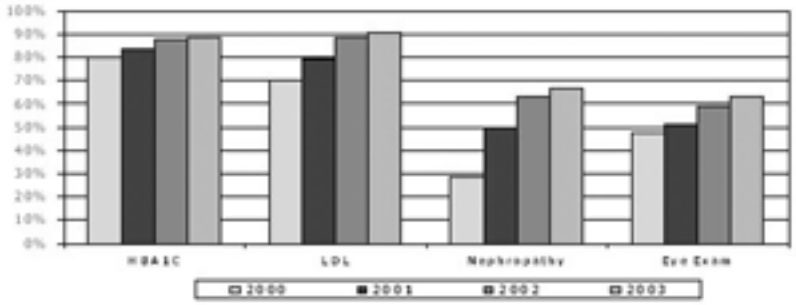
[3] Monitoring frequency of at least one measurement of International Normalized Ratio (INR) per month for patients on chronic warfarin

Thus far, our delivery system has achieved virtually every target under these. We do not expect to be able to maintain this record indefinitely, because the targets are becoming increasingly ambitious. In general, we budget based upon the assumption that we will attain 75% of our withhold. Our higher level of success to date reflects improvements in efficiency and quality that have led our Network to be among the region's leaders.

Highlights of this performance include:

1. Inpatient utilization—In the two contracts in which the health plans are providing us with comparative data, our inpatient utilization (as measured in medical-surgical admissions or days/1000 members) has decreased and is better than the rest of the market.
2. Pharmacy—Our rate of rise in pharmacy spending in our contracts averaged about 5% in 2004, compared with the national average of about 9%.
3. Imaging—Under new targets for moderating the rate of rise of utilization of high cost imaging tests, we have developed decision support to help guide physicians to more appropriate ordering, and deployed this through order entry systems at our AMCs and for our community physicians. We have only limited data on the impact of this intervention at this date, but early information indicates that our rate of rise is less than the national trend of 15–18%.
4. Diabetes and other HEDIS measures—For virtually all NCQA HEDIS measures and for about 75% of inpatient cardiology measures, we are performing above the national 90th percentile. Perhaps more important is the finding that we have steadily improved in targeted areas (e.g., diabetes—see Figure 1) under our pay for performance contracts. Pooled data that were publicly released on February 3, 2005, indicate that PCHI is among the region's leaders—*The Boston Globe* ranked PCHI second out of nine delivery systems, with performance exceeded only by a staff model HMO in which all physicians are salaried and using the same electronic medical record.

Figure 1. Improvement in Diabetes HEDIS Performance for Partners Network During First Three Years of Pay for Performance Contract (2001-2003)



System adoption as key success ingredient

This improvement has not been achieved solely by dangling incentives before physicians, and providing them data on their current performance. PCHI physicians use a combination of electronic and "humanware" systems aimed at improving quality and efficiency (Table 2, next page).

For example, in radiology, we have implemented a web-based ordering system for high cost tests that uses clinical information to assess the necessity and appropriateness of the tests. This program was stimulated by the introduction of a radiology management program by one payer that requires physician offices to call a 1–800 number to obtain authorization before scheduling any high cost tests (MRI, CT, nuclear cardiology, PET scans). We were able to negotiate an agreement with the payer so that our physicians instead use our software program, which uses established guidelines to rate tests as to their appropriateness. When tests are rated as being of marginal appropriateness (about 15% of all tests ordered to date), the ordering physician is given that feedback. Over half the time, physicians change

their behavior when they receive this message from our decision support. Physicians can proceed with tests of such uncertain appropriateness, but with the additional hurdle of prospective or retrospective peer-review (i.e., they must talk to a colleague about why they believe the test will be useful).

Table 2. PCHI Medical Management Programs

Program	Description
Focus on reducing costs	
Inpatient utilization management	Practice-based nurse care coordinators working predominantly with primary care physicians through weekly pod meetings and other forms of contact
High risk patient interventions	Telephonic case management program
Congestive heart failure	Nurse practitioner-based programs at PHS hospitals
Pharmacy	Programs to increase generic and preferred brand drug use; educate physicians and patients; assist physicians in switching individual patient prescriptions
Radiology	Computerized decision support program
Focus on improving reliability of care	
Registries for patients with targeted chronic conditions	Computer software for populations with asthma and diabetes, and patients being treated with anticoagulatant medications
Registries for improvement of preventive care	Databases to support improved reliability in use of mammography, cervical cancer screening, well-child care, and Chlamydia screening
Patient education programs	Monthly mailings of educational materials for patients with diabetes

We and most health plans/employers believe that the improvements needed to meet the market's needs in efficiency and quality cannot be attained without comprehensive adoption and use of systems that will improve care. Accordingly, Partners has launched a major program called The Signature Initiatives, which include five teams with the following goals:

1. Information systems—to promote quality and efficiency through use of electronic medical records.
2. Patient safety—to implement integrated medication ordering/administration systems to minimize adverse drug events.
3. Uniform high quality—to ensure that Partners patients reliably receive interventions known to improve outcomes.
4. Disease management—to identify high risk patients and to connect them to programs likely to improve the coordination of their care.
5. Trend management—to improve efficiency by having Partners physicians order drugs and radiology tests using decision support.

A major focus of the contractual incentives and the Signature Initiatives is dissemination of electronic records. Currently, about 80% of our academic medical center physicians and about 10% of community physicians are using electronic medical records. Achieving our withhold targets will require major increases in use of electronic records among community physicians in the next three years.

However, the "business case" for adoption of such systems is challenging for small physician practices. First year adoption costs are on the order of $25,000 per physician. Even for five-physician practices, the costs-per-MD spread over a five year period are about $10,000 to $15,000 per year for systems sophisticated enough to provide high quality decision support. These costs include hardware, software licenses, interfaces with other systems, and training expenses. Smaller steps, such as adop-

tion of hand-held prescribing devices, provide only a small part of the value of a full clinical system.

Current fraud and abuse rules make it difficult for Partners and other delivery systems to assist physicians who are affiliated but not employed by the organization in overcoming these financial hurdles. We and other delivery systems are meeting with CMS on this issue, and would welcome congressional support for an anti-kick-back safe harbor or an expanded Stark exception to permit systems like ours to help physicians adopt electronic records.

Pay-for-Performance for physicians not integrated into delivery systems

The majority of physicians in the U.S. are not currently participants in organized delivery systems that can negotiate pay for performance contracts or increase the likelihood of success under them by providing the systems described above. What kind of measures might be useful for encouraging such physicians—both primary care and specialist—to adopt systems that will improve quality and efficiency under Medicare?

Ideally, such measures should have the following characteristics:

- Measurable at minimal expense
- Valid and reliable at an individual physician level
- Can be adjusted for differences in patient population (socioeconomic; health status)
- Identify areas in which improvement is feasible and practical
- Improvement will lead to meaningful improvements in efficiency and/or patient outcome

At this time, measures of efficiency and quality based upon claims data fall short of these goals—particularly for the second and third characteristics. Therefore, interest has focused upon incentive structures under which physicians are rewarded:

- If they have adopted certain systems that are believed to improve quality and/or efficiency, or
- If they report clinical data on intermediate outcomes (e.g., diabetes or cholesterol control), and meet specified standards of excellence

One model program that can be used to provide incentives for both primary care physicians and specialists is the physician office link program of Bridges to Excellence (http://www.bridgestoexcellence.org/bte/). This program requires that physicians who want to be eligible for rewards fill out a detailed survey administered by NCQA (and pay a fee that varies with the number of physicians in the practice). The survey assesses the presence or absence of office-based systems with the following goals:

- Monitor their patients' medical histories
- Work with patients over time not just during office visits
- Follow up with patients and with other providers
- Manage populations, not just individuals, using evidence-based care
- Encourage better health habits and self-management of medical conditions
- Avoid medical errors.

There are three distinct areas under which physicians can earn bonuses (maximum $50 per patient per year):

- *Evidence-based Clinical Information System.* Key processes in this group include a reliable system for providers to track and understand the health status of their patients, and to compare the care they are receiving to widely accepted standards; and the use of electronic prescribing of drugs and laboratory exams, combined with smart edits to ensure higher patient safety and reduce overuse.
- *Patient Education and Support.* Key processes in this group include whether or not a patient's educational and language assessment was made; and whether or not the patient was provided with self-management tools and support specific to their condition.
- *Care Management.* Key processes in this group include the identification of patients with chronic illnesses and the deployment of appropriate resources to manage their care; and the identification of high-risk patients and use of systems to prevent emergency hospital admissions or readmissions.

These areas and the specific components identified within them were determined using a Six Sigma product design exercise in a process that included employers, health plans, and healthcare providers from Partners and elsewhere.

NCQA audits a small percentage of applications to ensure that the surveys are being completed accurately. NCQA then determines the amount of reward/member

that physicians are eligible to receive. This reward is based upon the number of points assigned for each of three modules within each of these categories (See Table 3, next page). The number of modules in which physicians must have a minimum number of points increases each year, thereby encouraging physicians to improve office systems in order to keep receiving the same level of financial incentives.

Medstat then determines the number of members per physician, and the size of the reward. The bonuses are based upon the size of the savings expected from these programs as determined by actuaries working for GE and other purchasers sponsoring Bridges to Excellence. Specialists and primary care physicians can both participate; rewards are given to all qualifying physicians engaged in the care of patients who are from Bridges organizations, reflecting the logic that greater savings are likely to occur for higher risk patients who need both primary and specialty care. Rewards are capped at $20,000 per physician.

Table 3. Specific Components and Points for Physician Office Link Program of Bridges to Excellence

Clinical Information Systems/ Evidence-Based Medicine		Patient Education and Support		Care Management	
Basic Registries and Follow-up	*Pts*	**Educational Resources**	*Pts*	**Care of Chronic Conditions**	*Pts*
1. Type of registry used for chronic conditions	10	1. Assessment of patient language preferences and risk factors	30	1. Identification of the practice's top three chronic conditions	10
2. Percentage of patients in registry	10	2. Identification of preferred languages in patient population	35	2. Structured process for disease management for patients with the top three conditions	45
3. Use of registry to identify patient populations	40	3. Provision of educational resources in preferred languages for risk factors and chronic conditions	35	3. Use of resources to assist with medication compliance, appointments and barriers to care	45
4. Use of paper or electronic system to track and follow upon referrals and test results	40				
	100		100		100
Electronic Registries, Rx and Test Ordering	*Pts*	**Referrals for Risk Factors & Chronic Conditions**	*Pts*	**Preventable Admissions**	*Pts*
1. Types of patient information in registry	10	1. Percent of patients who have specific risk factors	50	1. Using data to identify patients who are at risk for emergency admissions	20
2. Capabilities of an electronic system for prescriptions and tests	20	2. Provision of referrals for education & support to patients with risk factors and chronic conditions	50	2. Identification of the reasons and prevalence of emergency admissions	20
3. Use of electronic system for ordering prescriptions and checking for safety & efficiency	40			3. Structured system to prevent emergency admissions	60
4. Use of electronic system to order and retrieve tests	10				
5. Use of electronic system to track missing test results, distinguish abnormal results and prompt follow upon test results	20				
	100		100		100
Electronic Medical Records	*Pts*	**Quality Measurement and Improvement**	*Pts*	**Care of High-Risk Medical Conditions**	*Pts*
1. Types of patient information in an EMR	10	1. Identification of opportunities for improving outcomes or processes	20	1. Resources for managing patients with high-risk conditions	5
2. Percentage of patients who have information in the EMR	20	2. Setting goals for performance for identified opportunities of improvement	20	2. Number and percent of patients who receive high-risk care management	5
3. EMR's capability to report across practice on multiple fields	30	3. Measurement of performance and identification of goals not met	20	3. Contents of the high-risk care management program	30
4. EMR's capability to use decision support to prompt physician interventions	30	4. Implementation of improvement activities	40	4. Qualifications of the high-risk care manager	10
5. EMR's capability to capture services ordered, delivered or paid	5			5. Types of information in database of patients with high-risk conditions	15
6. Use of EMR to track referrals and test results	5			6. Frequency of communication between physician and care manager	5
				7. Frequency of communication between care manager and patient	30
	100		100		100

Bridges to Excellence also includes examples of programs in which physicians voluntarily submit clinical data (as opposed to the presence or absence of office systems, as in the Physician Office Link) based upon review of their own charts in order to qualify for "Provider Recognition" and bonuses. In the Diabetes Care Link and Cardiac Care Link programs, physicians can achieve awards of up to $100 per patient with the condition if their data indicate that they are achieving high levels of reliability and excellence in their care. For example, see Table 4 on next page, which lists the measures, goals, and rewards criteria for physicians applying for the adult diabetes provider recognition.

As with the Physician Office Link, physicians interested in receiving the incentives apply to NCQA and complete the survey tool. Rewards reflect an expected savings of $300–400 per patient with diabetes who sees a physician with these clinical performance levels. Early analyses by Bridges to Excellence indicate that physicians who achieve this status have lower costs in the care of their diabetic patients.

Table 4: Measures for Adult Patients in the Diabetes Care Link Program

	Measures	Goal	Points	Frequency
Measures For Both 3-Year Recognition and Rewards and Annual Rewards	HbAlc * (most recent result)	93%	NA	Once per year
	Proportion w/HbAlc <8%	55%	5.0	
	Proportion w/HbAlc >9.5% *	21%	10.0	
	Blood pressure frequency (most recent result)	97%	10.0	Once per year
	Proportion <140/90 mm Hg	65%	5.0	
	Lipid profile *	85%	5.0	Annual **
	Proportion with LDL <130 mg/dl *	63%	5.0	
Additional Measures for 3-Year Recognition	Eye exam *	61%	10.0	Annual **
	Foot exam	80%	10.0	Annual
	Nephropathy assessment *	73%	10.0	Annual **
	Total Points		**70.0**	
	Points to Achieve Recognition & Receive Rewards		**52.0**	
	Points to Receive Annual Rewards		**30.0**	

Conclusion

In summary, my colleagues and I at Partners Healthcare System believe that pay for performance contracts can drive meaningful improvement in both quality and efficiency, and are currently speeding the adoption of systems such as electronic medical records that we believe critical to the re-engineering of care. Organized provider systems such as staff model organizations (e.g., Kaiser, the VA) and more heterogeneous provider groups (e.g., Partners Healthcare System) are particularly well positioned to respond to such incentives. However, we believe that it is possible to provide incentives to small 1–2 physician practices to adopt systems likely to improve care. Bridges to Excellence provides an example of a program that provides rewards

based upon the presence or absence of such systems, and upon self-reported clinical performance.

Disclosures: Dr. Lee is a member of the Board of Directors of Bridges to Excellence, and co-chairman of the Committee on Performance Measures of NCQA. He receives no compensation for either role.

Chairman JOHNSON. Thank you, Dr. Lee. Dr. Gee.

STATEMENT OF WILLIAM F. GEE, M.D., AMERICAN UROLOGICAL ASSOCIATION, LINTHICUM, MARYLAND

Dr. GEE. Thank you, Madam Chair, Members of the Subcommittee. I am Dr. William Gee from Lexington, Kentucky. I am going to not attempt to read everything in the statement but rather highlight several things. I am the Chair of the American Urological Association Health Policy Council. I have been a member of the AMA Relative-Value Update Committee, the group which establishes relative value units for physician work and practice expense, for 10 years. I am here today actually representing the Alliance of Specialty Medicine, a coalition of 13 physician specialty societies, including the AUA, which represents over 200,000 specialty physicians in the United States. I want to talk first about the SGR, and I will truncate those comments because much of what I will say will agree with previous speakers. Then I want to talk briefly about P for P, or pay for performance.

First, on the SGR formula, it has significant flaws which have all been recognized, causing steep reductions in physician payment. The four biggest flaws we feel are, first, including the cost of Medicare-covered outpatient drugs and biologicals even though these items are not physician services and lead to decreases in annual payment updates; two, the linking of physician fees to the GDP, which does not accurately reflect changes in the cost of caring for Medicare patients; three, inadequately accounting for changes in volume of services due to new preventive screening benefits that CMS puts forward, national coverage decisions that increase demand for services and a greater reliance on drugs and a greater awareness of benefits by the Medicare population; and, finally, improperly accounting for costs and savings associated with new technology. We know that recent congressional action has fixed some of these temporarily.

Earlier, when the Committee was making comments, it was mentioned by Mr. Stark that physicians' incomes were as high as they had ever been. I would just like to note that, in 1992, when the Medicare fee schedule was instituted, the conversion factor was $40. It is now about $37. That is an 8 percent decrease. However, if you adjust $40 into 2004 dollars from 1992, it would be $53.86. So, actually, the conversion factor has gone down 33 percent in the last 13 years. So, I think we have to look at inflation when we talk about those numbers. There is, as we have heard, drastic reductions coming if the situation isn't fixed. The situation was temporarily adjusted, but in 2006 through 2012 we have heard the 5 percent reductions coming unless something happens. What is the solution? There are two things the Alliance feels needs to be done.

First, Medicare-covered outpatient drugs and other incident-to services included in the expenditure target need to be removed retroactively back to the base period, as Dr. Nielsen said, 1996, 1997. The second thing that needs to be done is to replace the SGR formula with a system that adequately accounts for the true costs of delivering healthcare services, the Medicare Economic Index. The Alliance believes the current SGR formula needs to be repealed and replaced with a system that is more predictable and recognizes the true cost of providing physician services to Medicare beneficiaries. The current MEI is a conservative measure of these costs. Other providers, such as hospitals and skilled nursing facilities, are reimbursed on inflation and their costs. The physician reimbursement formula should be based on the true cost of providing services to the Medicare beneficiaries.

Now, I would like to very briefly touch on pay for performance, P for P. The Alliance's member specialty organizations are continually striving to offer high specialized care. P for P measures for specialists are different than those for generalists, and this is one of the problems that we are grappling with in trying to see how to come up with P for P and what it would mean for specialties. We feel there are a number of things that are bulleted in our comments that need to be addressed on P for P. First, any system that rewards providers by improving patient care and outcome should not be subject to budget neutrality or be used as physician volume control. Two, reporting needs to be able to be administered without being prohibitive and expensive and yet an unfunded mandate to providers, particularly for smaller offices. Three, pay for performance programs must not be punitive. Four, measures need to be specialty specific. Some measures may be appropriate for some specialties but not for others, particularly in areas of surgery. Five, performance measures must be developed by the physician community in conjunction with CMS, but they should not be developed by CMS alone. Six, in order to be effective, collecting data has to be reliable and easy for physicians to record and report. Seven, given the limitations of the current status of specialty performance measures, the Alliance believes incentives should be placed on optimizing quality of care and physician participation, not on reporting uncontested quality data simply for the purpose of reporting data. Finally and most importantly, if a pay for performance requirement is implemented, it must be phased in and pilot tested on a voluntary basis first to see what works and what doesn't. Thank you very much, Madam Chair, for the opportunity to comment.

[The prepared statement of Dr. Gee follows:]

Statement of William F. Gee, M.D., American Urological Association, Linthicum, Maryland

Madame Chair, Members of the Subcommittee, I am Dr. William Gee from Lexington, KY. In addition to serving as the managing partner of a 17 member private urological practice, I am the Chair of the American Urological Association's (AUA) Health Policy Council and a member of the AMA Relative-Value Update Committee since 1995.

I am here today representing the Alliance of Specialty Medicine—a coalition of 13 physician specialty societies, including the *AVA*, representing over 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 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 that 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 doctor wants to turn away patients or leave a practice and the patients she or he have been serving for years. No doctor wants to end a career earlier than he or she intended. To take such actions goes against the very reasons we became doctors.

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 upon 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

While 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 percent reduction to the conversion factor. Since then, the flaws with 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.

In 2003, after the Centers for Medicare and Medicaid Services delayed a second payment reduction for three 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 percent 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. While 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 ten years. Reimbursement Rates in 2006 and Beyond Again, if the SGR formula is not fixed this year, physicians will receive negative updates of approximately 5 percent each year from 2006 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. While reimbursement will likely be cut by over 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 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. It is now time, however, to put an end to these stop-gap measures and fix the formula and the Alliance of Specialty Medicine looks forward to working with this Committee and Congress to develop a

solution. Physician payments must be stabilized and further cuts must be prevented, and to this end, the Alliance of Specialty Medicine believes the following issues need to be addressed: Medicare-covered outpatient drugs and other incident-to-services that are included in the expenditure target need to be removed retroactively back to the base period. CMS must exercise its statutory authority and remove Medicare covered drugs from the physician payment pool retroactively. We thank you, Madame Chair, as well as Mr. Thomas and the other Members of this Committee who have supported the removal of these drugs. As you know, physicians do not control the costs of these products and services and each year these costs represent a greater proportion of actual costs incurred by the Medicare program. And, as the agency has acknowledged in the past, physician-administered drugs are not a "true physician service." Yet the costs of these drugs continue to have a negative impact on reimbursement for real physician services.

The Congressional Budget Office (CBO) has predicted that spending for outpatient drugs and other incident-to-services will grow faster, on a per-beneficiary basis, than allowed by the expenditure target. Each year these services will consume a greater portion of the expenditure target, rising from $12 billion (20 percent of the $62 billion expenditure target) in 2004 to $28 billion (23 percent of the $121 billion expenditure target) in 2012. These services must be removed from the expenditure target retroactively, back to the base period, so that it accurately reflects what it is supposed to represent—payment for physician services. Recent estimates show that this will have an immediate substantial impact on the predicted cuts by bringing up the baseline and, therefore, filling in much of the "hole" that has been created. Only Congress can replace the flawed SGR formula. However, without assurance from CMS that it will remove drugs from the physician payment pool, we understand that Congress will be left with few options for replacing the flawed formula.

Replace the SGR Formula With a System that Adequately Accounts For the True Costs of Delivering Healthcare Services.—The Medicare Economic Index (MEI)

The Alliance believes that the current SGR formula needs to be repealed and replaced with a system that is more predictable and recognizes the true costs of providing physician services to Medicare beneficiaries. The current MEI is a fairly accurate measure of these costs. Other providers, such as hospitals and skilled nursing facilities, are reimbursed based upon changes in the costs of providing services and the physician reimbursement formula should be based on this, as well.

Pay for Performance

The Alliance's member specialty physician organizations are continually striving to offer the highest specialized quality care to all Medicare beneficiaries. However, with our physicians facing over 30% reductions in Medicare reimbursement from 2006 through 2013 compounded by exorbitant liability premium increases, many of these specialty physicians are reconsidering their Medicare participation status. Therefore, the Alliance believes that if Congress is to begin to explore alternative payment requirements—such as pay for performance—then the current unsustainable Medicare physician payment system needs to be fixed. The Alliance represents 12 physician specialties, which are all at varying stages of sophistication regarding pay for performance initiatives; therefore, we believe that the following points need to be considered: Any type of system that rewards providers by improving patient care and outcomes should not be subject to budget neutrality or be used as a physician volume control.

The reporting of quality or efficiency indicators and health outcomes data could be administratively prohibitive to many physicians, especially those in small practices that do not have electronic medical records. It could be difficult to link payment to performance without an interoperable health information technology infrastructure. Pay for performance programs must not be punitive. Measures will need to be specialty specific. Some measures may be appropriate for some specialties, and not others. In some areas, particularly surgery—it can be difficult to keep quality measures up-to-date enough to be perceived as relevant. Any measures would have to be developed by the physician community.

In order to be effective, collecting data must be reliable and easy for physicians to record and report based on a clinical data set and in a manner that is acceptable to the physician community. The collection of such data must be timely and easily submitted and should not create a burden on practices. Furthermore, the data collected must allow for physicians to comply with Medicare HIP AA requirements. Given the limitations on the current status of specialty performance measures, the Alliance believes that incentives should be placed on optimizing quality of care and physician participation, not on performance of specific quality measurements. If a

pay for performance requirement is implemented, it should be phased-in and pilot tested on a voluntary basis first.

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, insures fair reimbursement for physicians, and continued beneficiary access to quality specialty health care.

Chairman JOHNSON. Thank you, Dr. Gee. Mr. Hayes.

STATEMENT OF ROBERT M. HAYES, PRESIDENT, MEDICARE RIGHTS CENTER, NEW YORK, NEW YORK

Mr. HAYES. Madam Chairman, Mr. Stark, Committee Members, thanks so much for having us. I run the Medicare Rights Center, which is a nonprofit consumer service organization. Every day we help people with Medicare access, needed care. Tens of thousands of callers use our help-lines annually, and we work with these folks to help them navigate the healthcare system in rural programs and to help them pay for the health care that they need. We are consumer driven and independent. We rely on a small staff and hundreds of deeply committed volunteers. Madam Chairman, the issue under consideration in today's hearing is very critical to the continued vitality of Medicare from a consumer perspective. We don't envy you, how to determine how Medicare can best balance the demands of fair payments to doctors and maintain access to people—to care for people with Medicare. As we report from the trenches in which we work each day, I remind myself that these tough issues are really important for a single reason. The issues are all about how we best meet our moral obligations to assist our mothers, our fathers, our grandparents and our neighbors secure the health care they need. We are all doing a lot of talking and analyzing today about numbers, dollars, policy but we struggle with these issues, each of us, because ultimately we care about human health, human dignity, human survival.

Alice Kavanagh is one of the millions of Americans whose well-being depends on Medicare. Ms. Kavanagh, from Durham, New Hampshire, is 82 years old, lives in a family home with her son, active in her church, spends a lot of time on the phone connecting with her friends and neighbors. She is a cancer survivor. Two years ago she was treated for colon cancer, and she can see her oncologist and other doctors regularly. So far she is free from cancer, and she is grateful for the Medicare coverage that enabled her to have surgery and followup care. I mentioned Ms. Kavanagh because she is why we celebrate Medicare, warts and all, as a national treasure. It does provide the financial security, access to health care, choice of doctors and peace of mind that are a lifeline to many older and disabled Americans. One of Medicare's traditional strengths, of course, is that most doctors across the United States participate in the program. Yesterday's report from the GAO, along with work by MedPAC and our own hotline experience, consistently demonstrates that nearly all people with traditional Medicare are able to see the doctors they need when they need to. On our hotlines, to be sure, we occasionally do hear from people with Medicare who

have trouble finding a doctor. It usually turns out that those doctors are not taking any new patients into their practices regardless of payer.

From the customer point of view, this broad access gives people with Medicare the ability to choose a doctor based on provider relationships, transportation needs, and other critical factors. That is why on behalf of consumers we are grateful for this Committee's stated interest in preserving access to doctors by ensuring that payment rates do not drive high-quality physicians away from Medicare patients. It is not just rates that allows such wide access to doctors for people with Medicare. MedPAC has reported—and this is our on-the-ground experience as well—that the speed and reliability of Medicare payments, in sharp contrast with many of the Subcommittee's largest private insurers, makes Medicare the extraordinarily attractive insurer that it is for patient and doctor alike. Now, this is not to say that people with Medicare do not see trouble on the horizon; it is coming from many directions. It does appear obvious that repeated 5-year 5-percent annual cuts in physician payments, as modeled by the CBO, could well undermine physician access for people with Medicare, if not immediately, then over time. We do credit MedPAC and GAO for carefully monitoring access to services and providing this Congress with their unvarnished analyses. In these thorny and technical analyses, both of these agencies in our view shoot straight, and we rely heavily on their intelligence.

We can also say that at times there has appeared to be a contradiction between what physician lobbyists say about access to physicians and what is really happening. We believe that payments should be about reality, not political pressure or influence, and we say that because the soundness of the Medicare system is of single importance to people with Medicare. On that particular issue, Madam Chairwoman, let me wrap up by commenting on an issue raised by Mr. Emanuel this morning and which, Mrs. Johnson, you followed up on; that there is indeed a great deal of struggle among people with Medicare to pay the out-of-pocket expenses involved with that, with their coverage. The numbers are well-known, that 40 percent of the people with Medicare live on under $18,000 a year income. It is true that Medicare savings programs can help very low-income people meet their premium needs and their coinsurance requirements in some cases. We look forward in the year ahead to work with this Committee and with anyone else to try to find a way that, moving ahead, those programs can be made more available to the 50 percent of folks who are eligible for that help who don't get it; and as we go into low-income support program under Part D, that we have enrollment programs that work to actually get people the support that they do need. Thank you so much.

[The prepared statement of Mr. Hayes follows:]

Statement of Robert M. Hayes, President, Medicare Rights Center, New York, New York

Good morning, Madam Chairman, Mr. Stark and Members of the Committee.

I am Robert M. Hayes, President of the Medicare Rights Center. We very much appreciate the opportunity to address you today on consumer issues related to

changes in Medicare payment policies and bring before the Committee our day-to-day experiences assisting people with Medicare obtain good health care.

The Medicare Rights Center (MRC) is the largest independent source of Medicare information and assistance in the United States. Founded in 1989, MRC helps older adults and people with disabilities obtain good affordable health care. Every day we help people with Medicare access necessary services. Tens of thousands of callers use our help-lines annually. We help people with Medicare navigate the healthcare system, enroll in programs that may help them pay for health care, and overcome barriers to care.

The Medicare Rights Center is a not-for-profit consumer service organization, with offices in New York, Washington and Baltimore. It is supported by foundation grants, individual donations and contracts with both the public and private sectors. We are consumer driven and independent, relying on a small staff and hundreds of deeply committed volunteers to carry out our mission. We are not supported by the pharmaceutical industry, insurance companies or any other special interest group. Our mission is to serve the 41 million men and women with Medicare.

Through national and state telephone hotlines, casework and professional and public education programs, MRC provides direct assistance to people with Medicare from coast to coast. We are also bringing to counselors and consumers across the country Medicare Interactive, a web-based counseling tool—developed with major support from the United States Department of Commerce—that assists people with Medicare access the health care they need.

MRC gathers data on the healthcare needs of the men and women that we serve, and devises policy recommendations from those data. We share the data with researchers, policymakers and the media. Just one of MRC's services, its New York State Health Insurance Assistance Program (SHIP), offers counseling support to one out of every 14 Medicare recipients in the nation. Each year, the Medicare Rights Center receives over 75,000 calls for assistance from people with Medicare. Our counselors are trained to assist consumers with complex problems and we complement the basic services offered by the 1–800–MEDICARE hotline operated by the Centers for Medicare and Medicaid Services (CMS). 1–800–MEDICARE is the largest source of referrals to our hotline, and CMS, through the SHIP program, provides about 25 percent of the financial support for the MRC hotline; the rest we raise privately.

The issues under consideration at today's hearing are critical to the continued vitality of Medicare—how can Medicare balance the demands of fair payment to doctors, appropriate growth in a major federal budget item, and access to care for people with Medicare coverage.

As we report from the trenches in which we work, I remind myself that these tough issues are important for a single reason: these issues are all about how do we best meet our moral obligations to assist our mothers, our fathers, our grandparents and our neighbors secure the health care they need. We all are doing a lot of talking about numbers, dollars and public policy. We do struggle with these issues because, ultimately, we care about human health, human dignity, human survival.

Alice Kavanagh and John Rowe are two New Hampshire citizens whose very well-being depends on Medicare. They reflect the realities of many of the 41 million men and women with Medicare.

Mrs. Kavanagh, from Durham, New Hampshire, is 82 years old, and lives in her family home with her son. She is active in her local church and spends a lot of time on the telephone staying connected with her friends. She is a cancer survivor—in 2003, she was treated for colon cancer. She sees her oncologist and other doctors regularly, and so far is free from cancer—and she is thankful for the Medicare coverage that enabled her to have surgery and followup care. She has other needs that aren't covered by Medicare—she recently paid $300 for a tooth extraction and needs further expensive dental work. She also needs eye care, but has put off seeking care because of the cost.

Mr. Rowe, aged 67, hails from Raymond, New Hampshire. He is extremely grateful for his Medicare coverage—he was uninsured twice in the last decade, first when he was working as an independent contractor, and then for the two years he was unemployed before turning 65. He still looks for work, but now he knows that with Medicare he has health coverage he can depend on, particularly since he must monitor his cholesterol, triglycerides and blood pressure following triple-bypass surgery. He says that Medicare's wide choice of doctors was very important when he needed to change doctors.

I mention these folks because they are why we celebrate Medicare, warts and all, as a national treasure. It provides the financial security, access to health care, choice of doctors and peace of mind that are a lifeline to many older Americans.

One of Medicare's traditional strengths is that most doctors across the United States participate in the program. Yesterday's report from the Government Accountability Office, along with work by MedPAC and our own hotline experience, consistently demonstrates that nearly all people with traditional Medicare are able to see doctors when they need to. For example, the CMS-sponsored Consumer Assessment of Health Plans—Fee For Service (CAPHS–FFS) survey found that 90 percent of beneficiaries report "always" or "usually" obtaining a timely appointment for routine care.

On our hotlines, we occasionally hear from people with Medicare who have trouble finding a doctor, but it usually turns out that those doctors are not taking any new patients into their practices, regardless of payor. From the consumer point of view, this broad access gives people with Medicare the ability to choose their doctor—based on personal preference, long-standing patient-provider relationships, convenience, transportation needs and other factors—and get the care they need.

So we are grateful for the Committee's stated interest in preserving access to doctors by ensuring that payment rates do not drive high quality physicians away from Medicare patients. Rates are obviously one of the main mechanisms to make sure that the Medicare program delivers on its promises to older Americans and people with disabilities. It is not just rates, however, that allows such wide access to doctors for people with Medicare. MedPAC reports, and our on-the-ground experience, demonstrate that the speed and reliability of Medicare payments—in sharp contract with many of the nation's largest private insurers—make Medicare the extraordinarily attractive insurer that it is for patient and doctor alike.

That is not to say that people with Medicare do not see trouble on the horizon. It is coming from many directions. For example, it is obvious that repeated five percent per year cuts in physician payment, as modeled by the Congressional Budget Office, would undermine physician access for people with Medicare—if not immediately, then over time. I'm not competent to tell the Committee what the magic number is that will create appropriate payment levels and maintain vibrant access to doctors within Medicare.

We do credit MedPAC and GAO for carefully monitoring access to services and providing the Administration and the Congress with their unvarnished analysis. In these thorny and technical analyses, both of these agencies shoot straight, and we rely heavily on their intelligence.

We also can say that there has appeared to be a contradiction between what physician lobbyists say about access to physicians, and what apolitical clinicians actually do. Too often lobbying hyperbole is the rule, and this causes needless anxiety among many people with Medicare—especially the older and frailer men and women for whom Medicare, and their access to good medical care, is indeed a lifeline.

So, consumers look to this Committee to strike the proper balance in paying providers enough, but just enough. Payment should be about reality, not political pressure. We say that because the soundness of the Medicare system is of single importance of people with Medicare.

Further, many of our clients struggle to pay the out-of-pocket healthcare costs that accompany Medicare: their co-insurance and deductibles, their Part B premiums and uncovered needs. Month after month, calls about the affordability of the Part B premium—you all know of this year's record increase—top the list of our clients' concerns. Changes in patient out-of-pocket costs create real hardship, and provider payments contribute to these costs. According to the Department of Health and Human Services (HHS), increases in physician payments and other payment increases in fee-for-service Medicare were the "principal contributing factor" to the $11.60—17.3 percent—increase in Part B premiums from 2004 to 2005.

On average, Medicare-covered individuals living in the community spent 22 percent of their income in 2003 on out-of-pocket costs, including Medicare premiums, cost-sharing, and services not covered by Medicare, while individuals with long-term care needs spent considerably more. And these data are based on average incomes and average healthcare expenses. The poorer, the frailer and the sicker men and women with Medicare inevitably face greater hardship. Forty percent of people with Medicare live on incomes below 200 percent of poverty ($18,620 for an individual and $24,980 for a couple in 2004) and struggle to manage their out of pocket healthcare costs—going without necessary care, or forgoing other necessities of life.

People with Medicare would also be dramatically affected by any cuts in the Medicare program in response to a "Medicare Funding Warning" provoked by the cap on the percent of general revenues dedicated to Medicare spending. Any increases in general revenue spending on Medicare—including any unnecessary increases in provider payments—will accelerate the timetable for considering program cuts that may have a devastating impact on the Medicare program as a whole. A prudent and balanced approach to increasing payment levels is clearly imperative.

We believe that one of the best ways to approach these countervailing pressures is through innovative strategies for improving access and quality of care for people with Medicare. Nearly 80 percent of people with Medicare have a chronic condition such as stroke, diabetes, congestive heart failure, emphysema, heart disease, hypertension, or Parkinson's disease. It is imperative that fee-for-service Medicare adopt improvements in chronic care management and other quality improvement strategies. Madam Chairman, you personally, and this Committee as a whole, have provided important leadership in this area, most recently exemplified by the Chronic Care Improvement Program. While it is true that current systems for measuring quality are imperfect, the impact of financial incentives on quality of care will be forever limited unless large purchasers such as Medicare use their market clout to experiment, evaluate and reform. Some long-standing models, like the team management approach at the heart of the PACE program, have already proven their worth over time.

In particular, MRC is interested in new approaches that focus on improving health outcomes, individual function and quality of life, in addition to creating more effective and efficient modes of care. Recent private-sector efforts to improve chronic care management have experimented with financial incentives, performance profiling and other strategies to improve care for diabetes, coronary artery disease, depression and other chronic conditions. For example, Rochester Rewards Results uses quality bonuses, provider reports on clinical, service and efficiency measures, and patient engagement to focus on chronic care management and improve appropriateness of acute care services. Similarly, the Integrated Health Association in California uses bonus payments tied to a scorecard that measures clinical quality, patient satisfaction and investment in information technology; chronic conditions included in this scorecard include asthma, diabetes and coronary artery diseases. Other approaches to chronic care management can be found on the Leapfrog Compendium at http://www.leapfroggroup.org/. These experiments are interesting, but since they are relatively new efforts, we do not yet know how significant an impact they will have on quality, effectiveness or efficiency.

Up to now, Medicare demonstrations have focused more heavily on efficiency and cost-effectiveness, rather than improved function, quality of life, or other measures that reflect consumer needs and experiences. These needs should be balanced—Medicare can use its power as a purchaser to ensure that consumers get improved value, not just lower cost. MRC is eager to work with CMS, this Committee and other experts to identify the next wave of quality improvement and care coordination strategies.

It's a tough balance to be sure: but remember Alice Kavanagh who needs dental and vision care that Medicare does not cover. And remember John Rowe, who was uninsured for the two years before he became eligible for Medicare when he turned 65. Those are gaps that a generous and efficient healthcare system should fill. That may not be where today's political winds are blowing, but we submit that without system efficiencies, the necessary debate over how Medicare can best serve the American people, how it can best allow us to meet our moral obligations and meet the health needs of our neighbors, will be compromised.

So we offer our on-the-ground assistance as you work, Madam Chairman, with doctors, consumer groups, economists—whoever it takes—to balance delicately the question of how much is enough, but not too much, to pay physicians.

Chairman JOHNSON. Thank you. I thank the panel. I will just make a comment, and then I am going to let other people question, and if I can I will come in at the end, but some of them have been here quite a long time. In my work in disease management and getting out there and looking at hospitals that have good integrated electronic systems and in large practices, I firmly believe that there is a relationship between integrated care, quality, prevention, holistic medicine and technology. In other parts of the Medicare law, we explicitly reimburse for at least some of the costs of technology. Technology requires investment, it requires knowledge and learning, it requires training and staff development, and it is an ongoing cost, but it has ongoing power to increase quality. As you answer other people's questions—or at the end—I hope you

will come back to this issue of the costs of technology. I am starting from the assumption of—Mr. Hayes, if you disagree with me—I don't disagree with anything you said in your testimony—but if you disagree that systems are essential to the next round of quality improvements, we do need that on the record today, because I think that is sort of indisputable. So, I will—let me just lay my comments aside, you can leave them, or you can think about them later, but some of the Members have been here a long time and I would like to move on to them rapidly. Mr. Stark, out of courtesy.

Mr. STARK. I thank the Madam Chair, I thank the panel. I guess I too would make some comments. I have been here 20 years—longer than that, actually—but 20 years that I have been fussing with Medicare. At least physician-lobbyists are consistent. In 20 years, I have never heard the American Medical Association come, either to my office or to this Committee, and ask for anything on behalf of patients or the uninsured, or anything but more money for their members or lower malpractice rates from their insurance companies. So, at least they are right on target. Many of the specialists, Dr. Gee, have done the same thing. In Dr. Nielsen's surgery, mentioned here that cataract surgery will drop from $684 in 2005 to $469 in 2013. I can remember back in the early 1980s when cataract surgery was paid around 1,800 bucks, and then Fitzburg recommended—I think these are the right numbers, maybe it was 1,200. There was a learning curve and the ophthalmologists became more efficient and they recommended we should drop it to 1,500, because it took a lot less time to train to use the laser equipment. Of course, they screamed and did not want to share with us what technology provided, and that was greater productivity.

I guess in the LASIK area today, it started out maybe at 5 or 6 grand for a couple of eyes, and now you maybe have—although these guys may be the charlatans of the practice, you can get them for 495 an eye. We don't pay for that, but I am just suggesting that as physicians, like auto mechanics or anybody else, become more efficient, they become more productive, and should in fact share some of that savings with the taxpayers who fund this. Now, it may be that the index has dropped, but urologists, for example, between 2003 and 2004, their compensation ranges, according to modern health care here, ran from 250- to 440,000 bucks a year. That is an increase of around 18 percent. Now, if I were wondering how I would make more money as a urologist, I don't think I would be—and I were at the 250 level—I wouldn't be back here getting me to raise those fees a few bucks. I would go to see those guys who are making 450 and find out what he is doing. That is a good jump. I don't think that Medicare should have to take care of that. Also, in the pay-for-performance issue, a bit of mugwumpery on the part of the American Medical Association. I think what you were suggesting in your testimony, Dr. Nielsen, is you think it is all right, but you don't want any penalties, you want it all up. In other words, if it is a lousy performer, you don't want us to cut—is that right—you just want it to go up.

I am saying, well, that may be good, but we do have a zero-sum game here, and it may surprise you to know I am rather reluctant for Congress to get into the quality issue. I don't think we are capa-

ble of doing that. With all the wonderful staff help we have, I think actually MedPAC is barely able. I think it is up to the docs to regulate themselves. We had suggested one time, sometimes doctor-specialists have to go in every 7 years and take a test to be recertified. Fought like hell to stop that. They wouldn't have anything to do with that. The AMA led the charge. So, if the physicians won't govern themselves—and they generally won't—I don't think you will find a physician in there in a fee-for-service area who would criticize another physician and rank his colleagues or her colleagues from a score of 1 to 10. They just won't do it. It is just not built into their psyche. So, my theory is we ought to demand a minimum high quality from everyone who is licensed to practice medicine, because I think that is basically where we are. In technology, sure, if we got outcomes research, and could get everybody to use the same kinds of electronic medical records, physicians would have a better information base on which to base their decisions.

We should decide that if a urologist is board certified, that is good enough for me. Should I rank you with Dr. Walsh? I don't think so. I mean, he will rank himself with anybody. Doc—everybody is going. At any rate, what I am suggesting is how could we get into that fight? I mean he has got to write books and promote his stuff, and down there in Virginia you probably just go ahead and do what you are supposed to do and treat your patients well, and I don't—I shouldn't make that decision. You see what I am saying? You are saying you are certified and you are good. You are an internist, and I have got to depend on somebody else, hopefully, that you are good. Because if we start trying to sort out about are you this much better than somebody two floors down, I think we run into trouble. I hope we will get some help.

Chairman JOHNSON. Mr. Hulshof.

Mr. HULSHOF. Thanks, Madam Chair. I certainly don't have the institutional memory or the longevity of the gentleman from California, the number of years that he has been here and having these discussions. I will say to the gentleman, I know when I mention his name to certain providers back in my district, it evokes a response. I will leave it, leave it at that.

Mr. STARK. Do that after you get off of the examining table.

Mr. HULSHOF. I do. Dr. Nielsen, I teed this up for you with Mr. Hackbarth earlier, and to paraphrase what he mentioned in response to my question was, let us—okay, we do this, the SGR, and I hope everyone understands the fact that Mrs. Johnson has made this an issue, we are going to make strong strides to solving the issue. I think back to last year's discussion. The reason that there is a generous practice expense, for instance, for oncologists is because of Mrs. Johnson and others. So, the fact that we are here discussing this reimbursement and she has made this a priority means that we are going to accomplish something, and hopefully something significant. Dr. Nielsen, what Mr. Hackbarth, as I recall, the last hour said, that we could do this in tandem. In other words, we could address the flawed formula and at the same time begin to institute a pay for performance. I seem to read from your testimony—and you invited a question along this line—that we should first fix the formula and then look at a transition to pay for per-

formance. Have I adequately set out—or let me just let you elaborate on your opinion on that.

Dr. NIELSEN. That is partly right. First of all, let me talk about pay for performance. Theater troops perform, belly dancers perform. Doctors care for patients. We can do a better job. So, the idea is to increase the quality of the care that is rendered to Medicare beneficiaries. That is what everybody is here about. It is not about asking for an increase in fees at all, with all due respect to Congressman Stark. It is not. Let me now go to the issue of can you do it in tandem, the pay for performance. Pay for performance absolutely works. I would agree with my colleague from Massachusetts that it does work. I have seen it. I have been part of that. On the other hand, you really have to be careful that you pilot these projects to make sure you are measuring the right things. It needs to be identified by the profession, and so I would absolutely agree with Congressman Stark about that. Let me tell you that the American Medical Association over the past 5 years have spent $5 million in convening the Consortium for Performance Improvement, where we in fact do exactly what he asked for; we came up with measures of performance, the critical measures that are going to make a difference in outcomes. So, yes, I think they—I think we have clear—we clearly can't let this formula go on. It just can't go on. So, the simple answer is please, please, fix it. Absolutely, we want to be part of the solution in terms of improving the quality for our seniors and for all our patients.

Mr. HULSHOF. Dr. Nielsen, Dr. Gee suggested in his testimony that if we were to scrap the present formula and move to something like the MEI, the Medicare Economic Index, does your group have an official position on that or not?

Dr. NIELSEN. Well, sure. We are the only group that is not treated in that way. So, absolutely. The inequity should be fixed.

Mr. HULSHOF. Last, Dr. Lee, Dr. Gee mentioned in his testimony that there may be certain specialties that would not fit well with a pay for performance. Any response to that point?

Dr. LEE. Well, I think that there are—like the Bridges to Excellence model, specialists can participate in them, adopt electronic records, do computerized prescribing and so on. There are some specialists for whom it is not—it wouldn't make a big difference, and there isn't a lot of data on measures. I would say where there aren't good measures and where computerized prescribing isn't going to produce a lot of value, it probably isn't that important for the healthcare system to get them on pay for performance, because the stakes aren't that high and we don't know what to do. There are enough specialties where we do know what to do; my own specialty, cardiology, being an example.

Mr. HULSHOF. Thank you. Thank you, Mr. Chairman. I yield back.

Mr. ENGLISH. [Presiding.] Thank you, Mr. Hulshof. Dr. Lee, you have testified that Partners HealthCare and several pay-for-performance contracts work, and intuitively we know that well-defined, achievable targets can improve quality and efficiency in a range of settings. I listened to Dr. Hackbarth's—I am sorry, Mr. Hackbarth's testimony in the first panel, and came away with the fact that he apparently is offering us a very generalized model

without a lot of details in approaching performance measurement in this area. Can you give us some more detailed examples? Here I particularly want you to describe your experience with Bridges to Excellence, what you have learned about the application of private-sector systems to reducing errors in healthcare delivery. Is this a model that can be broadly applied and, in your opinion, for what other provider services would a pay-for-performance model likely increase quality and improve efficiency?

Dr. LEE. Thanks very much for the opportunity to address some of those issues which are on my mind, too. If I seem like I am singing a slightly different tune from my physician colleagues, it is because the role that I am representing here is a delivery system trying to work with the insurance companies in our area to make the healthcare system work for our region. So, we are—we are very focused on quality, but we actually have to sit at the table and think about the affordability of care, so that is why we really feel as Partners HealthCare System we have to work toward aggressively improving efficiency as well as quality. So, our measures, we want to improve diabetes care to be nice to diabetics, but we also need to work on the affordability of care if we are going to take good care of everyone. So, the things we are trying to focus on—reduce admissions; we focused on trying to shorten hospitalizations where the contracts were paid by the day, and we have been able to do that, reduce 5 to 10 percent of admissions by having practice-based case managers follow their high-risk patients, stay in touch with them, make sure that they know how to take their medications. By the time they come to the emergency department, it is too late to prevent the admission. You can't get into our hospitals these days unless you are close to dying.

We have to be doing things in the week or two before they might have gone to the emergency department to prevent that, so you can lower admissions. As I say, you can improve your pharmacy prescribing. You can improve your radiology utilization. It is not just—just yelling at doctors to be more efficient doesn't do it. It is giving them the tools so it is easy for them to go to the most cost-effective choice. That is really what they need to perform. Now, we have done good things in the quality sector too. I wanted to play up the efficiency side, because as you think about SGR and you try to make Medicare work, doctors' fees is not where the action is. It is what the doctors do during the visit. So, trying to make Medicare work by cutting doctors' fees, that is not where the action is. It is when they prescribe radiology tests, when they prescribe drugs, that is where you should be trying to look, because that is going up 10, 15, 20 percent. Doctors' fees certainly are not. Now, in terms of Bridges, Bridges is a program that you think the jury is still out, because it is new. I was part of the design team, and I am one of the board of directors on it; unpaid, but I am a believer in it. It takes the approach that we can't measure the quality and efficiency of all the onesies and twosies doctors out there. It is going to be a long time before the systems are in place to allow us to do that. What we can do is determine whether or not they have systems which we think should improve efficiency and quality. That is a leap of faith that will actually lead to efficiency quality. At least we can go that step and say do they have the electronic records,

are they prescribing them by computers, do they have systems to identify high-risk patients and to take good care of them?

Mr. ENGLISH. Your focus is not on actual performance at the individual level, it is on tools and incentives.

Dr. LEE. Right, because these systems are not there to measure, to measure the performance at this point. I think it will be several years before they are there.

Mr. ENGLISH. I presume you listened to Mr. Hackbarth's testimony.

Dr. LEE. Yes.

Mr. ENGLISH. Do you think the sort of broad vision of performance measurement that he laid out without I think some of the important specifics spelled out, is that a viable model for us to be pursuing at this stage?

Dr. LEE. I believe it is, and I believe it is not ready yet. I think it—but I think that—and he and I talked beforehand. The measures will never be perfect, so I think—I say to my physician colleagues, we have to recognize they are not going to be perfect, and I think that the provisions should work with policymakers, with the understanding we have to get something out there in like a 3- to 5-year timeframe, where we are measuring performance that we can live with. We are going to have to have systems that protect against gross unfairness in their application, but we have to recognize that they are not going to be perfect, but we can't let imperfection be the enemy of the good.

Mr. ENGLISH. I would like to thank the panelists for providing us each individually with an exceptional presentation today. This has been very helpful to us. With that, I believe all Members having had an opportunity to inquire, I will adjourn this hearing. Thank you.

[Whereupon, at 12:47 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of Wendy Gaitwood, American Academy of Family Physicians

Introduction

This statement is submitted on behalf of the 94,000 members of the American Academy of Family Physicians to the House Ways and Means Health Subcommittee as part of its hearing on Medicare reimbursement to physicians. The AAFP appreciates the work of this Subcommittee to examine the issue of how Medicare reimburses physicians services and we share the Subcommittee's concerns that the current system is unproductive. This fee-for-service system as presently constructed rewards increased volume of services whether or not these services enhance quality outcomes for Medicare beneficiaries. Such a system of physician reimbursement by itself and without improvement is unworkable and unsustainable over the long-term. This is why the AAFP supports the restructuring of Medicare reimbursement to reward quality and care coordination. This restructuring must be built on a fundamental reform of the underlying fee-for-service reimbursement system.

Family physicians have a unique perspective on the effectiveness of the Medicare system. After all, the majority of Medicare beneficiaries who identify a physician as their usual source of care report that they have chosen a family physician. Family physicians take very seriously the obligation to provide the best health care possible to our Medicare patients. But Medicare reimbursement policies are challenging the ability of family physicians to fulfill that obligation.

Sustainable Growth Rate (SGR)

The American Academy of Family Physicians supports congressional action to replace the formula known as the sustainable growth rate (SGR) used to determine the annual updates in the Medicare Physician Fee Schedule (MPFS) conversion fac-

tor. Above all, the reimbursement system should be designed to ensure that Medicare patients can continue to receive the care they depend on and deserve.

Because of the leadership of the Ways and Means Committee, the *Medicare Prescription Drug and Modernization Act* (MMA), signed into law in December 2003, included a provision that waived the SGR formula and set the increase in the conversion factor for the Medicare Physician Fee Schedule for 2004 and 2005 at no less than 1.5 percent each year. However, unless Congress acts again, the SGR formula used to calculate annual updates will be reinstituted in 2006 and Medicare actuaries are predicting a 5.2 percent decrease that year. Moreover, because of the cumulative nature of the arcane formula, similar sized decreases are projected annually for many years into the future. Such unrelenting decreases will make it impossible for many more family physicians to accept new Medicare patients. To avoid this, the AAFP supports the recommendation of the Medicare Payment Advisory Commission (MedPAC) that calls for repealing the SGR formula and basing the conversion factor on the Medicare Economic Index (MEI) minus a productivity adjustment.

AAFP agrees with concerns expressed by commissioners of the MedPAC that necessary changes made to the SGR going forward will not eliminate the SGR deficit that has accumulated due to the cumulative nature of the flawed formula. Nevertheless, Congress must act to protect the stability of the ambulatory care portion of the Medicare program which is essential to meeting the medical needs of our nation's seniors. Without action to fix the SGR, these insufficient updates will continue to disproportionately affect primary care offices relative to other subspecialties because of higher overhead costs.

Until a complete revision of the reimbursement formula is accomplished, there is an administrative adjustment that CMS can make immediately. Congress should join AAFP and the community of organized medicine in urging CMS to immediately remove, retroactive to the inception of the SGR, the physician-administered drugs from the SGR. These in-office medications are not reimbursed under the MPFS and should never have been part of the formula used to calculate the conversion factor for physician services. Moreover, the MMA restructured how these medications are paid for. CMS's continued inaction, in the face of a growing Medicare ambulatory care reimbursement crisis, is irresponsible.

The SGR has failed to result in a Medicare payment rate that has kept pace with the cost of delivering care. While the SGR update contributes to the crisis of Medicare reimbursement, the negative impact of Medicare's reimbursement system on ambulatory-based primary care is a much larger issue.

Care Management Reimbursement

Medicare's current visit-based reimbursement system has compromised both the ability of primary care physicians to serve in the role for which they are best trained and the beneficial services they are prepared to deliver. Rather than rewarding cost-effective care coordination and care integration, the system rewards physicians for ordering tests and performing procedures. There is no direct compensation to physicians for the considerable time and effort of assuring that the patient's care is organized correctly and is integrated in a way that makes sense to patients, while remaining cost-effective to the Medicare program.

Congress and CMS must be willing to adequately reimburse primary care functions. Without the necessary resources to allow physicians to redesign their clinical workflow to deliver quality outcomes, Medicare beneficiaries will continue to experience fragmented and ineffective care.

The urgency to transform the design, delivery, and financing of primary care converges well with interest in more broadly implementing a model of chronic care that demonstrates improved quality and cost-effectiveness. CMS is currently engaged in congressionally-created demonstration projects such as the chronic care improvement program and in projects of its own design such as the high-cost Medicare beneficiary demonstration program. There is strong evidence that the Chronic Care Model, as developed by Ed Wagner, M.D., does produce both quality and efficacy. The six components of this model (self management, decision support, delivery system design, clinical information systems, healthcare organizations, and community resources) have been tested in more than 39 studies and have repeatedly demonstrated their value.[1] The implementation of the Chronic Care Model can reduce unneeded specialty referrals, as well as lead to increased patient satisfaction and improved clinical outcomes. These components are not specific to the care of the

[1] Casalino L, Gillies RR, Shortell SM, Schmittdiel JA, Bodenheimer T, Robinson JC et al. External incentives, information technology, and organized processes to improve healthcare quality for patients with chronic disease. JAMA 2003; 289(4):434–441.

chronically ill, rather they are generally applicable to the needed redesign of primary care for all Medicare beneficiaries.

A blended model of payment combining fee-for-service reimbursement system plus a per-beneficiary, per-month stipend for care management, paid directly to the patients' designated personal physician, is a promising option that would enable family physicians to redesign their offices to deliver high quality preventive and chronic care with improved outcomes for Medicare beneficiaries. Bodenheimer et al. suggest that through blended payments Medicare, specifically, could best make the business case to primary care for taking on chronic care management by paying for chronic care costs (including information technology) and paying for performance through reimbursement enhancements.[2]

Others have made similar recommendations to Medicare for blended payments that support additional coordination responsibilities, electronic communication and documentation, and community-based care as well.[3]

Medicare Pay-for-Performance

Pay-for-performance programs are rapidly growing among private health plans. Payers see pay-for-performance as a means of tailoring reimbursement to physician performance. Its increasing use in the private sector has prompted federal health policymakers to examine whether pay-for-performance could be applied to Medicare physician reimbursement.

For example, MedPAC recommended during the January meeting that Congress create Medicare pay-for-performance programs for physician services. According to the MedPAC commissioners, such a program should begin with structural measures such as whether a physician office is utilizing a patient registry to notify patients of followup appointments or whether a physician is utilizing an electronic health record (EHR). MedPAC commissioners recommend the subsequent gradual inclusion of performance measures such as whether patients with diabetes have had their cholesterol checked or whether they have received an annual foot exam.

Such a recommendation for structural measures as an initial step makes sense particularly in regard to office based technologies such as EHRs which can provide more complete and integrated health data along with clinical reminders during the office visit. An EHR would allow a physician to track his or her performance along with CMS, as well as appropriately risk-adjust the reported data. However, even in the absence of an EHR, there is still a minimum data set that could be collected. The AAFP is working in a collaborative effort with the America's Health Insurance Plans, the American College of Physicians, the Agency for Healthcare Research and Quality and many other groups to develop a starter set of performance measures from a larger set of ambulatory measures undergoing expedited review by the National Quality Forum. The collaborative effort plans to have agreed on an initial set of performance measures by this summer. Data on these measures will come from both administrative claims as well as clinical data sources.

As MedPAC has recommended, several legislators have expressed an interest in designing a pay-for-performance system that holds physicians accountable for the care they deliver. The Academy would support a Medicare pay-for-performance program for physicians that occurred within the context of a positive annual update in Medicare; rewarded physicians who were reporting performance measures as chosen by the collaborative efforts of the AAFP, ACP, AHRQ, and AHIP and medical specialty societies; and did not force physicians to compete for limited withholds.

For example, any competitive system that creates bonuses for those physician practices that can report clinical performance measures through the use of health information technology by taking withholds from physicians who have not been able to purchase technology will only delay the rapid dissemination of technology. In addition, it could in some areas create real access problems as physicians opt not to take on additional Medicare patients. Likewise, inequities may be created among different types of physicians. Currently, the NQF, for example, is examining a subset of clinical performance measures for ambulatory physician offices. However, this set of measures does not cover every medical subspecialty. If some physicians, such as primary care physicians, have withholds on some portion of their reimbursement while other physicians do not, it would create a profoundly unfair system for Medicare physician reimbursement.

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[2] Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: The chronic care model, part 2. JAMA 2002; 288(15):1909–1914.

[3] Berenson RA, Horvath J. Confronting the barriers to chronic care management in medicare. Health Aff 2003; W3:37–53.

Conclusion

The Academy remains deeply concerned about the inadequate and flawed Medicare physician reimbursement system. The Academy suggests that an MEI-based formula should replace the SGR. As for alternative payment schemes, they should focus on adequately reimbursing the functions of primary care with a per-member per-month fee for care management separate from and in addition to fee-for-service. Pay-for-performance programs in Medicare should focus on improving quality through the use of the starter set of performance measures currently under development. Pay-for-performance programs should give bonuses to reporting physicians while maintaining annual positive updates in Medicare reimbursement to keep pace with increased expenses.

The Academy looks forward to working with the Ways and Means Health Subcommittee in its work to improve Medicare physician reimbursement.

AAFP Policy On Pay-for-Performance Programs

The Academy recognizes the need to explore alternative methods of reimbursing physicians and supports voluntary pay for performance (PFP) programs that incorporate the following guidelines:

- Improving clinical outcomes and quality of care should be the central purpose.
- Practicing physicians should be involved in the design of these programs and the selection of performance measures through a practicing physician advisory committee.
- PFP programs should provide incentives to physician practices:
  - for adoption and utilization of health information technology,
  - for implementation of systems to improve care and patient safety,
  - for measuring patient satisfaction with care delivered.
- Incentive payments should reward progress towards improving clinical performance up to, and including, achieving overall clinical performance targets.
- Financial awards to physician practices must sufficiently cover the administrative costs (e.g., data collection and measurement) of participating in the program in addition to bonuses that may be awarded.
- PFP programs must rely on new sources of revenue. Preferably these revenues can be accessed by redistributing a portion of projected savings. There should be no reduction in existing reimbursement to physicians as a result of a PFP program.
- PFP should state the source of the data for measuring performance, e.g., claims data, medical record audit, pharmacy claims, or patient surveys.
- Performance data feedback should be provided to physicians as soon as possible and should show comparisons to peers and performance targets.
- Physician practices decide when to share performance data with an independent third party who collects and analyzes such data. The third party maintains data confidentially and shares with physician offices any analysis done to improve efficiency, quality or safety. Processes should be in place to assure the accuracy of reported data and physicians must be allowed to validate their reported data.
- Reported performance measures must be based on medical evidence. They must address areas where treatment for common medical conditions can be substantially improved and where such improvement would be cost-effective for both patients and payers. In addition, performance measures must be measurable in a risk-adjusted, accurate manner; and they should represent achievable, feasible areas for improvement without creating any undue financial burdens on physician practices.
- Physician profiles should be provided only to the physician profiled and disclosed to individuals or organizations only with the approval of that physician. Physician profiles should include only clinical performance measures that are clearly linked to improved clinical outcomes; measures of timely and appropriate care; patient satisfaction; and financial or resource allocation measures related to clinical outcomes.
- For a complete statement of AAFP policy on pay-for-performance, see *www.aafp.org/x30307.xml*, and for policy on data stewardship see *www.aafp.org/x30300.xml*.

Statement of Stephanie Reed, American Association for Geriatric Psychiatry, Bethesda, Maryland

The American Association for Geriatric Psychiatry (AAGP) appreciates the opportunity to share our concerns with the Members of the Subcommittee on Health on the problems associated with the Medicare physician fee schedule. AAGP is a professional membership organization dedicated to promoting the mental health and well-being of older people and improving the care of those with late-life mental disorders. Our membership consists of 2,000 geriatric psychiatrists as well as other healthcare professionals who focus on the mental health problems faced by senior citizens.

Physicians who treat Medicare beneficiaries, as Medicare providers, accept a fee schedule that is, at baseline, often significantly lower than their "usual and customary" fee schedule for providing services to their self-paying patients. As you are aware, these physicians continue to face the prospect of additional across-the-board reductions in the fees paid by the program. Unlike many other payment "cuts" in Washington, these reductions are not simply reductions in a rate of increase, but are absolute reductions in fee levels. In 2002, fees were cut by 5.4 percent *below 2001 levels*. Although Congress has taken action since that time to hold off additional reductions on a temporary basis and in fact provided for a positive update of 1.5% for 2004 and 2005, it is clear that a permanent resolution to the flawed formula governing physician payments must be enacted. This issue is most important because of the effect it will have on access to care for Medicare beneficiaries, especially for the vulnerable among them—those elderly and disabled persons who have multiple, complex medical conditions and limited financial resources.

As a result of the recent and projected reductions, many physicians are having to reevaluate their willingness to treat Medicare patients, as well as their willingness to be "participating physicians" who accept Medicare payment as payment-in-full for their services. Consequently, many Medicare patients are already having trouble finding physicians to treat them. A survey by the American Medical Association following the 5.4 percent cut in 2002 found that 24 percent of physicians had either placed limits on the number of Medicare patients they treated or planned to institute limits. In the case of geriatric psychiatrists—most of whose patients are enrolled in Medicare—the impact of these reductions is particularly severe and is causing at least some in our profession to consider leaving clinical practice altogether to enter other fields where their experience and expertise are valued more appropriately.

The impact on geriatric psychiatrists—and their patients—is compounded by the discriminatory reimbursement policies Medicare already imposes on consumers of mental health services. Under current law, Medicare requires beneficiaries to pay a 20 percent co-payment for Part B services with the single exception of a requirement of a 50 percent co-payment for outpatient mental health services. The lack of parity for mental health treatment is unconscionable—and of great consequence to older adults who feel more stigmatized by psychiatric illness than any other group. Despite widespread need, many seniors decline, delay, or drop out of treatment because of the high co-payment. In addition, current law discriminates against the non-elderly disabled Medicare population, many of whom have severe mental disorders.

The result of these factors—declining reimbursement rates, existing discriminatory reimbursement for mental health care, and stigma—will undoubtedly compound the existing serious access problems for Medicare beneficiaries in need of mental health treatment—either in finding a physician to treat them or in "balance billing" charges by physicians who previously accepted assignment.[1] Shifting costs to beneficiaries—many of whom are low income—can make essential mental health care unaffordable.

The fee reductions that are forcing these choices stem from the mechanism for automatic annual fee "updates" that is currently part of the Medicare statute. For most types of providers, Medicare law incorporates a mechanism by which payment rates are automatically updated annually for inflation, in much the same way that Social Security and other Federal cash benefits are automatically increased by the cost of living adjustment (COLA) each year.

However, since the inception of Medicare physician payment reform in the early 1990s, updating physician fees has been handled somewhat differently from those

[1] Although "balance billing" may provide a short-term safety valve that allows some physicians to continue treating Medicare patients, the additional amount that Medicare permits physicians to collect from beneficiaries under its balance billing limits will not fully offset the cumulative reductions in program payments in the future. Moreover, some States prohibit balance billing Medicare beneficiaries as a condition of licensure in the State, which leaves those physicians without this option.

of other providers. The payment reform law established a mechanism under which the annual inflation update for physicians' services is automatically adjusted—above *or below* the rate of inflation—based on how actual Medicare spending for physicians' services compares to an annual spending target computed by the Centers for Medicare and Medicaid Services (CMS) based on a formula set out in the law.

Until recently, this mechanism resulted in some relatively modest reductions below full inflation—as well as some "bonuses" above inflation. However, changes made in the "Balanced Budget Act of 1997" (BBA) tightened the annual spending targets, making it substantially more difficult for physicians to meet them.

Before the BBA, the annual spending target was based on a formula that included a reasonable allowance for spending increases due to changes in technology and other related factors affecting the "volume and intensity" of services provided by physicians. The BBA replaced this allowance with a much less generous proxy—the estimated increase in the gross domestic product (GDP)—which bears no relationship to the factors affecting volume and intensity of services provided. The impact of this change can be demonstrated quite simply. Where the volume and intensity allowances for 1992 and 1993 were 6.8 percent and 6.0 percent, respectively, the corresponding GDP allowances for 1999 and 2000 were 1.3 percent and 2.7 percent.

Furthermore, because the BBA made the new targets cumulative—so that a breach in one year's target would have to be fully offset by corresponding expenditure reductions in later years—inaccurate CMS estimates of several components of the formula used to compute the spending targets for 1998 and 1999 have been carried forward, producing inappropriately low targets in each subsequent year.

For example, actual growth in the GDP for 1998 and 1999 was greater than the estimates on which CMS based its targets. Growth in the beneficiary population is another component of the target. CMS overestimated beneficiary migration from traditional Medicare into managed care plans during 1998, which had the effect of understating beneficiary enrollment growth in the traditional program. All of these forecasting errors resulted in lower targets than would have occurred if better data had been available.

Unfortunately, CMS interprets the law as precluding it from correcting these errors. Although AAGP takes no position on this arcane legal issue, we do think that it is fundamentally unfair to make physicians—and Medicare beneficiaries—pay for estimates that everyone agrees in hindsight were wrong.

Physicians want to serve all Americans. However, they simply cannot afford to accept an unlimited number of Medicare patients into their practices when they are facing continued payment reductions. These drastic cuts must be stopped before they devastate Medicare beneficiaries' access to health care.

We commend the Congress for its action to avert the impending reductions in Medicare physician fees for 2004 and 2005. We note, however, that the legislation does not address the fundamental defects in the formula for setting annual Medicare spending targets for physicians' services and that projections for 2006 under current law will result in a cut of 5.2 percent.

Especially in light of the recent recommendation by the Medicare Payment Advisory Commission (MedPAC) for an increase of 2.7 percent for 2006, we urge Congress to revisit this issue this year and—at a minimum—to replace the GDP component of the formula with a more realistic proxy for changes technology and other factors affecting the volume and intensity of the services furnished to Medicare beneficiaries.

Thank you again for the opportunity to share our views on this important issue. We look forward to working with you as you craft a correction to the Medicare physician payment formula.

Statement of Josh Cooper, American College of Radiology

The American College of Radiology (ACR), which represents over 32,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit written testimony on the subject of Medicare payments to physicians.

Image Over Utilization

The ACR encourages and supports the technological innovations and advances in diagnostic medical imaging, which have unequivocally improved the quality of health care while producing cost savings through less invasive diagnostic techniques. The College appreciates and supports the tremendous developments imaging has brought to patient care, however we have concerns regarding the quality, safety

and costs associated with the dramatic rise in the volume of procedures utilizing high-cost diagnostic imaging modalities and would like to address these concerns in our testimony.

The Medicare Payment Advisory Commission's (MedPAC) June 2004 report to Congress shares the College's concerns, stating that diagnostic medical imaging is the fastest growing type of medical expenditure within the category of physician services in the United States, boasting an annual growth rate that is more than three times that of general medical procedures. The ACR, as well as lawmakers and federal regulators, recognize that this trend line, which is growing exponentially every year is unsustainable and that the growth of imaging utilization, some of which may be inappropriate, must be controlled. As troubling as the rising costs associated with the increased over utilization of imaging services is, MedPAC also has expressed a growing concern that both the quality and safety necessary for effective diagnosis may be decreasing.

The ACR shares MedPAC's concerns regarding the quality, safety and costs associated with the dramatic rise in the volume of procedures utilizing high-cost diagnostic imaging modalities. To address this alarming imaging utilization trend, the College and several private insurance companies have worked closely with MedPAC to establish a Medicare physician payment policy focused on quality of care, patient safety and expertise of the physician interpreter as a means for obtaining needed cost savings in the area of diagnostic medical imaging services.

MedPAC believes this policy is appropriate as evidenced by their unanimous approval of recommendations to establish quality standards for the provision and interpretation of imaging services. (See attached summary of MedPAC Recommendations). The MedPAC recommendations, many of which the College fully supports, will be published in its March 2005 report to Congress. In short, these recommendations call for all diagnostic imaging providers to meet quality standards for imaging equipment, non-physician staff, images produced, patient safety protocols, and increased training for physicians who bill Medicare for interpreting diagnostic imaging procedures.

According to data compiled for the ACR, congressional implementation of these MedPAC recommendations designed in part to stem the financial incentive associated with some of the growth in imaging utilization, could save the Medicare program a minimum of $6 billion over ten years (the analysis behind this cost savings has been provided to Committee staff). Moreover, the quality of care Medicare beneficiaries receive should significantly improve with the implementation of quality and safety requirements for medical imaging.

Concerns

Many medical specialty organizations do not share the ACR's and MedPAC's concerns regarding the growth in diagnostic imaging utilization. Some suggest that the shift in the site of service from inpatient hospital to physician offices has inflated the increase in imaging utilization. However, while the growth in in-office imaging was much more rapid than the overall growth, there is no evidence that this is simply a shift in site of service. Imaging procedures in Part B Medicare (measured in terms of number of procedures as well as professional component RVUs per 1,000 beneficiaries), increased in both inpatient and office settings. As per the Physician Supplier Procedures Summary (PSPS) Masterfile, the three-year growth in imaging per 1,000 beneficiaries for the period 2000–2003, in *all* sites of service combined, was 17% (5.3% per year) in number of procedures and 26% (7.9% per year) in professional component RVUs.

Other medical specialty organizations cite patient convenience and "one stop shopping" as a reason not to pursue quality and safety standards for imaging procedures. Frankly, the ACR questions whether patients receiving imaging services in the office of a non-radiologist physician truly receive a more convenient encounter. A preliminary analysis of the 2001 Medicare 5% physician Standard Analytical File (SAF) reveals that of all the imaging billed by non-radiologists, at most 3.1% of CTs and 2.58% of MRIs were billed with an Evaluation and Management (E&M) code on the same day. Therefore, based on available data, approximately 97% of the cases of imaging performed by non-radiologist physicians are not done on the same day and patients must return for a second visit in order to receive an imaging procedure. In other words, there is little or no evidence indicating a "same day" convenience for the patient having a CT, MRI or PET performed in the office of a referring physician. Additionally, throughout the private payer health system, the use of prior-authorization and other screening procedures almost always, with the exception of emergency services, results in one to multi-day delays in obtaining these diagnostic tests. Perhaps a more precise analysis on this matter could be conducted by Medi-

care officials, who would have access to fully identified Medicare files that are now restricted to the public as a result of privacy regulations.

Established Quality and Safety Programs in Diagnostic Imaging

The use of Accreditation standards is one mechanism to help attain the goal of increasing quality and safety, while at the same time reducing utilization costs to Medicare. MedPAC's imaging standards recommendations are based on the concept of accreditation and are similar to the standards facilities and physicians who perform mammograms must meet under the federally established Mammography Quality Standards Act of 1992. Accreditation programs evaluate the equipment specifications and calibration, dose (where appropriate), clinical image quality, physician and non-physician personnel qualifications, and quality control protocols among other items.

The ACR's history of developing and administering accreditation programs that assess the quality of imaging facilities dates back to 1963 and is a testimony to the College's dedication to quality patient care in imaging and radiation therapy. While there may be some who believe that the important requirements associated with accreditation may be covered by state radiation protection programs, it must be understood that these programs vary by state and typically only evaluate the amount of radiation exposure and other equipment related measures. State radiation protection programs do not evaluate the entire imaging system the way accreditation does.

Currently, the ACR has established and maintains nine different accreditation programs, all with pathways for radiology and non-radiology practices to receive accredited status. For example, approximately 15% of the facilities accredited by the ACR in nuclear medicine are cardiology practices. The College is also ready and willing to collaborate with other specialty organizations in the development of our quality and safety resources. For example, the ACR Stereotactic Breast Biopsy Accreditation Program was developed in collaboration with the American College of Surgeons.

Radiologists are physicians who are *the* imaging experts. Unlike other specialties, radiologists have received years of unique, specific, post-medical school training in the performance of radiological procedures and interpretation of diagnostic images. The ACR is the premier organization with unmatched breadth, depth and expertise in radiological sciences, medical imaging, radiation safety, radiation protection, dose delivery and image interpretation programs. The College has demonstrated its commitment to evidence based decisionmaking in health care and dedication to high quality, safe and effective patient care through all of its available resources. The ACR, we assure you, shares your goal of quality imaging provided by individuals and facilities that can demonstrate they are qualified to perform and interpret these life-saving examinations.

Conclusion

The American College of Radiology recognizes that the unbridled growth of high cost diagnostic imaging services within the Medicare program is unsustainable and that the costs associated with inappropriate volume must be contained. The policy recommendations developed by MedPAC that the Congress will soon review can significantly help accomplish this goal.

Please avail yourself of the ACR's expertise and experience. The American College of Radiology is available to work with MedPAC, Congress and CMS to establish quality standards in diagnostic imaging services that will benefit our patients and the healthcare system in general.

MedPAC Recommendations Regarding Imaging Utilization

At the January 12, 2005 meeting of the Medicare Payment Advisory Commission (MedPAC), the Commission voted to recommend to Congress six manners in which to improve Medicare physician payment policy, especially in the area of diagnostic medical imaging services. The Commission weighed the likely administrative costs against expected benefits before reaching the following recommendations:

1. *The Secretary should use Medicare claims data to measure fee-for-service physicians' resource use and share results with physicians confidentially to educate them about how they compare with aggregated peer performance. The Congress should direct the Secretary to perform this function.*

   - In terms of spending, the Commission anticipates that measuring resource use activity could reduce the volume of physician services over time, but from a

budget scoring standpoint, it is unlikely this recommendation will affect program spending relative to current law.
- The Commission foresees no adverse impact on access or quality for beneficiaries by implementing this tactic. To the extent that physicians adopt more conservative practice patterns, beneficiaries may pay less in terms of coinsurance and Part B premiums.
- From the perspective of physicians and providers of services, this recommendation has the potential to affect the volume of services that providers furnish over time.

2. *The Secretary should improve Medicare's coding edits that detect unbundled diagnostic imaging services and reduce the technical component payment for multiple diagnostic imaging services performed on contiguous body parts.*

- The Commission expects better coding edits to reduce physician fee schedule spending, but has not estimated the magnitude of savings.
- Assuming it would reduce Medicare spending, the Commission believes this recommendation would also decrease beneficiary premiums and cost-sharing. Because past coding edit changes do not appear to have reduced beneficiary access to quality health care, the Commission does not anticipate any effect on access and quality in this instance.
- According to the Commission, providers who bill for unbundled or multiple imaging procedures would experience a decrease in Medicare payments. However, the Commission does not predict this recommendation will affect providers' willingness or ability to provide quality care to beneficiaries.

3. *The Congress should direct the Secretary to set standards for all providers who bill Medicare for performing diagnostic imaging services. The Secretary should select private organizations to administer the standards.*

- The Commission acknowledges such standards could include imaging equipment, non-physician staff, image quality, a supervising physician, and patient safety. For example, Medicare's rules for independent diagnostic testing facilities require that each facility have a supervising physician who is proficient in interpreting clinical images produced in diagnostic imaging studies. Several private accreditation programs also require that the imaging provider have onsite a supervising physician who is qualified to interpret these images.
- In making this recommendation, the Commission relied upon evidence suggesting that providers vary in their ability to perform quality diagnostic imaging studies. Moreover, poor quality studies can lead to repeat tests, misdiagnoses, and improper treatment. In order to remedy this problem, the Commission advocates establishing national standards that would apply in all settings. These standards should improve the quality of imaging services, thereby increasing diagnostic accuracy and reducing the need for repeat tests.
- In order to be reimbursed by Medicare for this technical component of diagnostic medical imaging services, providers must meet or exceed these quality standards.

4. *The Congress should direct the Secretary to develop standards for physicians who bill Medicare for interpreting diagnostic imaging studies. The Secretary should select private organizations to administer the standards.*

- The Commission acknowledges such standards could be based on training, education, and experience required to properly interpret clinical images produced in diagnostic imaging studies.
- The Commission further acknowledges such standards should apply to all physicians who interpret clinical images in the United States, regardless of location of interpretation. Therefore, a physician interpreting an image in a different location from where its corresponding diagnostic test was performed falls within the scope of this recommendation.
- Similar to the rationale used in recommendation three, the Commission cites evidence of variations in the quality of physician clinical image interpretation and formal reports. More specifically, the Commission recognizes that inaccurate interpretations and incomplete reports could lead to improper treatment. By ensuring that only qualified physicians are paid for interpreting imaging studies, diagnostic accuracy and treatment should improve for patients.
- In order to be reimbursed by Medicare for this professional component of diagnostic medical imaging services, the physician interpreting the clinical image that is produced in a certified facility must meet or exceed these standards.

- *Impact of Recommendations Three and Four:*
  - Based on the experience of private plans that have implemented selective privileging and other similar programs for diagnostic medical imaging services, the Commission foresees a reduction in Medicare program spending if recommendations three and four are implemented. Some providers would be unable to meet these standards and consequently be driven from the marketplace, which would reduce the overall number of studies. In addition, the Commission expects these standards to result in a reduction in the number of initial poor quality imaging tests, thus significantly limiting the number of repeat exams.
  - Both recommendations should improve care for beneficiaries because better quality studies should increase diagnostic accuracy and reduce unnecessary exposure to radiation, which could result from the need for repeat CT scans if the initial exams are of poor quality. To the extent that spending is decreased, beneficiary cost sharing should also decline.
  - If a diagnostic medical imaging service provider chooses to satisfy these new Medicare standards and remain in the marketplace, that provider would likely incur additional costs to do so. For example, physicians offering diagnostic medical imaging services may need to invest in newer equipment and higher credentialed technicians, as well as obtain additional education.
  - Many diagnostic imaging providers already receive accreditation by private organizations and are familiar with these types of standards.

5. *The Secretary should include nuclear medicine and PET procedures as designated health services under the Ethics in Patients Referrals Act ("Stark II").*

- The Commission asserts that physician investment in facilities that provide nuclear medicine services are associated with higher use. Such investments create financial incentives to order additional services and to refer patients to facilities in which the physician is an investor, thus undermining fair competition.
- While this recommendation prohibits physicians from owning nuclear medicine facilities to which they refer patients, it does not close the loophole for in-office ancillary services found in the Stark law.

6. *The Secretary should expand the definition of physician ownership in the Ethics in Patients Referrals Act ("Stark II") to include interests in an entity that derives a substantial proportion of its revenue from a provider of designated health services.*

- This recommendation prevents physicians from owning companies whose primary purpose is to provide services to facilities that are covered by the Stark prohibitions on self-referral.
- *Impact of Recommendations Five and Six:*
  - The Commission anticipates that these recommendations should decrease physician fee schedule spending because they would reduce the financial incentive for physicians who order additional imaging studies.
  - To the extent that fewer studies are ordered, beneficiary cost sharing would decline. The Commission does not expect that beneficiary access to quality diagnostic medical imaging services would be affected.
  - If these recommendations are implemented, physicians would no longer be able to refer Medicare or Medicaid patients to nuclear medicine facilities in which they are investors. Moreover, physicians would no longer be able to refer patients to a provider that contracts with an entity that they own if that entity derives a large share of its revenue from that provider. However, these changes should provide a competitive balance for healthcare providers.

Statement of Justin Moore, American Physical Therapy Association, Alexandria, Virginia

Executive Summary

The American Physical Therapy Association (APTA) is vitally interested in the efforts to reform the physician payment formula. On behalf of APTA's 67,000 member physical therapists, physical therapist assistants and students of physical therapy, we would like to dispel the notion that the physician fee schedule is solely a physician concern. The physician fee schedule impacts numerous health professions, including physical therapists. Our members work closely with Medicare beneficiaries

in private practice, inpatient and outpatient rehabilitation facilities, hospitals, skilled nursing facilities and other settings. For these patients, physical therapists utilize the physician fee schedule to bill independently for services.

APTA is concerned that the negative payment updates to the physician fee schedule will hinder the ability of physical therapists to care for Medicare beneficiaries needing rehabilitation services. It is important that these individuals continue to receive the rehabilitation and other services that they need in order to achieve their maximum level of functional independence. Because rehabilitation enables beneficiaries to function more independently, rehabilitation will save the Medicare program dollars in the long term.

APTA commends Congress for its action in 2003 to implement the 1.5% increase to the physician fee schedule in 2004–2005 as a provision of the Medicare Modernization Act (MMA). However, this was merely a temporary solution to the problem, as CMS project that the formula will produce a negative payment update of approximately 5% per year beginning in 2006. We urge Congress to:

- Move forward with a MedPac recommended 2.7% increase for CY 2006 to avoid the proposed 5% cut.
- Adopt MedPAC's framework for updating the Part B provider fee schedule, which includes eliminating the sustainable growth rate (SGR) and replacing it with a factor which will more appropriately account for changes in the cost of providing services.
- Remove Medicare-covered drugs from the SGR in order to prevent physician services from exceeding the SGR target.
- Update and improve the MEI so that it measures inflation in practice costs and separates productivity.

Should Congress fail to act, physical therapists and other healthcare professionals will experience draconian cuts in reimbursement over the next several years. APTA feels strongly that remedying this issue must not be a budget neutral exercise as additional resources are necessary to address this fundamental problem. We recommend the Committee seek appropriate resources through the Budget Committee to meet this challenge.

Chairwoman Johnson and Members of the Subcommittee on Health, the American Physical Therapy Association (APTA) is submitting testimony concerning the need to reform the update formula of the sustainable growth rate (SGR) in the physician fee schedule. The APTA represents 67,000 physical therapists, physical therapist assistants and students of physical therapy. This issue is of great significance to our members, many of whom who bill their services to the Medicare program under Part B.

The APTA applauds the Committee for holding this hearing today and for the commitment of Committee Members to address the outstanding problems that exist in the update formula for the Part B fee schedule. Many health professionals, including physical therapists, utilize the fee schedule to bill for services. We wish to dispel the conception that this is solely a physician concern, as physical therapists are affected by the potential cuts in reimbursement.

Physical therapists provide services to patients who have impairments, functional limitations, disabilities, or changes in health status resulting from injury, disease or other causes. As clinicians, physical therapists are involved in the evaluation, diagnosis, prognosis, intervention, and prevention of musculoskeletal and neuromuscular disorders. On a daily basis, physical therapists provide care for Medicare patients with acute, chronic, and rehabilitative conditions such as stroke, Parkinson's disease, arthritis and musculoskeletal disorders. Physical therapy is a dynamic profession whose goal is to preserve, develop, and restore optimal physical function.

Patient Access Problems Will Result from Flawed Update Formula

APTA is concerned that the negative payment updates to the physician fee schedule will hinder the ability of physical therapists to care for Medicare beneficiaries needing rehabilitation services. It is important that these individuals continue to receive the rehabilitation and other services that they need in order to achieve their maximum level of functional independence. Because rehabilitation enables beneficiaries to function more independently, rehabilitation will save the Medicare program dollars in the long run.

The impact of the Medicare cuts needs to be viewed in the context of significant legislative and regulatory changes affecting physical therapists that have occurred over the past few years. Since 1992, physical therapists in private practice have been reimbursed under the physician fee schedule. Prior to 1999, all other out-

patient therapy settings were reimbursed under a cost-based system. The 1997 Balanced Budget Act (BBA) required that outpatient therapy services in all settings be reimbursed under the physician fee schedule, beginning in January 1999. Thus, in addition to impacting physical therapists who own and operate private physical therapy practices, the anticipated 5% cut in payment and the flawed update methodology also impacts the provision of outpatient therapy services in outpatient hospitals departments, skilled nursing facilities (Part B), home health agencies (Part B), rehabilitation agencies, and comprehensive outpatient rehabilitation facilities (CORF).

The BBA also imposed a $1,500 cap on outpatient therapy services in all settings except for hospitals. The present moratorium will expire at the end of 2005 unless Congress acts. If the cap goes back into effect, it will compound the Medicare payment cuts.

In addition to the cap, physical therapists continue to deal with increased documentation requirements, conflicting Medicare rules, non-uniform application of Medicare requirements among Medicare contractors, and impending privacy requirements under HIPAA. When combined with the current and impending cuts, it will be difficult for physical therapists and other health professionals to continue providing services within the Medicare program.

The majority of physical therapists in private practice are small businesses. As small business, their ability to operate is in jeopardy when they lose necessary revenue or cannot forecast revenue accurately from year to year. As a result, maintaining access to providers like these cannot be sustained without immediate reform of the payment update formula.

Flawed Medicare Payment Update Formula

Medicare payments are updated annually based on the SGR system. Because the SGR system is flawed, updates under the system do not reflect the cost of providing services. In 2005, the payment update to the physician fee schedule is 1.5%, which is not keeping pace with increasing healthcare costs. However, CMS is predicting payment reductions for 2006 and later years as a result of the formula for determining the updates.

The SGR system sets spending targets for services reimbursed under the physician fee schedule and adjusts payment rates to ensure that spending remains in line with those targets. If spending equals the targeted amount, payment rates are updated in accordance with the percentage change in input prices, which is determined by the MEI. If the spending for that year exceeds the target, the increase in payment rates is smaller than the increase in input prices (MEI). If spending for that year is less than the target rate, payment rates are allowed to be increased by a greater amount than the rise in input prices.

The annual target is a function of projected changes in four factors: input costs, enrollment in traditional Medicare, real gross domestic product (GDP) per capita, and spending attributable to changes in law and regulations. Revisions to any of these four factors or to estimates of prior spending can change the spending estimate significantly.

One of the problems with this methodology is that payments under the SGR are tied to the GDP which bears no relationship to patients' healthcare needs or physical therapists' practice costs. By linking annual changes in the targets to annual changes in GDP, Medicare ties the target to the business cycle. Health care needs of Medicare beneficiaries do not follow the same cycle. The cost of providing care to these beneficiaries does not lessen when the economy is in a downturn. The current methodology also increases the volatility of the SGR, as economic forecasts frequently change. The unpredictable rate fluctuations make it very difficult for providers to continue to participate in the Medicare program.

Another problem relates to estimating beneficiary enrollment. Increased utilization rates are often beyond the control of the physical therapist. While physical therapists strive to meet the clinical needs of increased patient volume and maintain a high standard of care, they are penalized with lower payments when utilization exceeds the SGR spending target. As the number of Medicare beneficiaries dramatically increases in coming years, this problem will only worsen if Congress does not intervene.

Additionally, prescription drug expenditures under Medicare are growing at a rate that far outpaces those of physician and physical therapy services. Inclusion of drugs in the SGR increases the odds that Medicare spending on physician services will exceed the SGR target, resulting in lower payments for physicians. Moreover, drugs are not paid under the physician fee schedule and should not be included in the definition of physicians' services. Inclusion of the drug expenditures in the SGR

remains a substantial barrier to creation of a workable payment system for healthcare professionals.

While prescription drug should be removed from the SGR, the potential costs from government legislation and regulations should be included in the calculation of the SGR target. The Medicare Modernization Act (MMA) includes several provisions that lower patients' out-of-pocket costs on health care, which also is shown to increase utilization on physician, physical therapy and other healthcare services. The MMA's new prescription drug benefit is designed to enable Medicare beneficiaries who could not afford to purchase drugs to do so. Increased patient utilization of healthcare services and increased access to prescription drugs will also increase expenditures for physician services, and should be given consideration in the SGR. In addition, local coverage determinations have a significant impact on physical therapist practices in some areas of the country and should be taken into account as spending due to changes in law and regulations.

Changes Needed in the Medicare Economic Index (MEI)

In addition to eliminating the SGR, the MEI, which is calculated by CMS and used to measure practice cost inflation, also needs to be improved. The MEI is a weighted average of price changes for inputs, which include provider time and effort (work, non-physician employees, and office expenses) used to provide care. The outdated MEI was developed in 1972 and only accounts for growth in labor productivity which overstates productivity gains in services.

In its framework, the Medicare Payment Advisory Commission (MedPAC) recommends that the MEI measure inflation in practice costs and that productivity be separate from the MEI. In addition, MedPAC recommends that the productivity adjustment be based on multi-factor productivity (which would include both labor and capital inputs), instead of labor productivity. Making this change would ensure that it would account for changes in productivity for all relevant inputs used to provide services. According to MedPAC, this would significantly reduce the productivity adjustment that CMS uses currently in updating the Medicare fee schedule. APTA urges Congress to adopt MedPAC's recommendation regarding MEI.

Action Needed by the Subcommittee on Health

APTA commends Congress for the 1.5% increase in 2004–2005 and urges the Committee to consider the following immediate actions to address the problem:

- Move forward with a MedPac recommended 2.7% increase for CY 2006 to avoid the proposed 5% cut.
- Adopt MedPAC's framework for updating the Part B provider fee schedule, which includes eliminating the sustainable growth rate (SGR) and replacing it with a factor which will more appropriately account for changes in the cost of providing services.
- Remove Medicare-covered drugs from the SGR in order to prevent physician services from exceeding the SGR target.
- Update and improve the MEI so that it measures inflation in practice costs and separates productivity.

It is important that Congress act this year as CMS has projected that the formula will produce significant negative payment updates beginning in 2006. Should Congress fail to act, physical therapists and other healthcare professionals will experience draconian cuts in reimbursement over the next several years.

APTA feels strongly that remedying this issue must not be a budget neutral exercise. Clearly, additional resources are necessary to address this fundamental problem. We recommend the Committee seek appropriate resources through the Budget Committee to meet this challenge and other necessary Medicare reforms.

Conclusion

As the older adult segment of our population continues to rapidly grow, it will be paramount that they have access to qualified healthcare professionals who are able to serve their healthcare needs. Prompt and coordinated services provided by health professionals can help to avoid hospitalization, decrease the length of institutional stay, reduce the amount of care required after discharge, prevent complications, and improve the individual's level of function. Continued cuts to payments may force healthcare professionals to limit the number of Medicare patients they serve. Therefore the health of older Americans will be at risk if access to and payment of healthcare providers does not keep pace with the growing number of Medicare beneficiaries.

Thank you for the opportunity to submit this testimony before the Subcommittee.

Statement of Coalition for Patient-Centered Imaging

The Coalition for Patient-Centered Imaging (CPCI) represents the undersigned healthcare organizations committed to ensuring that patients have full access to high quality, convenient, and up-to-date imaging technology. The Coalition organized in response to efforts to limit the availability of imaging services provided in physicians' offices.

As the use of imaging services has increased, some medical organizations and health plans have sought to place the "blame" for this change on physicians, such as obstetricians/gynecologists, neurologists, orthopaedic surgeons, cardiologists and urologists, to name a few, who use these technologies in their office practices. Because these physician services are included under the volume considerations of the sustainable growth rate, they are clearly relevant to today's hearing on physician payments.

Office-based imaging services offer three important advantages to patients. First, office-based imaging speeds correct diagnosis and treatment of the patient's medical condition. For example, a patient who visits an orthopaedic surgeon with knee pain will almost certainly need an image of the knee for proper diagnosis. If the orthopaedist provides these services in the office, examination, diagnosis and initiation of therapy can be done in one encounter with the patient. If the physician were not able to provide the service, diagnosis and treatment would be delayed until the patient was seen by the radiologist and that physician sent the report back to the orthopaedist. Another patient visit to the orthopaedist would be needed to review the findings and determine the appropriate therapy. This results in unnecessary delays in treatment and added costs as noted below.

Second, as can be seen from the preceding scenario, in-office imaging is very convenient for the patient. This is especially important for elderly Medicare beneficiaries who may have limited transportation options or mobility problems. The fact that their physician is skilled in both the imaging aspect and physiology of their ailment increases patient confidence as well.

Third, in-office imaging can limit Medicare spending by reducing the number of office visits and other physician encounters that are billed to the system. By providing "one stop shopping" the orthopaedic surgeon has reduced the number of office visits required to complete the diagnosis and treatment decisions for the patient. The alternative requires one visit to the physician to determine that an image is needed. This is followed by the encounter with the radiology practice. Finally, the patient must return at least once to the physician's office for review of the image and treatment decision. All of these encounters engender a separate billing to Medicare. In-office imaging reduces the number of billed encounters, thereby reducing spending for evaluation and management services.

The Medicare Payment Advisory Commission (MedPAC) is in the process of finalizing its March report to Congress that will include recommendations relating to imaging services. They fall into two main categories: (1) safety and quality and (2) billing and payment. CPCI has cautioned MedPAC to frame any recommendations carefully to ensure that they are not interpreted in a manner likely to impede patient access to high quality physician imaging services.

Furthermore, we have urged the Commission to assure that any statistics cited in the final report regarding utilization of imaging services do not overstate actual growth due to shifts in site of service. According to MedPAC, about 20 percent of the overall 8.6 percent growth in imaging services are attributable to shifts in site of service, rather than new volume. If these shifts in site of service were appropriately accounted for, the actual overall growth rate for imaging would be about 6.9 percent by our estimates. Because some interests will urge Congress to respond to the increase in imaging services, we believe it is important not to overstate that number. Congress needs greater certainty in the data on increased use of imaging services than now exists. It is also important to understand that the greatest increases are in the higher technologies, such as CT and MRI, areas already dominated by radiology.

The public needs to understand the extraordinary contributions of diagnostic imaging to physicians' ability to diagnose and treat illness quickly and accurately. We do not believe that the issue of whether or to what extent the increase in diagnostic imaging utilization is medically unnecessary has been fully explored, and, therefore, we believe any action, such as mandatory accreditation and privileging, that could result in arbitrarily limiting diagnostic imaging utilization would not be appropriate.

Opponents of office-based imaging have challenged the competence of the physicians who provide such services, as if only they possess the knowledge required to safely perform and interpret diagnostic imaging. The ability of a physician to inter-

pret a diagnostic image cannot be determined based exclusively on the physician's specialty. In fact all specialties include as a part of their training the education and experience needed to use the imaging technologies that have become an essential component of their practice. If Congress looks to the use of accreditation programs as a means of assuring safe and appropriate use of imaging, it is critical that those organizations that explicitly or implicitly authorize only radiologists to perform or interpret imaging studies not be the sole source of accreditation. To the extent that specific accreditation organizations are named, we urge that a number of such organizations be included, to avoid any implication that Congress endorses any particular set of standards.

Congress should not assume that there is consensus in the physician community regarding the training, experience, and other requirements for interpreting physicians in each modality. In fact, standards of practice are always evolving and it is not uncommon for there to be disagreement regarding the appropriate training and experience standards among different specialties or even within a particular specialty. We seriously doubt whether sufficient credible data exists to determine which standards are appropriate. In addition, we do not believe it is practical or prudent to place CMS in the position of arbiter in this arena, nor do we believe that it is appropriately within the purview of the Federal Government to review each interpreting physician's particular credentials.

CPCI also cautions Congress from accepting the notion that significant cost savings to the Medicare program can be achieved by mandating accreditation and physician qualifications without a thorough analysis into why growth in imaging services is occurring and who is responsible for that growth.

Those who purport significant cost savings claim that the growth in imaging services is due to inappropriate utilization. However, the few studies that MedPAC has cited during its public discussions to justify its recommendations for accreditation and privileging are insignificant and overtly biased. For example, MedPAC has referenced a 1998 study by Verrilli for Blue Cross Blue Shield of Massachusetts that suggests 2 percent savings in imaging services were realized when physician privileging and facility accreditation standards for diagnostic imaging services were combined. However, MedPAC has failed, in public discussions, to acknowledge that the study found a higher failure rate among chiropractors and podiatrists than among medical and surgical specialists during site inspections. We suggest that MedPAC's claim of cost savings should not be based on a study that found a higher failure rate among non-physician providers that have limited ability to bill Medicare for imaging services. In another study frequently cited by MedPAC (Moskowitz), the findings were based solely on an examination of radiography, or X-rays, and did not outline any clear cost savings. While quality improvement is a goal shared by all physicians, to assume savings from such studies is inherently risky.

Congress should be cautious about statements that raise issues of imaging safety in the absence of credible and impartial studies documenting that medical imaging raises serious public safety concerns. Data cited on this issue in prior MedPAC reports is based on an unpublished survey conducted in Utah by a company that sells radiology benefits management services to insurers and authored by a radiologist who is one of the most vocal opponents of in-office diagnostic imaging. Various aspects of medical imaging equipment safety are already regulated by the Nuclear Regulatory Commission, the Food and Drug Administration, the Occupational Safety and Health Administration and by state authorities. In the absence of credible, published, peer-reviewed literature documenting safety concerns arising from the use or misuse of diagnostic imaging, we urge Congress to shy away from the conclusion that these agencies are not performing their designated functions adequately.

MedPAC has proposed changes to coding edits and billing practices that could reduce the number of individual imaging services that can be billed by physicians. As imaging technology has evolved, it is appropriate that Congress review current billing rules to determine if they are still relevant for current use. It is not yet clear to what extent savings might be found. We believe that further analysis is needed before Congress directs CMS to incorporate new billing rules.

CPCI appreciates the opportunity to provide these comments to the Subcommittee on the subject of the current use of imaging technology in medical practice. We urge caution in the examination of MedPAC's recommendations and encourage Congress to assure that any actions it takes in this area reflect the consensus of a broad and balanced group of affected organizations and are done in the best interests of Medicare beneficiaries.

American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology

American Association of Clinical Endocrinologists
American Association of Orthopedic Surgeons
American Association of Neurological Surgeons
American College of Cardiology
American College of Obstetricians and Gynecologists
American College of Surgeons
American Gastroenterological Association
American Medical Group Association
American Society for Gastrointestinal Endoscopy
American Society of Breast Surgeons
American Society of Echocardiography
American Society of Neuroimaging
American Society of Nuclear Cardiology
American Urological Association
Congress of Neurological Surgeons
Heart Rhythm Society
Medical Group Management Association
Society for Cardiovascular Angiography and Interventions
Society for Cardiovascular Magnetic Resonance

Critical Care Cardiology, Inc.
Chula Vista, California 91910
February 11, 2005

Honorable Members of House Ways and Means Committee
United States House of Representatives
Washington, DC

Dear Respected Members:

This letter is to inform you of an increasingly difficult situation being imposed upon myself and all physicians in the United States. As you may know, physicians since 1985 have had to endure annual cuts in Medicare re-imbursement rates. While the U.S. economy during this time has experienced unprecedented prosperity, we physicians have sustained continued reduction in our income. In fact, in 2005, if present rates are allowed to continue, physicians will get paid less than they did in 1991 (CBS News Report, November 22, 2002). Indeed, I get paid less for a heart catheterization than a plumber gets for working on your pipes! Cardiologists get paid by MediCare $345.00 for performing a cardiac catheterization, a procedure requiring plastic tubes to enter the heart arteries to diagnose coronary artery blockages. Cardiologists have to train for at least 10 additional years out of college to perform these procedures. Yet, plumbers get at least $350.00 for fishing your wedding ring out of the pipe under the kitchen sink. They get paid 1½ times that amount if they have to work on evenings or weekends. Physicians get neither right. My own employess are permitted "time and a half" if they work overtime, but I, as a physician, get no such right. Physicians have to go through seven to 10 years of extra schooling beyond college having to work >100 hrs/week and working 36 hours in a row every 3rd or 4th night to complete training as an MD or DO. *Why this double standard?*

At the same time our overhead has climbed to 41% of the total operating budget as of 1999. To make matters worse, the Medicare system has increasingly complex rules and regulations making it necessary for professional billers and office managers to be able to conduct a physician's office. At this point many bright physicians will be forced to retire prematurely or change careers. Perhaps Dr. Frist, the Senate Majority Leader, saw this coming in 1990 when he chose to run for Senator to attempt to change this disturbing trend.

I wish to invite you to spend 24 hours on call with me to demonstrate the value of cardiologists on call for potential heart attack victims. Even living the life of a doctor on call for one day will give you a glimpse of the investment in time, money and delayed gratification to achieve the skills and experience needed to properly take care of sick people. I am asking you as a champion of the rights of patients to make certain there will be bright enthusiastic doctors available when the baby boom generation reaches Medicare age. These people have paid into the system and deserve excellent care. We have the best medical care system in the world. Do not let this great system deteriorate into a labyrinth of bureaucrats and accountants.

Let doctors be free to be doctors and allow the best physicians to care for patients without having to worry about how they can make ends meet.

I am a cardiologist—I practice interventional cardiology. As you know 22 million people worldwide suffer from heart failure. Heart failure cost the Medicare system 44 billion dollars in 1999. This is the *single largest expenditure for the Medicare system*. As you well know, a timely cardiac catheterization and, if required, an intervention performed during an acute MI can reduce if not abolish altogether the prospect of heart failure. Yet the Medicare system has been systematically reducing reimbursements for cardiac catheterization and angioplasty for the last twenty years. Now a doctor gets $300 for a heart catheterization. He could not even get the fan belts in his car changed for $300. And for that $300, the doctor has to wait months to get paid. In fact, *Medicare has long abandoned additional payments for middle of the night emergencies or weekend emergencies*. Elective procedures get paid at the same rate as emergent procedures. Yet when my staff works even one extra hour in excess of their 40 hour week, time and a half kicks in. We are obligated by labor laws. Yet there are no such laws for doctors even though they routinely work in excess of 100 hours per week. There is, therefore, no incentive (other than to save the patients life), to handle emergency heart ailments. *As you can clearly see, the Medicare system presently provides disincentives for emergent procedures thereby increasing the incidence of heart failure.* These very procedures that, if performed emergently by an experienced cardiologist, can save the life of a heart attack victim and more important save him/her from heart failure. These very procedures that can save the Medicare system 44 million dollars in expenditure for CHF therapy are being discouraged by Medicare!

So far physicians have no alternatives to Medicare reimbursements. Moreover, whatever Medicare chooses to do, HMOs and insurance companies soon follow suit. We are at your mercy and yet I am certain if you understand the continuous cuts and slashes to physician's reimbursement that has taken place, you will understand our plight. If this trend is to continue, I and many of my collegues will have no choice but to give up clinical care of patients and find an alternative source of income. Already physicians are showing up on TV screens as " Doctors to the Media." Many doctors are serving as consultants of medical devices and pharmaceutical companies as well as investment banking guides. These are talented physicians that have left clinical medicine because of the continued and relentless annual cuts in Medicare reimbursements. Why cut pay to doctors when doctors are your front line to patient care? Why not cut in places where there is excessive waste already? Let us examine objectively where there is waste and cut them out first. Doctors who help save patients money from unnecessarily expensive medications when cheaper drugs will do, should be rewarded. Physicans can be given incentives to help the government save money while preserving excellent health care. Government must also do more to curb cost with the larger portion of the Medicare budget: Medicare Part A. This and other ancillary services are where the bulk of the waste occurs. We physicians have too long taken the brunt of the cuts while hospitals and other ancillary agencies have only gotten pay hikes every year. Finally, insurance companies and HMOs must also be made to account for proper spending of Medicare funds. Medicare funds must not be available to pay for the multimillion dollars of HMO CEOs. In fact the HMO United Healthcare pays its CEO 75 million dollars. For that amount of money you can pay the annual salary of 7,500 physicians each at $100,000.00. That does not include the large administrative burden added from HMOs and insurance companies. According to a February 10 article in the San Francisco Chronicle, 50% of Medicare funds are not used for direct patient care spending and are wasted.

You as our Representatives and Congressional leaders now have the unique opportunity to initiate a true reversal of these disturbing trends in Medicine we have seen in the past twenty years. A few good people in the right position at the right time can accomplish a great deal. There has been no better time than now to objectively re-examine the flawed formula Medicare uses to pay physicians and replace it with the Physicians Payment Fairness Act S. 1707. It is my hope you now understand this true paradox in the Medicare system and are willing to fix it. *We ask you to do your utmost to rectify the flawed formula for physician payments and put an end to annual reimbursement cuts for physicians.* We doctors can do a lot to save the Medicare system of needless expenditures. Allow doctors to earn what from their

expensive and long education. I am certain that you will make doctors and their patients your utmost priority in 2005!

Respectfully Yours:

Vimal Indravadan Nanavati

Statement of Dawn Lipthrott, Ethical Health Partnerships, Winter Park, Florida

I am grateful for this opportunity to speak to you about the proposed reductions in Medicare reimbursement for physicians and the SGR formula.

I understand and appreciate your great concerns about the ability to finance Medicare for the future while trying to be fair to physicians. This becomes even more of an issue for you in light of the recent budget estimate for the prescription drug benefit, which assumed the 5% per year reductions in reimbursement for physicians and is nearly double the original estimate. You are faced with urgent fiscal challenges, as are many physicians. However, even in the face of these challenges, I urge you to avoid the temptation to take the easy way of adjusting expenditures by cutting physician reimbursement. Physician payment is no doubt the easiest to control, but it puts undue burden on the very people who provide the care—and it avoids the more difficult and high cost problems like reducing obesity, non-compliance with treatment, and defensive medicine—each of which costs more than the entire amount Medicare spends on physician services. Each one of these problems also increase both the volume and intensity of Medicare services. In contrast, physician care has historically been the slowest growing category of healthcare spending and has increased very little in recent years. (Source: *Tracking Health Care Costs*, Strunk, BC and Ginsburg, PB, Center for Studying Health System Change, December 2004.)

Ethical Health Partnership as a Framework for Your Decision

I am a patient, a relationship specialist, and I represent EthicalHealthPartnerships.org, a beginning community of people committed to building more ethical health partnerships not only between physicians and patients, but also between all groups that impact health care, whether that be your Committee, Congress, insurance companies, hospitals, pharmaceutical companies, the legal profession and others.

While the purpose of health care is the well-being of the patient, the core of health care is the physicians who provide care for the patient. Ethical health partnership implies that the good of one is not gained at the undue expense or damage of the other. To place unfair burden on physicians, and even to damage some through reducing payment, is in our view, unethical and unacceptable. You would create a situation of further injustice by essentially penalizing physicians for expansion of Medicare benefits and increased utilization, when both are outside their control.

The attempt to save Medicare or balance the budget by decreasing reimbursement and placing undue financial burden on physicians will erode the quality and accessibility of health care at it's core. This is not only a physician issue, it is a patient issue.

Past 'Increase in Medicare Spending on Physician Services' is Misleading

In the hearing of your Committee on February 10, 2005, Rep. Pete Stark (D–Calif) stated that "aggregate payments have increased comfortably" with spending on physician services increasing 6% annually since 1997.

While the increase may be true overall, it does not take into consideration the uneven distribution of that spending or the increasing cost of living, practice expense, and malpractice premium increases that have far exceeded any benefit from that 6%. The general figure of 6% does not acknowledge that many physicians in high risk specialties, in high malpractice rate states, and/or those in solo or small group practices are not experiencing 'comfortably' increasing payments. The increase in physician services payment can have more to do with increased volume of services. That must be balanced by the fact that average practice expenses for physicians in general has increased approximately 22% from 1995 to 2004. (Source: *American Medical Association*.)

Specialties Like General Surgery Have Had Decreasing Reimbursement for 10 Years with Significantly Increasing Expense

Some medical specialties like general surgery have had more difficulty than others, partially due to outdated RBVRS formulas in considering physician work, practice expense and liability risk. As a result, Medicare rates for common surgical procedures like gallbladder surgery, partial mastectomy, hernia repair and others have already been reduced 15–29% over the past 10 years.

At the same time, in Florida, the average malpractice premiums for general surgeons in Florida, excluding the Miami area, was $174,000 in 2003 and $227,000 in the Miami area in 2003, an increase of 30% from the previous year. In 2004, the rate in Miami went up to $277,000 and while I don't have the exact amount for the rest of the state, the percentage of increase is usually close to the same. Florida has seen double digit increases, sometimes 60–70%, in premiums for over 4 years for surgeons and other higher risk specialties. Surgeons in Miami paid 220.2 percent more than those in Los Angeles in 2003. (Source: *Medical Liability Monitor*.) Similar percentage increases have occurred in other states as well.

The trend of increasing practice expense and increasing malpractice premiums will continue with practice expenses expected to increase 19% from 2006–2012. (Source: *American Medical Association*.)

Reduced Access and Quality to ALL Adult Patients, Not Just Medicare

According to a report on your February 10th hearing, physicians told you that the proposed cuts could result in reduced access to care for Medicare patients and that fundamental change in the reimbursement system is needed.

However, the actions you take to address these issues will have far-reaching negative consequences beyond physicians and patients directly involved in Medicare. The cuts will reduce accessibility and possibly quality of care for nearly every adult patient in the United States and every physician who provides care to adults.

Medicare Cuts Will be Mirrored by Private Health Insurance Plans

Most insurance companies, network management companies and health plans base their rates of reimbursement on the Medicare rates, even though Medicare was never intended to be the model for reimbursement. Some base their fees just above Medicare rates and others set their rates at 80% of the Medicare rate. Therefore if the cuts are allowed, the same percentage cuts will be mirrored to a great extent in the private insurance sector, putting an enormous burden on physicians. Solo and small group practitioners, especially those in certain specialties, like surgery and Ob-Gyns, will find it increasingly untenable to remain in practice.

The Medicare Cuts Would Put My Healthcare, as a *Non-Medicare* Patient, at Risk

I, a middle class patient with private insurance, living in Orlando, Florida, have had my gynecologist close her practice, my family's orthopedic surgeon stop doing surgery, and our family's cardiologist stop doing any invasive procedures—all because of their stated reasons of decreasing reimbursement and increasing malpractice risk and costs. These are physicians in their 50's, in the prime of their career in knowledge and experience, who love medicine and patients, who are respected in their community, but who find it increasingly difficult to sustain a practice.

My own surgeon, who is known for giving exceptional care and who has over 25 years experience in our community, was paid less for gallbladder surgery in 2004 by private insurance than she would have been paid by Medicare in 1995. This is a direct result of the progressive reductions in Medicare payment and the fact that private insurance companies and plans base their rates on the Medicare schedule. That is unjust. Expecting her and other surgeons and specialties to absorb a further 30% reduction puts the physicians, and their patients, at risk.

Physician Dissatisfaction, Stress and Quality of Care

In addition to potential restrictions in access for all adults, there is indication that quality of care may suffer as well if the proposed cuts are left in place.

A recent article in *Health Affairs* talked about the connection between physician dissatisfaction and the quality of patient care, including dissatisfied physicians' own perceptions of their reduced ability to provide the quality care they want to give their patients. (Source: *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, Michelle M. Mello; David M. Studdert; Catherine M. DesRoches; Jordon Peugh; Kinga Zapert; Troyen A. Brennan; William M. Sage, Health Aff 23(4):42–53, 2004.)

DIRECTIONS FOR THE FUTURE

A Note on the Pay for Performance Suggestion

Rep. Nancy Johnson (R–Conn.) has suggested a pay for performance approach. Some health plans have begun similar reimbursement strategies with mixed benefits and problems. Adding bonuses, rather than withholding fees for services already provided is essential in terms of fairness. One of the problems with the approach is that if performance is based on successful outcomes, factors like non-compliance of patients with treatment, or patients with multiple conditions that impact outcome could unfairly penalize physicians doing everything in their power to provide quality care. And the bigger problem is that those patients may find it increasingly difficult to find physicians to take them as patients.

Another potential problem in pay-for-performance programs is that some specialties, like surgery, are difficult to separate from the system in which the services are performed. In the statement to the Federal Trade Commission and Department of Justice by LaMar McGinnis, MD, FACS of the American College of Surgeons Quality and Consumer Information testimony on May 30, 2003, while supporting quality performance, he states:

> "In addition, surgeons and the systems of which they are part are hard to separate. This makes it difficult to develop meaningful, surgeon-specific quality data. Primary care lends itself more to adherence to public health driven protocols that prevent or ameliorate chronic disease. There are guidelines that work to manage ischemic heart disease, high blood pressure, diabetes, and other conditions. On the other hand, surgical quality does not lend itself as easily to process measures. We feel strongly that the only appropriate way to measure the quality of surgical care is truly risk-adjusted, outcomes assessments reported before, during, and after the procedure. Risk-adjustment allows both the patient and the healthcare system to know that the service received was appropriate, considering the state of the patient and his disease.
>
> Unlike surgical care, there are some aspects of primary care that lend themselves to process measures as indicators of quality. For example, repeated visits to monitor the state of chronic care make sense and can be an indicator of quality in primary care. Physicians can diagnose increased sugar in diabetics, detect glaucoma, and discern extremity circulation problems as a result of scheduling repeat patient visits, thus the use of administrative "process" measures can yield considerable information about quality of care. In contrast, repeat visits to a surgeon or to the operating room are not generally viewed as quality indicators. In addition, surgeons are more likely to be confronting an emergent problem that must be identified in the first encounter, and the nature of the interventions they take are very different."

The American College of Physicians issued a position paper in April, 2004 on pay for performance that listed recommendations for the approach to be fair and effective. Some of their recommendations are:

- To create voluntary demonstration programs of performance measurement before implementing system-wide change.
- To use widely accepted, evidence-based measures that "provide valid and reliable comparative assessment across populations."
- To avoid rating physicians on factors that they cannot control (like compliance).
- To use incentives that are positive, not punitive.
- To use pay for performance to foster quality improvement, not just competition.
- To ensure that any data collection needed to demonstrate performance will protect patient privacy and avoid adding to the paperwork burden or additional costs of data collection.

One of our major concerns of pay-for-performance is that 'quality' may be based on how much money the physician or facility saves, rather than the quality of care provided. When physicians cut back or delay referrals or specialists, tests, patient care can suffer. That again creates potential risks for patients and for physicians.

Because of these concerns and needs, I urge you to look at the possibility of pay-for-performance not as an instant solution, but as one possible direction that requires time to plan, study and implement. Demonstration projects should be initiated not only in large group practices, as currently planned, but in practices of varying sizes and specialties (included solo practices) to study the fairness and feasibility before system-wide implementation.

It should also be noted that in some instances when private health plans have implemented this approach, they did not accurately forecast the budget expenses associated with paying for performance and paid physicians less than they had originally agreed.

Remove Part B Drugs and Supplies From Spending Targets

One option that others have recommended is that you remove Part B drugs and supplies from any determination of Medicare spending with target limits. We view this as one more band-aid approach and we strongly recommend a new system of determining reimbursement levels and increases.

Recommendations

We strongly urge you to consider not only the financial limitations, but also the ethical issues in this Committee's and the government's relationship with both patients and physicians. We believe that ethical decisionmaking includes the elements of fairness, justice, responsibility, valuing the well-being of all involved, respect, not placing undue burden, and preventing the well-being of one to be gained at the expense or detriment of another.

In light of those factors, the most ethical decision in your health partnership with physicians and patients is to prevent the proposed cuts in reimbursement for 2006–2012, even if viable, clear solutions for budget concerns are not yet evident. Reducing physician reimbursement while their expenses are increasing at double-digits, weakens the entire system of health care and puts physicians and patients at risk. The ongoing problem of fair reimbursement for physicians should be addressed for the long term and not based in one or two year reprieves as in the past. To me, it is unconscionable that this problem has been known for so long and has not been adequately addressed. I hope you will be the ones to finally accomplish that.

Ethical health partnership also require that you consider that the impact of actions taken to address Medicare problems will create direct impact on the reimbursement schedules of private health plans. Nearly all doctors and patients will be affected, even if they do not participate in the Medicare program. Those taking Medicare patients will receive double impact.

Moreover, we believe that ethical health partnership requires that a more just and equitable method of determining reimbursement be developed and implemented for the long term. There is substantial agreement in Congress and in health care that the formula is seriously flawed and that past attempts to modify it have failed. The SGR formula is also unfairly applied to physicians as a group, while other healthcare entities are not governed by the formula.

Therefore we suggest:

- **Base rates on current medical indices and update the RBVRS to better reflect current practice expense and liability.** MedPac's annual reports to the Congress recommend a physician fee update based on MEI. While it will increase the expenditures of the Medicare program, it makes health care a priority, creates positive and relatively fee updates, more accurate predictions of future needs, and protects patients and physicians and the quality health care we all want.
- **Implement more current geographic profiles for consideration of malpractice premium areas,** like Florida and other at risk states, in determining payment.
- **Provide either regular cost-of-living increases or regular increases to adjust for inflation and ongoing average increases in practice expenses.**
- **Remove volume and intensity of service factors from the determination of physician payment.** Most often this is outside the physician's control. In addition, the idea of rewarding physicians for cutting back on service or limiting referrals or tests, sets up a danger for patients in terms of quality health care and for physicians in terms of liability.

  Sustaining the Medicare budget short term and over the long term, should not be bolstered by penalizing physicians each time Medicare usage increases, or when there is a budget deficit or downturn in the economy. Decreasing physician fees weakens the system by putting patients and physicians at risk. Using physician payment as a way of managing the budget is easy because it is a factor over which Medicare has direct control, but it does not begin to address the root causes fueling increasing costs.

  While the focus of your hearings is on the problems in physician reimbursement and we fully support an ethical and fair resolution of that, we recommend that you consider that in the context of other drivers of high cost. When you look at ways to finance fair reimbursement, it is essential to look at the bigger picture of what is increasing and will continue to increase Medicare costs.

- **Therefore, we also recommend that your Committee make recommendations leading to appropriate departments to address those high cost factors that directly impact the Medicare budget.** When you look at these factors and remember that the amount spent for Medicare reimbursement of physician services was $36.9 billion in 2000 and an estimated $54.2 billion for 2005, it is clear that addressing the biggest drivers of increasing costs makes more sense than penny-pinching with the providers of health care. (Source: *MEDICARE PHYSICIAN PAYMENTS Information on Spending Trends and Targets*—May 5, 2004 Testimony Statement of A. Bruce Steinwald Director, Health Care—Economic and Payment Issues, Testimony Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives www.gao.gov/cgi-bin/getrpt?GAO-04-751T.)

Some of these high cost factors include:

- **Increasing prevalence of obesity in adults and children:** The rapidly rising prevalence of obesity puts people at greater risk for numerous serious illnesses such as certain forms of cancer (including breast and colorectal, kidney among others), diabetes, high blood pressure, arthritis, cardiovascular disease and more. The combined prevalence of both overweight and obesity averages 53.6% across all categories and is *largest* for those enrolled in Medicare (56.1%). Obesity-attributable expenditures by state totalled $75,051,000,000 from 1998–2000. We urge Medicare to work in partnership with private insurance to develop national and local campaigns to prevent and reduce obesity. (Sources: *Estimated Adult Obesity-attributable Percentages and Expenditures by State (BRFSS 1998 to 2000).* http://www.naaso.org/statistics/obesity_exp_state.asp. Also: National Medical Spending Attributable to Overweight and Obesity. Finkelstein, EA et al, Health Affairs, May 14, 2003).
- **Patient non-compliance with treatment for chronic conditions** such as diabetes, high blood pressure and others. In 1992, the cost of medication noncompliance alone was $100 billion ($45 billion in direct medical costs). $31.3 billion was spent on nursing home admission due to noncompliance, $15 billion was spent on hospital admissions due to noncompliance, $1,000 was spent per year per non-compliant patient versus $250 spent on per compliant patient. (Source: *Compliance in Elderly Patients*, University of Arkansas College of Pharmacy http://www.uams.edu/compliance/. Also, *Schering Report IX: The Forgetful Patient: The High Cost of Improper Patient Compliance*. Also Standberg, LR, *Drugs as a Reason for Nursing Home Admissions*, American Healthcare Association Journal 10, 20, 1984).
- **Defensive medicine:** Explore meaningful alternatives to the current tort system for handling complaints and patient injury to reduce cost, improve patient safety, and avoid unnecessary tests and procedures. If reasonable limits were placed on non-economic damages to reduce defensive medicine, it would reduce the amount of taxpayers' money the Federal Government spends by $23.6–42.5 billion per year. (Source: *Confronting the New Health Care Crisis*, U.S. Department of Health and Human Services, July, 2002).
- **Rising drug costs**, especially for Medicare beneficiaries: Marketing and research companies such as Delta Marketing Dynamics of New York and Price Alert show that 31 of the top 50 drug companies raised prices from November 2004–January 2005. The year before, 22 of those companies increased prices. Analysts believe that this is part of the preparation to take advantage of the prescription drug benefits through Medicare. We recommend that Congress change the law recently passed that prohibits Medicare from negotiating prices with pharmaceutical companies. Veteran Affairs already negotiates their prices. Even under the best of reimbursement systems, you negotiate physician services. Negotiating with pharmaceutical companies is the sensible choice of action.

Utilization will increase by the nature of the aging population and the fact that people live longer. But every attempt needs to be made by Medicare, private insurance, patients, and all others to take joint responsibility for addressing those other contributing factors. Medicare could think beyond the short-term and focus on those areas which would both improve health and reduce costs.

I realize that truly ethical and fair reimbursement of physicians without changes elsewhere in the federal budget could affect the long term sustainability of the Medicare program. However, failure to progressively and consistently address the real causes of rising costs and to take steps to create a more just reimbursement system will lead to a deeper erosion of physicians' ability to sustain their practices and provide the care that Medicare is designed to support. That will affect every person, not just Medicare beneficiaries.

We urge you to make decisions for true ethical health partnership with patients and their physicians by preventing further cuts in reimbursement and creating a more just payment system.

Statement of H. Stephen Lieber, Healthcare Information and Management Systems Society, Chicago, Illinois

Congresswoman Johnson and Members of the Subcommittee on Health of the House Committee on Ways and Means, thank you for this opportunity for the Healthcare Information and Management Systems Society (HIMSS) to submit testimony on potential solutions for problems with the current physician payment formula.

My name is Steve Lieber and I am president and chief executive officer of HIMSS. HIMSS is the healthcare industry's membership organization exclusively focused on providing leadership for the optimal use of healthcare information technology and management systems for the betterment of health care. Founded in 1961 with offices in Chicago, Washington, D.C., and other locations across the country, HIMSS represents more than 15,000 individual members and 240 corporate member employing more than 1 million people. HIMSS frames and leads healthcare public policy and industry practices through its advocacy, educational and professional development initiatives to promote information and management systems' contributions to ensuring quality patient care.

HIMSS agrees with your statement, Madame Chair, that "physicians are essential to the Medicare program and without their participation our seniors will lose access to high-quality care." And, we applaud your recognition of the relationship between payment systems and quality and efficiency.

Specifically, HIMSS would like to recommend the following three suggestions to your Subcommittee for consideration:

- Continuation and expansion of pay-for-performance initiatives through the physician reimbursement system that require:
  - Adoption of certified electronic health record (EHR) products;
  - Achievement of defined quality outcomes; and
  - Reporting of performance measures.
- A cost/benefit analysis of including in the Medicare physician fee schedule virtual provider-patient visits in response to a patient's inquiry that support (a) disease management, and (b) physician oversight of a diagnosed condition or similar criteria.
- Encourage physician adoption of certified EHRs by exploring cost differential options for Medicare enrollees.

In its 1997 report, the Institute of Medicine (IOM) estimated that between 44,000 and 98,000 preventable deaths occur each year as a result of medical errors in hospitals. These events are occurring at the same time that healthcare costs are escalating at double-digit rates. The Office of the National Coordinator of Health Information Technology of the Department of Health and Human services noted that 2004 will be the fifth consecutive year of double-digit increases in healthcare costs; a trend exerting increased pressure on payers, including Medicare, to find new solutions. But, with the dual realities of ever-advancing medical science *and* an aging U.S. population, the demand for care will only increase and further drive costs upwards.

The present situation grows increasingly dangerous and expensive. However, as the IOM has declared,[1] widespread adoption of HIT—such as EHRs—can reduce the risk of medical errors. Studies also show that such systems not only improve quality and safety, but also advance efficiency of care through lower utilization, better management of chronic disease, increased longevity, and increased health status.[2]

Unfortunately, the growing body of evidence showing advancements in quality and efficiency resulting from the use of HIT has not translated into rapid adoption by physicians. It is estimated that only 6% to 13% of physician practices have an EHR in place and adoption is lowest among small- and medium-sized practices

[1] Institute of Medicine (IOM), Committee on Quality in Healthcare in America. "To err is human: building a safer health system." Washington, DC: National Academy Press, 1999.

[2] Balas, E.A., and S.A. Boren. "Managing clinical knowledge for health care improvement." *Yearbook of Medical Informatics* (2000): 65–70.

where a majority of physicians practice.[3] There are a number of barriers to widespread adoption; one such barrier is financial, including limited access to capital and a lack of incentives.

The cost of acquiring an EHR for a small physician group practice of 1–5 doctors is estimated at $16,000–$36,000 per physician.[4] Plus, there are annual operating costs to be borne by the practice. Solo and small physician group practices are small businesses. And like other small businesses, limited cash and earnings restrict technology expansion. However, linking payments with quality and efficiency measures in the physician reimbursement system can address such financial barriers.

Significant discussions are underway to make a pay-for-performance system effective and affordable. Within the past several weeks, President Bush proposed to double the budget to $125 million for demonstration projects related to HIT. Last year, Senator Judd Gregg introduced S. 2710 that contained provisions with loan guarantees and grants for the purchase of interoperable HIT systems. The Department of Health and Human Services' Framework for Strategic Action describes a goal centered largely around efforts to bring EHRs directly into clinical practice; thereby reducing medical errors and duplicative work, and enabling clinicians to focus their efforts more directly on improved patient care.

A key action called for in the Strategic Framework is the establishment of private sector certification for EHR products. HIMSS, together with the American Health Information Management Association and the National Alliance for Health Information Technology, launched such an organization last fall. We are well on our way to having the certification mechanism ready for the industry to utilize.[5]

With such guidance in place to ensure that the technology available in the marketplace is robust, interoperable, and capable of supporting strategic goals, the Strategic Framework calls for payers to provide incentives for EHR adoption. A report by the Health Strategies Consultancy for the Foundation of the eHealth Initiative identified four types of financial incentive models used to promote the adoption of HIT: payment differentials, cost differentials, direct reimbursement, and shared withholds.[6]

Payment differentials, also known as pay for performance, provide bonuses for results (e.g., IT implementation or quality outcome measures). *Cost differentials* target consumer behavior by employing lower co-payments or deductibles at providers who have adopted IT or achieved certain quality standards. *Direct reimbursement* is pay for specific procedures involving technology, such as virtual provider-patient visits. The *shared withhold model* withholds or delays provider payments rate increases with release subject to IT adoption or quality improvements.

Already, some payers have implemented one or more of these approaches. Blue Cross Blue Shield of Rochester, NY, Empire BCBS and a number of other BCBS plans have programs that pay incentive bonuses for adoption of IT and standards that improve the safety of care. Bridges to Excellence, a coalition of physicians, health plans and employers have several programs that pay physicians who implement specific HIT processes to reduce errors and increase quality. And states, such as Wisconsin, are exploring changes to tax structures to encourage physicians and hospitals to purchase and implement HIT.

The Medicare program, as you know, is also exploring incentive options. A three-year demonstration project launches April 1 in 10 large medical groups across the country with CMS paying participating clinicians more if they improve the efficiency and quality of care while lowering costs.

The Connecting for Health project coordinated by the Markle Foundation estimates that incentives in the range of $12,000 to $24,000 per full-time physician per year should achieve broad adoption of EHRs on an accelerated timetable. This amount translates into about $3 to $6 per patient visit or $.50 to $1.00 per member per month for enrolled plans.[7]

In aggregate, incentives at this level require an investment of approximately $21.6 to $43.2 billion across all payers, according to the Connecting for Health work. The Federal Government, as the largest payer of health care, will need to contribute its share in an incentive system if it is to work. Without the Federal Government's

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[3] Miller, R.H., J.M. Hillman, and R.S. Given, "Physician Use of IT: Results from the Deloitte Research Survey." *Journal of Healthcare Information Management*, Vol. 18, No. 1 (2004):72–80.

[4] Miller, R.H., Sim, I., Physicians' Use of Electronic Records: Barriers and Solutions, *Health Affairs*, March 2004.

[5] http://www.cchit.org.

[6] http://www.healthstrategies.net/research/docs/HIT_Incentives_Report_Foundation_for_eHI.pdf.

[7] http://www.connectingforhealth.org.

incentives, there will not be an adequate level of funding for physicians to acquire and implement HIT.

However, the current physician reimbursement formula is not designed to assist physicians with IT adoption and—in fact—may achieve counterproductive results. The Office of the Actuary for the Centers for Medicare & Medicaid Services, as reported in the 2004 Annual Report of the Medicare Trustees, projects that under the current formula Medicare will reduce payment rates to physicians by approximately 5% annually for seven years, beginning in January 2006. Physician payment rates would decline more than 31 percent from 2005 to 2012, while costs of providing services would increase by 19 percent over the same period.

If this methodology continues, declining Medicare payments to physicians will create further barriers to IT adoption and therefore perpetuate barriers to improvements in the efficiency and quality of care. Savings may occur in the short term, but declining rates of participation in the Medicare program and failure to improve patient safety and quality will only result in higher, long term costs to Medicare and the U.S. healthcare system.

We are at an exciting juncture. Technology now has the components necessary to truly impact the quality, safety, and cost-effectiveness of patient care. Consumers, clinicians, payers, and other stakeholders are all exploring ways to get appropriate solutions into the hands of small- and mid-sized practices across the United States. The Subcommittee has a unique opportunity to positively influence these efforts. Again, on behalf of the HIMSS individual and corporate members, I thank the Subcommittee for this opportunity to share with you our views and we look forward to working with you on these recommendations to improve health care for all.

Managed Care Advocacy Program
Toledo, Ohio 43620
February 9, 2005

The Honorable Congresswoman Nancy Johnson, Chairman
Subcommittee on Health
2409 Rayburn Building
Washington, D.C. 20515

Dear Chairman Johnson:

The Managed Care Advocacy Program (MCAP), is a benefits counseling program for seniors. We do one on one as well as group counseling in helping them through the maze of Medicare, Medicaid, Medicare Advantage Plans and the healthcare delivery system. We are a program of our local Area Office on Aging.

On a daily basis, we connect with the senior population and hear their concerns and complaints.

We encourage your Committee to consider modifying the current SGR system. We understand the financial challenges of the Medicare system and the need for fiscal discipline of this program. We believe this can be done without shortchanging the physicians who care for our elderly. We hear from our elderly seniors that physicians often express their discontentment with the Medicare payment system.

Also addressed in this report was the fact that physician's compensation be based on quality and efficiency of care. If this is a concern, when physicians accept the Medicare Assignment, any concerns regarding these doctors should be addressed at that time. CMS would need a specific monitoring system to monitor quality and efficiency.

MCAP does not support any reduction in payments to physicians who care for the elderly. However, we do support CMS in ridding the Medicare system of fraud and any person or healthcare provider participating in such. We believe this savings could aid in paying physicians fairly.

We believe fiscal management must be found elsewhere—not in direct medical care to our elderly.

Sincerely,

Elizabeth A. Flournoy
Director

Statement of William F. Jessee, Medical Group Management Association

Madam Chairman, Congressman Stark, and distinguished Members of the Subcommittee, thank you for your leadership on an issue that dramatically impacts the ability of physician practices to continue providing high quality care to patients, and especially for steps taken by this Subcommittee to guarantee a minimum 1.5 percent increase in physician reimbursement rates for 2004 and 2005. That stopgap measure has provided the time we now have to help ensure access for Medicare and non-Medicare patients.

Medical Group Management Association (MGMA) data show that the cost of caring for patients has risen 48 percent over the last 10 years. However, according to the Medicare Trustees 2004 report, under current law Medicare physician reimbursements will be cut by more than 30 percent between 2006 and 2012, as costs continue to escalate. These two diverging trajectories represent an unsustainable future for patients and the providers who care for them, and a looming crisis for the American healthcare system.

Escalating costs, declining reimbursements

MGMA, founded in 1926, is the nation's principal voice for medical group practice. MGMA's 19,500 members manage and lead some 11,500 healthcare organizations in which more than 240,000 physicians practice. MGMA leads the industry with its research into practice costs. In fact, MGMA has conducted extensive surveys of medical practice costs for more than 50 years, and our data are widely respected as accurate benchmarks of the expenses associated with caring for patients. MGMA-collected data indicate that the cost of operating a group practice rose by an average 4.8 percent per year over the last 10 years. In fact, between 2001 and 2003, MGMA data show that operating costs increased nearly 11 percent.

Such escalating costs should come as no surprise. We are all familiar with skyrocketing professional liability premiums. Additionally, advancements in medical technologies have transformed the way we practice medicine, and hold great promise for future improvements. MGMA has long supported enhancing quality of care while reducing administrative burdens on physician practices. Information technology (IT), in particular, holds great promise in this area. However, the initial investment required to establish, for example, a fully interoperable electronic health record system, is prohibitive for many group practices. Moreover, while it seems intuitive that IT should help to restrain escalating costs by generating administrative savings, the vast majority of such savings will accrue to payers and others within the system, not to the physician group practices that provide the initial investment. Despite their desire to improve quality, physician group practices are largely unable to commit significant financial resources to IT because the investment seems unlikely to pay for itself in the foreseeable future. The projected Medicare reimbursement cuts also create an unstable economic environment, making it virtually impossible for many group practices to pursue the types of expensive technologies that hold great promise for improving patient care and generate administrative savings.

Unfortunately, even before the projected cuts may begin taking effect, Medicare reimbursement rates for physician services have fallen far short of the increased cost of delivering quality services to Medicare patients. And as you know, Medicare generally serves as the standard on which private payers base their reimbursement rates. **With escalating costs as shown by MGMA data, projected Medicare cuts of more than 30 percent and private payers sure to follow, there is no question that some group practices will be unable to afford continued care for patients under current law. It is absolutely crucial that policymakers address this concern now.** The timing of this hearing, so early in the 109th Congress, strongly emphasizes your recognition of the critical need to address this problem. Thank you again for your leadership. While MGMA recognizes that any solution will involve an investment by the taxpayers, it is necessary to protect some of the nation's most vulnerable citizens, the elderly and disabled, beginning as soon as next year.

Removing drugs from the Sustainable Growth Rate

There is a relatively easy way to begin improving the Medicare physician reimbursement system. The Centers for Medicare & Medicaid Services (CMS) should remove Part B covered drugs from the calculation used to determine Medicare physician updates beginning with the base year. This administrative action would help to mitigate the impact of the projected cuts and facilitate your efforts to establish long-term improvements to this broken reimbursement system. Such administrative change also represents the right thing to do from a policy perspective.

The definition used by CMS for "physician services" in the sustainable growth rate (SGR) formula inappropriately includes the cost of physician administered out-

patient prescription drugs. Medicare's coverage of costly prescription drugs administered in the physician's office has been a significant factor in the growth of Medicare expenditures. Since 1996 (the SGR base year), SGR spending for physician-administered drugs has more than doubled. These expenses reflect patient acquisition of products rather than services rendered by a medical professional and therefore are different than "physician services." These drugs are not even reimbursed under the physician fee schedule, but under a completely different system. Their inclusion in the definition of physician services runs counter to CMS' stated goal of paying appropriately for drugs and physician services.

A separate definition of physician services clearly distinguishes physician administered outpatient prescription drugs from services rendered by physicians. CMS adopted this definition in the December 12, 2002, "Inherent Reasonableness" rule (67 FR 76684). The definition of physician services must be applied consistently for fair and equitable administration of the Medicare program. Furthermore, the recent rule reforming the payment system for physician-administered prescription drugs refines a separate venue to address the utilization and cost of drugs. MGMA has strongly urged CMS to remove prescription drug expenditures from the definition of "physician services" used to calculate the physician reimbursement update, beginning with the 1996 base year. Although this would not retroactively impact reimbursements between the base year and 2005, it would appropriately correct the figures on which future updates are based and represent better Medicare policy.

Conclusion

MGMA is extremely concerned about the negative impact on Medicare beneficiaries, non-Medicare patients, and physician group practices that would result from the current physician reimbursement system. I strongly urge you to encourage CMS to remove Part B drugs from the SGR calculation beginning with the base year. Please let me know how we can help you to develop a long-term legislative solution to the flawed Medicare physician reimbursement system. Thank you again for your efforts to address the projected cuts of more than 30 percent in Medicare physician reimbursement rates, and for the opportunity to comment on this important issue.

Medtronic, Inc.
Minneapolis, MN 55432
February 22, 2005

The Honorable William "Bill" Thomas
Chairman, Committee on Ways and Means

The Honorable Nancy L. Johnson
Chairman, Ways and Means Subcommittee on Health
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Sir and Madam:

Medtronic would like to express its appreciation to you and your colleagues on the Ways and Means Committee for your commitment to improving the physician payment system under the Medicare program.

As you may know, Medtronic is the world's leading medical technology company, providing lifelong solutions for individuals with chronic disease. Our therapies span the fields of cardiology, neurology, spinal, vascular, endocrinology, urology, and gastroenterology, among others, and we value the essential services provided to Medicare beneficiaries by physicians who specialize in these critical areas of care.

Medtronic understands that a revised physician payment system will need to balance a number of priorities, including fiscal responsibility, continued beneficiary access to physician services, and adequate reimbursement for office visits and preventive services. While there may not yet be consensus on the best way to achieve these goals, Medtronic is concerned that future negative payment updates could place significant undue constraints on physicians.

Effective medical technologies play an important role in prolonging and improving the quality of beneficiary lives. But they can only be of benefit to patients if physicians receive adequate, predictable payments that enable them to sustain their practices and provide the highest level of care to their patients. We urge you to act to ensure that physicians do not face abrupt reductions in Medicare payment that

could jeopardize patient care or limit access to the latest advances in medical technology.

As demonstrated by the diverse views represented at the Ways and Means Subcommittee on Health hearing February 10, 2005, Medtronic is pleased that you are committed to working with all stakeholders in the design and implementation of changes to physician payments. We look forward to being a part of the discussion to improve and stabilize the Medicare physician payment system as you move forward.

Best regards,

Arthur D. Collins, Jr.
Chairman and Chief Executive Officer

Statement of National Coalition for Quality Diagnostic Imaging Services, Houston, Texas

Chairman Johnson, we are pleased to have this opportunity to provide testimony for the record to the House Ways and Means Subcommittee on Health at a hearing on "Medicare Payments to Physicians." NCQDIS is comprised of more than 2,400 outpatient imaging centers and departments in the United States. The coalition promotes "best industry practices," strategies for healthcare cost savings and advocates for public and private sector standards for quality and safety in diagnostic imaging services.

Advances in diagnostic imaging have led to great strides in patient care: from reducing the need for invasive surgical procedures to early detection of life-threatening diseases. NCQDIS and its members are at the forefront of medical technology, providing physicians and patients with the most state-of-the-art innovations, techniques and procedures available in diagnostic imaging.

We are pleased to have this opportunity to comment to the House Ways and Means Subcommittee on Health on the opportunities that we believe exist to increase quality of care to Medicare patients, while addressing the Committee's cost concerns about the physician payment system. We share the concerns expressed by the Medicare Payment Advisory Commission (MedPAC) regarding utilization of diagnostic imaging services in Medicare. There are significant costs associated with this increased utilization, as well as quality concerns regarding the use of this constantly evolving technology.

Fortunately, Congress can address these cost concerns while increasing the quality and safety of services provided to Medicare patients. Today, many of the policies and standards supported by NCQDIS have been implemented by private payers to successfully reduce costs and improve patient safety and quality. The coalition believes that the same policies and programs that are working in the private sector should be available to protect Medicare beneficiaries and safeguard the Medicare Trust Fund.

Medicare Should Incorporate the Innovations of the Private Sector

Empirical evidence demonstrates that private sector privileging strategies promote high quality care. For example, Tufts Health Plan uses an Imaging Privileging Program to address quality and utilization issues for non-emergency, outpatient diagnostic imaging provided by non-radiologists. Privileging to perform specialty-appropriate imaging procedures is granted based on a provider's specialty designation, and otherwise must be provided by a radiologist or imaging facility. Miriam Sullivan, representing Tufts Health Plan, has testified to MedPAC that by expanding the use of freestanding imaging facilities and increasing competition, physician groups have less desire to purchase equipment and more incentives to use Tufts' quality and evidence-based guidelines.[1]

We firmly believe that private sector quality standards should also be available to Medicare beneficiaries. Highmark uses privileging guidelines where imaging facilities must have a documented Quality Control Program, Radiation Safety Program, and As Low As Reasonably Achievable (ALARA) Program. Highmark providers must be appropriately licensed and meet the physician specialty criteria in the plan's privileging guidelines.[2]

States have also become concerned payers of diagnostic imaging services and are increasingly taking action at the state level to limit physician self-referral of serv-

[1] Medicare Payment Advisory Commission, Meeting Transcript, March 18–19, 2004, page 53.
[2] http://icael.org/icael/reimbursement/highmark_press.htm.

ices. The State of Maryland passed legislation in 2000 that is similar to the federal Stark ban on physician self-referral, except that § 1–301(k)(2) of the law specifically excludes magnetic resonance imaging services, radiation therapy services, and computer tomography scan services from the in-office ancillary services exception. The Maryland Attorney General released a legal opinion on January 5, 2004, stating that this law bars a non-radiologist physician from referring patients for tests on an MRI machine or CT scanner owned by that practice. Medicare should have the same opportunities to increase quality and contain unnecessary utilization that are being implemented at the state level.

Protecting Beneficiaries and the Trust Fund Requires Medicare Take a Closer Look at Use of Imaging

As you know, data from MedPAC and the GAO have raised concerns about the growth of diagnostic imaging performed by non-radiologists. Nevertheless, research shows that services performed by radiologists account for a small portion of the growth of diagnostic imaging. MedPAC found that imaging services increased by 9% between 1999 and 2002.[3] Other research has defined the growth in imaging services between 1993–2002 as a 7% increase by radiologists, 49% by non-radiologists, and 141% by cardiologists alone. In addition, the growth in Medicare payments for radiology services grew by 72% for radiologists and by 119% for non-radiologists.[4]

Non-radiologist physicians owning their own equipment use diagnostic imaging tests more frequently than physicians who refer their patients to radiologists. One study found physicians owning equipment used imaging 2–8 times more often than physicians who refer their patients to radiologists.[5] A similar 1994 GAO study revealed physicians owning their equipment use imaging 2–5 times more often than referring physicians.[6]

Based on this evidence, we believe that radiologists and independent diagnostic testing facilities (IDTFs) can provide the most cost-effective care. In addition, there is no differential in Medicare payment if services shift from non-radiologist physicians to radiologists and independent diagnostic testing facilities, where identical payments are made under the physician fee schedule. Updated statistics show that there are sufficient radiologists in the U.S. to meet patients' needs.

Medicare Beneficiaries Should Be Assured of Access to the Highest Quality Imaging Services

Like private payors, Medicare should only pay for imaging services that meet quality standards. Medical literature shows that imaging equipment and facilities operated by non-radiologists is often sub-optimal. One private sector imaging site inspection program revealed that over ⅓ of imaging facilities operated by non-radiologist physicians had one or more significant quality deficiencies, while only 1% of facilities operated by radiologists had such deficiencies.[7] Quality standards for equipment and facilities would reduce the need for duplicate scans or expensive therapy from incomplete images or misdiagnosis.

We are especially concerned that non-radiologists' offices are less likely to become accredited. Though the ACR has full accreditation programs for many diagnostic procedures, non-radiologist physician offices are not required to become accredited to provide these services. ACR began an MRI accreditation program in 1997, including standards for equipment and for qualifications of technologist's performing the test. Though non-radiologists may voluntarily become accredited, most do not. Almost all accredited entities are freestanding MRI centers owned by radiologists or hospitals, or are contracted with radiologists. NCQDIS believes that all physician offices providing imaging services should be accredited.

In addition, the recycling of obsolete diagnostic imaging equipment should be curtailed by implementing strong equipment standards. Dr. Thomas Ruane, BC/BS of Michigan, testified to MedPAC that, "The diagnostic equipment that becomes somewhat obsolete in our tertiary medical centers often does not go to the Third World.

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[3] Report to the Congress: Medicare Payment Policy, MedPAC, March 2003, page 77.

[4] Levin DC, Intenzo CM, Rao VM, Frangos AJ, Parker L, Sunshine JH. Comparison of recent utilization trends in radionuclide myocardial perfusion imaging among radiologists and cardiologists. J Am Coll Radiol, in press.

[5] Hillman BJ, Olson GT, Griffith PE, et al. Physicians' utilization and charges for outpatient diagnostic imaging in a Medicare population. JAMA 1992; 268:2050–2054.

[6] Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny; GAO, HEHS–95–2, October 20, 1994.

[7] Orrison & Levin, Radiology 2002; 225(P):550.

It often goes down the street to another doctor's office where it lives another life."[8] NCQDIS believes that Medicare patients deserve better.

NCQDIS Promotes the Appropriate Use of Diagnostic Imaging By Trained Specialists

Radiologists spend 4–6 years in residency training to learn imaging techniques and interpretation. Most non-radiologist physicians have limited or no formal training in image interpretation. Although some physicians in other specialties get limited amounts of training in certain areas of imaging, the training is often informal and does not meet defined standards. To protect patient safety and reduce medical errors, physicians billing Medicare for imaging services should meet certain training and education standards.

Radiologists working with other clinicians provide an important second opinion in clinical diagnosis, helping to minimize medical errors. As is being discussed in the hearing today, the best clinical outcomes are achieved when a team approach is used to manage patient care. The radiologists serve as an important second opinion in clinical diagnosis, treatment, and management of patients needing diagnostic imaging services.

It is important to note that imaging centers owned by radiologists and IDTFs do not create a demand for imaging services. Business is independently referred to imaging centers from third party physicians who determine that a patient needs a diagnostic imaging test. Therefore, radiologists and IDTFs are limited in their ability to generate business outside of that which is referred.

Evidence also demonstrates that quality of care is improved if radiologists read diagnostic images. In 2000, one research group used a standardized set of chest radiographs to compare the accuracy of interpretation of radiologists and non-radiologists. The composite group of board-certified radiologists demonstrated performance far superior to that of non-radiologist physicians. Even radiology residents in training out-performed non-radiologist physicians.[9]

NCQDIS Recommends That Medicare Take Steps Now to Protect Medicare Beneficiaries

NCQDIS is pleased to submit its recommendations to the House Ways and Means Subcommittee on Health on the best way to promote quality of care in diagnostic imaging. Congress has the opportunity to act now to address this important issue.

1. Congress should enact a privileging policy for high cost high tech imaging. A privileging policy for MRI, CT, and PET would require that physicians meet certain professional standards in order to directly bill Medicare for the technical and professional components of these procedures. This policy would allow current billing practices to continue for cardiac ultrasound procedures and plain X-rays. Medicare should promote quality of care and patient safety by reimbursing only those doctors who are certified and have the appropriate training in diagnostic imaging services. This approach would avoid the provision of low-quality images, interpreted by inadequately trained non-radiologists using sub-standard technology. NCQDIS supports privileging policies that address the professional and technical components of diagnostic imaging services. CMS conditions of coverage could require that a physician become certified by CMS as a qualified "designated physician imager" in order to bill Medicare for diagnostic imaging tests.

2. NCQDIS also suggests that CMS address the technical component of diagnostic imaging services by implementing standards for equipment quality. An image produced by a poor quality piece of equipment will inevitably lead to errors, misdiagnoses, and the need for repeat testing.

3. NCQDIS supports coding edits to allow financial intermediaries to detect improper billing.

NCQDIS understands that more expansive privileging policies targeting other procedures and specialties take time to develop and test. Therefore, NCQDIS recommends that Medicare be authorized to implement a broader privileging policy based on private sector privileging policies, to be implemented within one year from the date of enactment using a panel of experts. This policy should detail by medical specialty those imaging tests permitted by the specialty.

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[8] Medicare Payment Advisory Commission, Meeting Transcript, March 18–19, 2004, page 34.
[9] Potchen, RADIOLOGY 2000; 217:456.

Statement of James Weiss, Renal Physicians Association

Approved by RPA Board, 7/17/2004

RPA Position Paper on Legislative Issues Related to Linking Reimbursement to Performance Measures in ESRD Care (Part One of Two)

Introduction

A rapidly evolving movement in modern healthcare delivery is the effort to create a linkage between reimbursement to providers and measurements of the quality of the care delivered to patients. This change in direction has been fueled in large part by the growing necessity to focus on more cost-efficient use of increasingly scarce fiscal resources in health care, and the recent publication of high-profile reports on patient safety and provider accountability by major advisory organizations in medicine, such as the Institute of Medicine (IOM) report "*Crossing the Quality Chasm: A New Health System for the 21st Century*."[1]

There are a variety of structural and environmental factors that make the care delivered to end-stage renal disease (ESRD) patients a compelling subject for efforts to link reimbursement to quality. These include the federal data-gathering infrastructure long in place for this patient population, the capitated nature of the payment systems for these patients (the composite rate payment for dialysis facilities and the monthly capitated payment for physician services), and the reported suboptimal clinical outcomes for many ESRD patients. Accelerating the impetus to utilize a reimbursement-quality link in the ESRD program is the overt commitment by the Centers for Medicare and Medicaid Services (CMS) to pursue implementation of such a methodology for this target group.

In recognition of this changing environment, the RPA convened a panel of experts in quality, accountability, and safety from the renal community to address the link between quality measures and reimbursement for ESRD patients in a sensitive and responsible manner. The meeting included panelists involved in clinical and academic nephrology, representing physicians providing care to both the adult and pediatric patient populations, in addition to a representative from a large managed care organization with extensive experience in linking reimbursement to quality measures and a representative from a large kidney patient group.

This document is the first of a two-part discussion paper resulting from the RPA-convened meeting. Part one will provide background and counsel to congressional leaders as they consider the legislative initiatives affecting the Medicare program that will be necessary to appropriately assess and implement measures linking reimbursement to quality measures. Part two is intended to provide focused recommendations to CMS staff as they develop the specific methodologies for designing a system linking reimbursement to quality measures and making it operational. The segregation of the policy positions reflects RPA's belief that to effectively and appropriately implement change of this nature, a fundamental restructuring of elements of the Medicare program will likely be necessary.

This document will review the history of nephrology's role in quality measurement and improvement for ESRD patients, RPA's place in that history, and how quality efforts in renal care compare to similar efforts in other medical disciplines. In addition, included is a review of the current status of the scientific evidence in this area, and a discussion of how the underlying principles of the current Medicare physician fee schedule will contribute to the complexity of establishing a reimbursement-quality link. The document will conclude with recommendations for the next steps that the RPA believes are necessary to appropriately pursue such a course.

Quality Efforts in Nephrology—Historical Perspective

One of the unique aspects of nephrology's involvement in the issues of quality improvement relates to the prescient nature of the specialties' activities in this area over the past two decades. Nephrology's commitment to quality measurement and quality improvement has foreshadowed not only those efforts on the part of other disciplines within organized medicine, but has also guided CMS (and previously HCFA) toward the development of appropriate quality measures and information systems necessary to support quality improvement. A partial list of nephrology-specific activities in this area includes:

- The 1988 creation of the United States Renal Data System (USRDS) by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)

[1] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. 2001. National Academic Press.

- The 1994–1996 NKF Dialysis Outcome Quality Initiative (DOQI) on adequacy of hemodialysis, adequacy of peritoneal dialysis, anemia, and vascular access[2]
- The renal community project to convert high priority evidence-based clinical practice guidelines into well-defined clinical performance measures
- The 1995 publication of the RPA Position on Implementation of Health Care Quality Improvement (HCQIP) in Medicare's End Stage Renal Disease Program[3]
- The release of the 2000 RPA/ASN clinical practice guideline on Shared Decision Making in the Appropriate Initiation of and Withdrawal from Dialysis[4]
- The release of the 2002 RPA clinical practice guideline on Appropriate Patient Preparation for Renal Replacement Therapy[5]
- The 2003 publication of the RPA White Paper on the Use of Performance-Based Incentives in Renal Care[6]

These initiatives, lead by organized nephrology, have resulted in sustained improvement in all targeted clinical measures to a degree unprecedented in medicine. These improvements occurred without any financial incentive, but rather capitalized on the innate desire of the majority of nephrologists to provide the highest level of care possible to their patients. It is important to note that these changes were greatly supported by and ultimately only made possible by development of data collection and reporting systems, heretofore unseen in medicine.

Thus, the work of clinical nephrology in general and the RPA specifically over the last two decades has to some extent influenced many healthcare quality improvement initiatives in the U.S. It also puts the clinical arm of nephrology in a position of unique sensitivity to the risks and benefits associated with implementation of incentive-based quality improvement initiatives for ESRD patients. Further, the degree to which nephrology has pursued quality measurement and improvement, and modifications in provider behavior in ESRD care, predates and transcends many of the circumstances leading to the concerns outlined in the IOM's *Crossing the Quality Chasm* report. As a result, the substantial experience that nephrology has gained in the area of quality improvement has fostered a judicious perspective toward the use of performance-based reimbursement systems.

Accordingly, the RPA endorses the concept of linking reimbursement to performance—providers should be rewarded for good performance. But in designing truly effective reimbursement systems to reward performance, there are a number of hazards that must be avoided. In particular, since few such systems have been tested extensively, and since little empirical research exists to provide evidence of benefit, the design and implementation of such systems should be undertaken with extreme caution. Further, and likely most significant from the patient perspective, it is particularly important that the issue of adverse risk selection or "cherrypicking" be addressed and prevented to the extent possible in the development of such systems. The implementation of a performance-based reimbursement system can be subject to cherrypicking, so the principle of "do no harm" should clearly apply in the development of these systems as much as it does in routine reimbursement situations.

Policy Implications of Current Scientific Evidence

Beyond the public policy considerations of whether performance-based reimbursement systems represent an appropriate and effective means of improving the quality of care provided to ESRD patients, questions regarding the science behind such efforts remain unanswered. It has been postulated that the three primary predictors of patient outcomes of hemodialysis—dialysis adequacy, hemoglobin, and albumin—explain only 15% of the variance in ESRD patient outcomes.[7,8,9] Other measures

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[2] National Kidney Foundation. Dialysis Outcomes Quality Initiative Clinical Practice Guidelines on Hemodialysis Adequacy, Peritoneal Dialysis Adequacy, Vascular Access, and Anemia Management. 1997. NKF.

[3] Renal Physicians Association. RPA Position Paper on Implementation of Health Care Quality Improvement in Medicare's End Stage Renal Disease Program. 1995. RPA.

[4] Renal Physicians Association/American Society of Nephrology. Clinical Practice Guideline on Shared Decision Making in the Appropriate Initiation of and Withdrawal from Dialysis. 2000. RPA/ASN.

[5] Renal Physicians Association. Clinical Practice Guideline on Appropriate Patient Preparation for Renal Replacement Therapy. 2002. RPA.

[6] Renal Physicians Association. RPA White Paper on the Use of Performance-Based Incentives in Renal Care. 2003. RPA.

[7] Lowrie E, Teng M, Lacson E, Nancy L, Owen W, Lazarus JM: "The Association Between Prevalent Care Process Measures and Facility Specific Mortality Rates." *Kidney International* 60:1917–1929, 2001.

[8] Lacson E, Teng M, Lazarus JM, Lew N, Lowrie E, Owen W: "Limitations of the Facility-Specific Standardized Mortality Ratio for Profiling Healthcare Quality in Dialysis." *American Journal of Kidney Disease* 37:267–275, 2001.

provide little additional explanatory power. This level of uncertainty in the science underlying efforts to promote performance-based incentive systems is clearly problematic.

Accordingly, the predictive limits of current measures of outcome suggest the need for a more robust scientific foundation on which to base these initiatives. Elements from both the basic science and health services research realms that would complement these efforts should include: (1) research on the full range of appropriate outcomes measures, including relevant patient behaviors and patient-reported quality-of-life, by the Agency for Healthcare Research and Quality (AHRQ), seeking to differentiate actionable factors under the control of physicians (process), facilities (structure), patients, as well as others; and (2) additional research by AHRQ on the impact of existing institutional structures, such as the ESRD Network quality program, and other economic and financial levers.

Recent literature underscores the dearth of scientific evidence in this area. The March/April 2004 edition of *Health Affairs* includes an article entitled "*Paying for Quality: Providers' Incentives for Quality Improvement*,"[10] that endeavors to systematically assess the relationship between provider' incentives and quality improvement. Among the authors' findings are: (1) confirmation that there in fact are no controlled studies on the efficacy of incentive programs in improving quality; (2) that existing incentive programs highlight the dichotomy between treatment of 'good' performance and 'improved' performance, tending to reward the former and not the latter, an orientation of particular importance for those individuals or entities at the lower end of the performance spectrum; (3) that the result of this orientation is that low performers are less likely to strive for incentive payments, and thus less likely to change their programs to improve performance; and (4) that most measures of quality currently used are a mix of process and structure measures, with a much smaller role for patient experience and outcomes measures.

Such a structurally triggered payment methodology could have several negative unintended consequences. First, for those low performers who likely need the fiscal resources the most in order to improve their systems of care delivery, programs of this nature would make it more difficult to obtain them. Further, over time this deficit could have the downstream effect of putting low performers who consistently do not achieve bonus payments out of business, negatively impacting ESRD patient access to care. These groups, unfortunately, tend to care for "at risk" populations already in dire financial straits. This model may further disenfranchise them by creating financial disincentives for physicians and dialysis chains dissuading them from investment. While this is certainly only a theoretical outcome, RPA strongly recommends that Congress direct CMS and other federal policymakers to consider this issue and others like it specifically during the development stage of an incentive-based quality improvement program, rather than placing patients at potential undue risk. RPA also urges Congress to direct CMS to recognize that the unique characteristics of the pediatric dialysis patient population requires special consideration, and that the likelihood that a performance-based incentive system is inappropriate for these patients is significant. Policymakers should consult with the American Society of Pediatric Nephrology (ASPN) before proceeding with policy development affecting that patient sub-population.

Linking Reimbursement to Quality in the Medicare Physician Fee Schedule

Implementation of a reimbursement system based on performance or quality measures would represent a drastic change within the current Medicare physician fee schedule context. Under its present, congressionally-mandated resource-based relative value scale (RBRVS) methodology, Medicare, through the Medicare fee schedule (MFS) reimburses physicians for the services they provide based on the resources necessary to furnish those services to the typical patient. Therefore, by current law the relative value units (RVUs) that ultimately determine the rank order payment for a specific physician service within the MFS must be resource-based and by definition exclude the use of a quality measure (or a surrogate measure) as a factor in determining payment. Thus, legislation would be necessary to allow for the implementation of quality or performance-based payment methodology within the RBRVS structure.

Another confounding factor that must be addressed is that the MFS by law is mandated to be budget neutral. One option that has been advanced to address the mandate for resource-basing in the MFS outlined above is to provide an additional

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[9] Lowrie E, Teng M, Lew N, Lacson E, Owen W, Lazarus JM: "Towards a Continuous Quality Improvement Paradigm for Hemodialysis Providers with Preliminary Suggestions for Clinical Practice Monitoring and Measurement." *Hemodialysis International* 7:28–51, 2001.

[10] Rosenthal MB, Fernandopulle R, Song HR, Landon B: "Paying for Quality: Providers' Incentives for Quality Improvement." *Health Affairs* 23:127–141, 2004.

payment to high performers beyond what is provided within the RBRVS system. However, budget neutrality limitations will force CMS to take funds necessary to provide the additional reimbursement from another sector of the Medicare payment arena, thereby creating a "withhold" situation, an approach that has been clearly shown to be ineffective in improving quality. Among the currently available policy lever options, desegregation of the Medicare Part A and Part B funding pools would offer one seemingly reasonable avenue for provision of the funds needed for a quality incentive program without resorting to a withhold. The separation of these funding pools may have been useful in the 20th century but currently appears to be more of an artifact of a previous policy structure that does not promote the more global responsibilities of healthcare providers participating in each pool. Because improved quality for dialysis patients will result in fewer hospitalizations, decreasing Part A expenditures, the desegregation of Part A and Part B for this purpose is quite appropriate. If this or a similar option were to be pursued, alignment of financial incentives across this chasm would be a necessary step in the linkage of quality measures to reimbursement, however contentious such a shift would be.

Conclusions

In spite of legislative, regulatory, and fiscal obstacles, the RPA is committed to designing effective systems linking payment to performance. The issue is not one of commitment but the complexity of the task. The necessity of implementing such a system without doing unintended harm to the most vulnerable Medicare beneficiary sub-population, the difficulties in developing a system within the current Medicare payment structures, and the paucity of research related to these issues all provide ample reason for proceeding cautiously. The combined impact of these considerations underscores the need for firm commitment, both philosophically and fiscally, from Congress, CMS and other federal policymakers to address the following recommendations prior to implementing a methodology linking reimbursement to quality.

Recommendations

1. **RPA believes that before CMS develops a payment methodology linking reimbursement to quality, Congress must direct the Agency to actively involve and draw on the intellectual resources and experience of the nephrology community throughout the process. This will help to ensure that the development and final products emphasize the expected benefits of a modified payment methodology and minimize negative unintended consequences.**
2. **RPA believes that Congress must support substantial research in both the pertinent basic science and health services arenas, especially related to nephrology outcomes research in order to strengthen the essential and necessary scientific evidence supporting a transition to a performance-based payment system.**
3. **RPA believes that Congress should direct CMS to develop a performance-based payment system that considers and separately rewards both high performance and measurable improvement.**
4. **RPA believes that for such a revised payment methodology to be effective longitudinally, the system must not disrupt the resource-based relative value scale (RBRVS) system, and must for the purposes of the incentive payments have budget neutrality waived. Incentive payments should not be derived by decreasing usual payments or establishing a withhold from the usual payments.**
5. **RPA believes that to effectively implement a payment methodology linking reimbursement to quality, Congress must consider fundamental change to the policy structure underlying the Medicare program, specifically assessing the desegregation of the Medicare Part A and Part B funding pools. Physician activities that improve quality and produce savings by decreased hospitalizations ought to be accounted for in the adjudication of the funds available for physician incentive reimbursement.**
6. **RPA urges Congress to direct CMS to recognize that the unique characteristics of the pediatric dialysis patient population require special consideration. It is likely that a performance based incentive system is inappropriate for these patients. Policymakers should consult with the American Society of Pediatric Nephrology (ASPN) before proceeding with policy development affecting pediatric dialysis patients.**

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