MEDICARE PAYMENT ADVISORY COMMISSION'S REPORT ON THE SUSTAINABLE GROWTH RATE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

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MEDICARE PAYMENT ADVISORY COMMISSION'S REPORT ON THE SUSTAINABLE GROWTH RATE

TUESDAY, MARCH 6, 2007

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

The Subcommittee met, pursuant to notice, at 2:08 p.m., in room 1102, Longworth House Office Building, Hon. Fortney Pete Stark (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 27, 2007
HL–3

CONTACT: (202) 225–3943

Health Subcommittee Chairman Stark Announces a Hearing on MedPAC's Report on the Sustainable Growth Rate (SGR)

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on the Medicare Payment Advisory Commission's (MedPAC) report on the Sustainable Growth Rate (SGR). **The hearing will take place at 2:00 p.m. on Tuesday, March 6, 2007, in Room 1100, Longworth House Office Building.**

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

BACKGROUND:

Since 1997, annual updates to Medicare's reimbursement for physicians and certain other providers have been determined by a formula known as the Sustainable Growth Rate (SGR). This formula sets a target for growth in Medicare expenditures for services reimbursed under the physician fee schedule based on growth in the gross domestic product. The SGR is also adjusted for volume growth and other factors. If Medicare expenditures for these services exceed the target, Medicare payment rates are reduced. If Medicare expenditures for these services are less than the target, payment rates are increased.

The first negative update resulting from the SGR took effect in 2002. In each of the following years, Congress acted to override the SGR and provide a positive update. In order to break this annual cycle, Congress directed MedPAC to issue a report on various options to refine the SGR in the "Deficit Reduction Act of 2005" (P.L. 109–171). MedPAC will issue this report on March 1, 2007.

In announcing the hearing, Chairman Stark stated, "Physicians are the gateway into the health care system, and a key driver of health spending. Medicare's physician reimbursement mechanism needs to be stable and accurate, while also incorporating incentives for physicians to deliver appropriate care. This topic will be a main focus of the Subcommittee this year."

FOCUS OF THE HEARING:

The hearing will focus on MedPAC's mandated report on the SGR, as well as trends in Medicare spending on physician services in recent years. On the first panel, MedPAC will review the deliberations on the statutorily mandated options for revising the SGR, and discuss their recommendations for physician payment reform. On the second panel, former Administrators from the Health Care Financing Administration (HCFA—now the Centers for Medicare and Medicaid Services, CMS) will discuss the history of Medicare's reimbursement policies for physician services, and the role of expenditure targets.

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 "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). 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 **Tuesday, March 20, 2007**. **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 STARK. Today we will begin the fun job of working on the Sustainable Growth Rate (SGR). We've overridden the payment cuts and that's made it more difficult I think for us to get a long-term fix, but as a result of ignoring this over the past many years, we've—the docs face a 10 percent cut next year and 5 percent reductions through 2015 if we do nothing. The Congressional Budget Office tells us we're looking at $330 billion over 10 years if we just repeal it and let Medicare Economic Index (MEI) go ahead.

Now taking a note from my former colleague in the Air Force who went to Iraq with the Army he had and not the Army he said

he wished he had, that goes for me as well. I got to work with the budget I have and not with the budget I wish I had.

Fortunately, we can count on MedPAC to at least provide us objective advice on how to improve and protect the programs, at least to criticize them for us in a fairly objective way even if they aren't willing to come up and give us an exact program to follow. We asked MedPAC to analyze options in the 2006 Congress, and Mr. Hackbarth is here to discuss the results of their analysis.

Also we have two people who many of us have worked with in the past who have firsthand experience in managing physician spending in Medicare, Dr. Bruce Vladeck and Dr. Gail Wilensky, who are former administrators of the Healthcare Planning Administration, now known as the Centers for Medicare and Medicaid Services (CMS).

Gail remembers that during much of her tenure I chaired this Committee when the President's father was in the White House and we worked with the physician community and the Republicans and developed a physician pay schedule. Glenn will tell you that one wasn't very good either, but maybe it was better than what we've got.

I don't know if we'll have a similar success, but I look forward to hearing from Glenn, and I'd like to give Dave Camp a chance to put his spin on this opening session.

Mr. CAMP. Well, thank you very much, Mr. Chairman. Again, welcome back Chairman Hackbarth. It's good to see you again. I want to thank you and your staff for the good work you did on the recent report on Medicare payments to physicians and the SGR, the SGR formula used to set those payments.

I also want to welcome Dr. Vladeck and Dr. Wilensky as two former administrators of Health Care Financing Administration (HCFA), now CMS. I know you're well aware of the physician payment issue, and so I look forward to hearing your thoughts as well.

In the SGR report, MedPAC examined alternative ways to curb the volume growth of physician services. The report laid out several options for Congress to consider including tweaking the existing formula, creating a completely different payments formula, promoting several new quality and efficiency initiatives. I commend you, Chairman Hackbarth and the MedPAC staff for completing such a comprehensive report.

This report wasn't only requested because of the inherent flaws in the SGR formula. Not only are physicians scheduled for a negative 5 percent payment cut through 2015, the incentives under the SGR formula are inappropriate. Medicare now pays physicians based on the quantity of services provided but not the quality. As physicians are threatened with payment cuts, a natural response is to provide more services.

In fact, CMS found that between 2000 and 2004 the volume of physician services grew at nearly 5 percent a year. The payment system for physicians needs to be changed so that they are encouraged to provide appropriate, high quality services. Even though MedPAC has proposed a wealth of alternatives in developing a long-term solution, there is no easy answer to address the issue of cost, and the cost is significant.

Scrapping the SGR formula and replacing it with an index similar to the MEI costs $262 billion over 10 years. Providing just a freeze in payments from 2007 levels costs $34 billion over 10 years. Year after year, we've enacted temporary fixes to the problem of Medicare payments for physicians.

These temporary fixes failed to address the underlying flaws with SGR and only make any future fix more expensive. What was a $218 billion problem last year is now a $262 billion problem this year.

We need to work together with MedPAC, the administration and physician groups to come up with a reasonable solution to the cost issue. Once the cost is resolved, Congress can start looking at long-term alternatives to the SGR formula, and we start paying physicians for the quality not the quantity of their services.

Again, I thank the Chairman for holding this hearing and I yield back the balance of my time.

Chairman STARK. There we go. Glenn, why don't you proceed in any way you'd like?

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

Mr. HACKBARTH. Thank you, Chairman Stark and Ranking Member Camp, Members of the Subcommittee. I appreciate the opportunity to talk about our report on alternatives to Medicare's SGR system.

As requested in the congressional mandate, MedPAC has analyzed the pros and cons of expenditure targets in general as well as the five options included in the mandate. We present to you two alternative policy paths for your consideration, one that does not include an expenditure target, repeals the SGR and does not replace it; the other would have an expenditure target although one structured significantly differently than the current SGR.

As you well know, MedPAC is a 17-member commission whose members are drawn from clinicians and healthcare executives and academics and former government officials. Despite the diversity of the commission, we have generally been very, very successful in reaching consensus on our recommendations to the Congress. Alas, in this particular case, it's not been possible to forge a consensus on all aspects of the SGR issue.

To help you understand where the commissioners do agree—and there are important areas of agreement—as well as where we disagree, I've divided the SGR problem into four dimensions. If you look at the slides, you see those four dimensions, and I will very, very briefly describe those each in turn.

The first is encouraging efficiency in the delivery of healthcare. When I use the term "efficiency," what we mean, what MedPAC means, is maximizing the benefit to patients for any given level of expenditure. The important point is efficiency is not just about reducing cost. It also includes consideration of the quality of the service provided.

So, increasing efficiency is an important, vital goal for the Medicare Program. There is unanimous agreement within MedPAC that expenditure targets themselves do not establish appropriate incen-

tives for efficiency. You've heard this before in previous MedPAC testimony on SGR.

Let me give you a couple examples. By constraining only the amount paid per unit of service, we fear that at least in some instances the expenditure target may induce inappropriate or cost increasing behavior that has little or no benefit for patients. Moreover, of course, we feared that payments that are too low, for example, as a result of sustained, repeated cuts in the payment rate, could end up impeding access to important beneficial care.

To establish proper incentives for efficiency in the Medicare Program, Congress must pursue the agenda briefly described on this slide. These four points are very broad. There's lots of detail behind them. I'm not going to, in my opening statement, go into that detail but I would refer the Committee to pages 17 and 18 of my written testimony for some additional detail, and I'd be happy to discuss them further during the questions and answers.

The commission is unanimous in believing that these sorts of steps are the policy changes needed to improve efficiency in the Medicare Program. It's not an easy agenda, but it's an urgent agenda and one that requires substantial investment in CMS's capability to develop, implement and refine payment systems. We're making progress on this agenda, but at this point it's far too slow given the needs of the Medicare program.

Let me go back to the dimensions of the SGR problem. The second is encouraging fiscal discipline in policymaking. As I just said, expenditure targets don't establish appropriate incentives for providers. Well, why would you want to use them?

Here is an issue where there is a division within the commission. There is a group of commissioners who believe that expenditure targets could be useful in establishing discipline in the policymaking process. To be real blunt about what that means, targets could be used to limit future increases in Medicare payment rates for providers.

In addition, this group of commissioners believes that having an expenditure target system in place may create a change in political dynamics and create the political leverage to force providers to accept reforms that they might otherwise resist.

The third bullet is Increasing Equity Among Regions and Providers. All MedPAC commissioners, substantially all the commissioners, agree that the existing SGR is highly inequitable in important respects. If the target is exceeded, all physicians are punished equally, regardless of their individual performance. Moreover, all regions of the country are treated equally even though there's abundant evidence that healthcare delivery is more efficient in some areas than others. Finally, the SGR targets only physicians when Medicare has a total cost problem not just a physician cost problem.

With those points in mind, the commissioners who favor expenditure targets believe that it will be possible to develop a fair or more equitable system, one that applied to total Medicare costs, that applied greater pressure in high cost regions than low cost regions, and one that allowed an opportunity for groups of providers to band together in what we refer to as Accountable Care Organiza-

tions that would be then be assessed on their own performance against the congressionally set targets.

Make no mistake, however, that making expenditure targets more equitable in this way, expanding them to parts A and B, geographically adjusting and so on, is not an easy task. Time, patience, determination, and not a little money would be required to accomplish that task. Without adequate time, patience, determination and money, the risk of failure and unintended consequences would increase.

The last of the four dimensions is minimizing or offsetting the budget score. MedPAC does not have a magic solution for the growing SGR budget gap, which was referred to earlier. It's in the hundreds of billions of dollars.

I would remind the Committee, however, that we have made proposals that could make a substantial contribution toward filling that gap, that budget gap. For example, the CBO says that the 10-year cost of repealing SGR and replacing it with an MEI-based update would be roughly $250 billion. CBO also estimates that MedPAC's proposals for going to financial neutrality for Medicare Advantage plans would save $160 billion. Couple that with restraint on updates for other providers. As you know, MedPAC has often recommended update factors lower than the baseline in the budget, and those proposals add up to a substantial contribution toward that $200-some billion cost for the repeal of SGR.

With that, Mr. Chairman, I'll stop. I welcome your questions.

[The prepared statement of Mr. Hackbarth follows:]

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

Chairman Stark, Ranking Member Camp, 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 afternoon to discuss alternatives to the sustainable growth rate (SGR) system used in Medicare's physician payment system.

Medicare pays for physician services on a fee-for-service basis using a resource-based relative value scale. Each service is assigned a weight reflecting the resources needed to furnish it. Payment is determined by multiplying a service's weight by a national physician payment rate, called the conversion factor.

Currently, as specified in statute, the annual update to the conversion factor is determined under the SGR, based on an expenditure target that is tied to growth in the gross domestic product (GDP). The SGR is widely considered to be flawed; it neither rewards physicians who restrain volume growth nor punishes those who prescribe unnecessary services. Some critics contend the SGR may actually stimulate volume growth. Other observers believe that, despite its flaws, the SGR has helped curb the increase in Medicare spending for physician services by alerting policymakers that spending is rising more rapidly than anticipated and constraining the ability of policymakers to increase fees.

Slowing the increase in Medicare outlays is important; indeed it is becoming urgent. Medicare's rising costs, particularly when coupled with the projected growth in the number of beneficiaries, threaten to place a significant burden on taxpayers. Rapid growth in expenditures also directly affects beneficiary out-of-pocket costs through higher Part B and supplemental insurance premiums as well as higher co-payments.

The Deficit Reduction Act of 2005 (DRA) requires MedPAC to examine alternative mechanisms for establishing expenditure targets. We also considered ways to reconfigure the existing SGR to improve its performance. We have reviewed the pros and cons of the different alternatives and outlined two possible paths for the Congress to follow. Significant disagreement exists within the Commission about the utility of expenditure targets. Moreover, the complexity of the issues makes it difficult to recommend any option with confidence. Absent careful development and significant

investment, the risk that a formulaic expenditure target will fail and have unintended consequences is substantial.

Despite disagreement about expenditure targets, the Commission is united on this: Whether or not the Congress elects to retain some form of expenditure target, a major investment should be made in Medicare's capability to develop, implement, and refine payment systems to change the inherent incentives in the fee-for-service system to reward quality and efficient use of resources while improving payment equity. Examples of such reforms include pay-for-performance programs for quality, improving payment accuracy, developing incentives to coordinate care, using comparative-effectiveness information, and bundling payments to reduce overutilization.

An expenditure target, however designed, cannot substitute for improvements to Medicare's payment systems; at best, it may be a useful complement. An expenditure target alone will not create the proper incentives for individual physicians or other providers; indeed, there is a risk that—in the absence of other changes—constraint on physician fees will stimulate inappropriate behavior, including the very increases in volume and intensity that the target system purports to control. It is better to think of an expenditure target as a tool for altering the dynamic of the policy process than as a tool for directly improving how providers deliver services. An expenditure target alerts policymakers that spending is rising more rapidly than anticipated and leads to an annual debate over the update to the physician payment rate. That debate may also influence the behavior of providers: To avoid rate decreases, they could be compelled to support payment reforms that they might otherwise find objectionable.

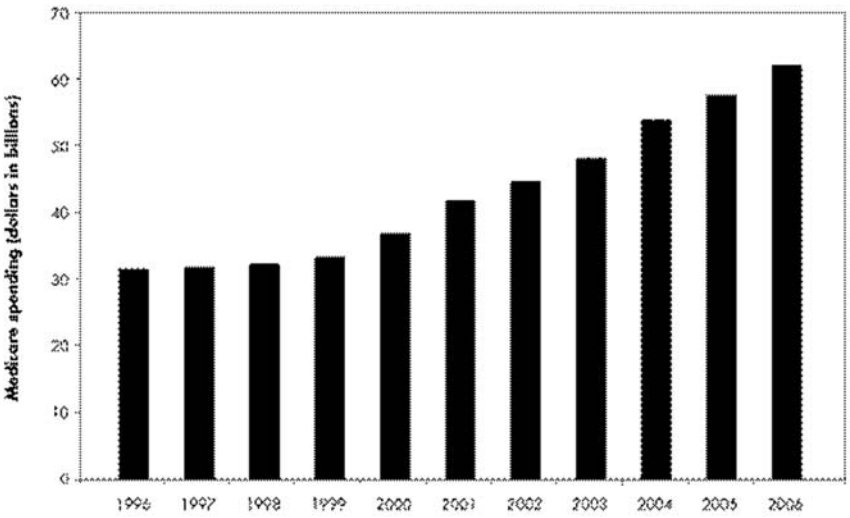
The Congress, then, must decide between two paths. One path would repeal the SGR and not replace it with a new expenditure target. Instead, the Congress would accelerate development and adoption of approaches for improving incentives for physicians and other providers to furnish higher quality care at a lower cost. If it pursues this path, the Congress would need to make explicit decisions about how to update physician payments. Alternatively, the Congress could replace the SGR with a new expenditure target system. A new expenditure target would not reduce the need, however, for a major investment in payment reform. Regardless of the path chosen, Medicare should develop measures of practice styles and report the information to individual physicians. Medicare should also create opportunities for providers to collaborate to deliver high quality care while restraining resource use.

If the Congress chooses to use expenditure targets, the Commission has concluded that such targets should not apply solely to physicians. Rather, they should ultimately apply to all providers. Medicare has a total cost problem, not just a physician cost problem. Moreover, producing the optimal mix of services requires that all types of providers work together, not at cross purposes. For example, physicians and hospitals must collaborate to reduce unnecessary admissions and readmissions. If used, an expenditure target should be designed to encourage all types of providers to work together to keep costs as low as possible while increasing quality. The Congress may also wish to apply targets on a regional basis, since different parts of the country contribute differentially to volume and expenditure growth. Moreover, high-spending areas have not demonstrated higher quality of care.

The sustainable growth rate system

Each year, CMS follows the statutory formula to determine how to update fees for physician services to help align spending with the SGR's expenditure target. The SGR allows growth in spending due to factors that one would expect to affect the volume of physician services: inflation in physicians' practice costs, changes in enrollment in fee-for-service Medicare, and changes in spending due to laws and regulations. In addition, the SGR includes an allowance for growth above these factors based on growth in real GDP per capita. Growth in GDP—the measure of goods and services produced in the United States—is used as a benchmark of how much additional expenditure growth society can afford.

Figure 1. FFS Medicare spending for physician services, 1996–2006



Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance.
Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

The SGR system has been widely criticized. In recent years expenditures for physician services have grown substantially, suggesting that the SGR does not provide a strong check on spending (Figure 1). It does little to counter the inherently inflationary nature of fee-for-service payment. In addition, the SGR is inequitable, treating all providers—regardless of their behavior—and all regions of the country alike.

The SGR also fails to distinguish between desirable increases in volume and those that are not. Some volume growth may be desirable. For example, growth arising from technology or changes in medical protocols that produce meaningful improvements to patients, or growth in services that are currently underutilized, is beneficial. But research suggests that some portion of volume growth does not advance the health and well-being of beneficiaries. In geographic areas with more providers and more specialists, research has found that beneficiaries receive more services but do not experience better quality of care or better outcomes, nor do they report greater satisfaction with their care.

Table 1. Cumulative actual expenditures for SGR-related services exceeded SGR-allowed expenditures starting in 2002

Year	Cumulative expenditures (in billions)		Difference (in billions)
	Allowed	Actual	
1996	$36.6	$36.6	N/A
1997	86.6	85.9	$0.7
1998	138.7	135.8	2.9
1999	194.1	188.4	6.7
2000	253.4	246.4	7.0
2001	316.4	312.2	2.7
2002	382.5	383.6	−1.1
2003	454.5	461.8	−2.3
2004	531.2	548.9	−17.7
2005	611.3	640.0	−28.7
2006	693.0*	734.9*	−41.9*

Note: SGR (sustainable growth rate), N/A (not applicable). Cumulative allowed and actual expenditures are as of calendar year end. Pursuant to the Balanced Budget Refinement Act of 1999, the SGRs for 2000 and all subsequent years are estimated and then revised twice by CMS, based on later data.
*Estimated.
Source: CMS 2006. Estimated sustainable growth rate and conversion factor, for Medicare payments to physicians in 2007. November.
http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2007f.pdf.

Medicare spending for physician services has exceeded targeted spending for several years, resulting in the SGR calling for cuts in physician payment rates (Table 1). The Congress has repeatedly prevented these cuts from being implemented without changing the SGR formula or the target. As a result, the cumulative SGR formula calls for larger fee cuts in multiple years. The Medicare trustees project that the SGR will call for annual cuts of about 5 percent well into the next decade. The trustees characterize this projected series of negative updates to physician fees as "unrealistic" because the Congress is unlikely to allow them. But the federal budget's baseline includes the large fee cuts, making it costly from a budgeting perspective to give zero updates, much less increase fees. If they were implemented, large cumulative cuts would likely compromise access to care. They might also have the unintended consequence of spurring volume growth as physicians attempt to maintain their income.

Using Medicare's physician and other payment systems to improve value

Medicare should institute policies that improve the value of the program to beneficiaries and taxpayers (see text box, p. 14). Those policies should reward providers for efficient use of resources and create incentives to increase quality and coordinate care. Policies such as pay for performance that link payment to the quality of care physicians furnish should be implemented. At the same time, Medicare should encourage coordination of care and provision of primary care, allow gainsharing arrangements, bundle and package services where appropriate to reduce overuse, ensure that its prices are accurate, and rethink the program's benefit design and the effects of supplemental coverage. To reduce unwarranted variation in volume and expenditures, Medicare should collect and distribute information about how providers' practice styles and use of resources compare with those of their peers. Ultimately, this information could be used to adjust payments to physicians. Findings from comparative-effectiveness research should be used to inform payment policy and furnished to beneficiaries and providers to inform decisions about medical care. Finally, concerted efforts should be made to identify and prevent misuse, fraud, and abuse by strengthening provider standards, ensuring that services are furnished by qualified providers to eligible recipients, and verifying that services are appropriate and billed accurately and that payments for those services are correct.

The Congress needs to provide CMS with the necessary time, financial resources, and administrative flexibility to make these improvements. CMS will need to invest in information systems; develop, update, and improve quality and resource use measures; and contract for specialized services. In the long run, failure to invest in CMS will result in higher program costs and lower quality of care.

DRA-mandated alternatives to the SGR

The DRA requires that we examine the potential for volume controls using five alternative types of subnational targets—geographic area, type of service, group practice, hospital medical staff, and physician outliers—and consider the feasibility of each. Policymakers should recognize that, by their very nature, these alternatives can only attempt to control total expenditures, not volume. Each alternative has advantages and disadvantages, but without accompanying payment policies that change the inherent incentives of fee-for-service payment, the ability to influence the behavior of individual physicians will be limited.

The Commission has not provided budgetary scores for the alternatives. MedPAC does not produce official scoring estimates. Further, many of the alternatives' administrative implications are unknown. For any of the alternatives, details of the formula—including where the target is set, how to deal with the existing difference between the target and spending, and whether the target is applied only to physician services or is extended more broadly—are the important determinants of projected total spending. Efforts to relax the current SGR (e.g., softening or eliminating the cumulative formula) will be costly under current baseline assumptions. However, the Congress may be able to maintain some expenditure control by retaining the expenditure target in some form.

Geographic area alternative

The geographic area alternative would apply targets to subnational geographic areas. Setting different fee update amounts by region acknowledges that regional practice patterns vary and contribute differentially to overall volume and expenditure growth. Use of different regional updates would improve equity across the country and over time could help reduce geographic variation. However, it is not clear what the optimum geographic unit would be. Choosing the unit involves tradeoffs between physician accountability, year-to-year volatility, and administrative feasibility. Using smaller units, such as hospital referral regions, might increase physician accountability but would also increase year-to-year volatility and be difficult to

administer. Large units, such as states or Part D regions, are more stable and are easier to administer but include too many physicians to encourage accountability.

Using different regional updates would not entirely address the inequities of the current system; for example, a physician who practices conservatively in a high-volume region would still be penalized. Using different regional updates could also create wide disparities in payment rates by area. Beneficiaries crossing the boundaries of geographic areas to seek care also would be an issue that would have to be resolved.

Type-of-service alternative

A type-of-service alternative would set expenditure targets for different types of services, as was done under the volume performance standard (VPS), which preceded the SGR. (Under the VPS, three targets were established—for evaluation and management services, surgical procedures, and all other services.) A type-of-service expenditure target recognizes that expenditure growth differs widely across types of services. Some might prefer this type of target because it would differentiate between services with the greatest growth in volume and expenditures and those with the smallest. This alternative also could be designed to boost payments for primary care services, which some believe are undervalued.

But service-specific targets present a number of difficulties. One problem is that, under such targets, inequities across services and specialties could arise. In addition, setting service-specific targets would implicitly require Medicare to know the optimal mix of services. This would be difficult, since the optimal mix of services will evolve with changes in the population served, patterns of illness, and medical knowledge and technology.

Multispecialty group practice alternative

The Congress asked MedPAC to analyze an alternative to the SGR that might adjust payment based on physicians' participation in group practices, since some studies suggest that physicians in multispecialty group practices may be more likely to use care management processes and information technology and to have lower overall resource use. But considering the small share of physicians in multispecialty groups (20 percent), and that not all group practices engage in activities that improve quality and manage resource use, payment policies focusing solely on group status may not effectively elicit the desired behavior. Further, using separate targets for group and nongroup physicians could be viewed as inequitable, since efficient physicians in smaller nongroup practices would be ineligible for the payment updates that physicians in multispecialty groups would receive. In addition, rural physicians may have few, if any, opportunities to join group practices. Such small groups of physicians would also increase year-to-year volatility and could be difficult to administer. Establishing payment incentives for performing specific activities associated with better care and lower resource use would likely be more effective than using separate targets based on group practice status.

While the Commission has not recommended a multispecialty group alternative for an expenditure target, such groups may still be an important locus for many of the policy changes that MedPAC believes are important. For example, these groups could serve as accountable care organizations (ACOs), together with independent practice associations (IPAs), hospital medical staffs, and other organized groups of physicians. The Commission's preliminary research has found that beneficiaries who regularly see physicians in multispecialty groups appear to use fewer resources than other beneficiaries. Multispecialty groups may be more likely to incorporate incentives to control resource use and monitor and influence practice styles, which may encourage providers to better coordinate care and ensure that patients are appropriately monitored and receive necessary follow-up care.

Hospital medical staff alternative

A hospital medical staff target system would use Medicare claims to assign physicians and beneficiaries to one type of ACO based on the hospitals they use most. Even if some physicians have little or no direct interaction with a hospital, they can be assigned to the group based on the hospital most of their patients use. This option creates a virtual physician group using the extended hospital staff as the organizational focal point. Initially, Medicare could collect and distribute information about the practice patterns of different groups. Ultimately, that information could be used to adjust payments for differences in resource use and quality.

Using hospital medical staffs as ACOs could better align incentives to control expenditures. The hospital could provide an organizational locus for physicians in the area to come together to monitor and influence practice styles. Although the size of the groups would vary substantially, each of them would be much smaller than the current national pool. Individual physicians could therefore more readily see a

link between their own actions and their group meeting its target. Over time, this alternative is intended to induce physicians and other providers to practice more as a system, optimizing care delivery and reducing overall expenditures.

There are significant barriers to this alternative. Some argue that hospitals and physicians are competitors who will not easily collaborate with one another, making this type of ACO an unlikely vehicle for change. Such small groups of physicians would increase year-to-year volatility and could be difficult to administer. Physicians may resist having Medicare assign them to an entity to which they may feel little or no affinity. Physicians who rarely refer patients for hospital care may be particularly resistant. Finally, there may be additional legislative changes to allow sharing of funds that would be required to implement this alternative.

Outlier alternative

Medicare could identify physicians with very high resource use relative to their peers. CMS could first provide confidential feedback to physicians. Then, once greater experience and confidence in resource-use measurement tools were gained, policymakers could use the results for additional interventions such as public reporting, targeting fraud and abuse, pay for performance, or differential updates based on relative performance.

The major advantage of this alternative is that it would promote individual accountability and would enable physicians to more readily see a link between their actions and their payment. However, a number of technical issues would need to be resolved. Implementation of an outlier system based on episode groupers may prove difficult if physicians cannot be convinced of the validity of episode grouping tools. Physicians will need to be confident that their scores reflect the relative complexity of their patient mix and that they are being compared to an appropriate set of peers. There would likely be considerable controversy around initial physician scores as some physicians realized that their practice patterns were not in line with those of their peers.

Reconfiguring the national target system

We also considered a reconfiguration of the current national target. For example, the current system could be changed to moderate or eliminate the cumulative aspect of the spending targets. Another option is to implement an additional allowance corridor around the allowed spending target line. Both options would relieve some of the budget pressure and result in more favorable updates but also would increase total expenditures and would not change the inflationary incentives inherent in fee-for-service payment.

Other changes could be made to the physician payment system to address services that are growing quickly. Such growth may signal that relative prices for those services do not reflect the time and complexity of furnishing them. In examining such services, the Secretary would need to take into account changes in both the number of physicians furnishing the services to Medicare beneficiaries and the number of hours physicians worked. CMS could use the results from these analyses to flag services for closer examination of their relative work values. Alternatively, the Secretary could automatically correct such mispriced services and the Relative Value Scale Update Committee could then evaluate these changes during its regular five-year review.

Choices for the Congress on expenditure targets

There are two paths the Congress could take. The Commission did not reach a consensus on which path is best. The issues surrounding the use of expenditure targets are complex, the information requirements are many, and the full effects are almost unknowable; in addition, the risk of failure and unintended consequences is high. Nevertheless, some Commissioners believe it is prudent to retain an expenditure target to limit rate increases and to provide leverage with providers to encourage them to embrace reforms they might otherwise oppose. At the same time, other Commissioners fear that undue restraint on rates may impede access to care in the long run. Moreover, across-the board restraint that fails to distinguish between good performers and poor performers may encourage providers to engage in undesirable behavior to maintain their profitability—for example, ordering services of marginal value or seeking to furnish services with payments that are high relative to costs.

Despite disagreement about the utility of expenditure targets, the Commission is united on this key point: Whether or not the Congress elects to retain some form of expenditure target, a major new investment should be made in Medicare's capability to develop, implement, and refine fee-for-service payment systems to reward quality and efficient use of resources while improving payment equity, as discussed below. An expenditure target, however designed, is not a substitute for improving Medicare's payment systems; at best, it may be a useful complement. An expendi-

ture target by itself cannot create the proper incentives for individual physicians or other providers. A target is a tool for improving the dynamics of policymaking, not health care delivery.

Following are two alternative paths for the Congress to consider.

Path 1

The first path would repeal the SGR. No new system of expenditure targets would be implemented. Instead, the Congress would accelerate development and adoption of approaches for improving incentives for physicians and other providers to furnish lower cost and higher quality care (see text box, p. 14). Increasing the value of Medicare in this way will require:

- Changing the payment incentives. Policies must be implemented that link payment to the quality of care physicians and other providers furnish. MedPAC's pay-for-performance recommendations would move toward correcting the problem of lack of incentives for quality care. At the same time, Medicare needs to encourage coordination of care and provision of primary care, ensure that its prices are accurate, allow gainsharing arrangements, and bundle and package services where appropriate to reduce overuse. ACOs like physician groups and other combinations of providers can be encouraged as a means to improve quality and reduce inappropriate use of resources. Medicare should also rethink the program's benefit design and the effects of supplemental coverage.
- Collecting and disseminating information. Variation in practice patterns may reflect geographic differences in what physicians and other providers believe is appropriate care. To reduce this variation, providers need information about how their practice styles compare with those of their peers. Ultimately, such information could be used to adjust payments to physicians. In addition, findings from comparative-effectiveness research should be used to inform payment policy and furnished to beneficiaries and providers to inform decisions about medical care. Both of these are activities in which collaborating with the private sector could lead to wider adoption and greater impact.
- Redoubling efforts to identify and prevent misuse, fraud, and abuse. This effort includes supporting quality through the use of standards, ensuring that services are furnished by qualified providers to eligible recipients, and verifying that services are appropriate and billed accurately and that payments for those services are correct.

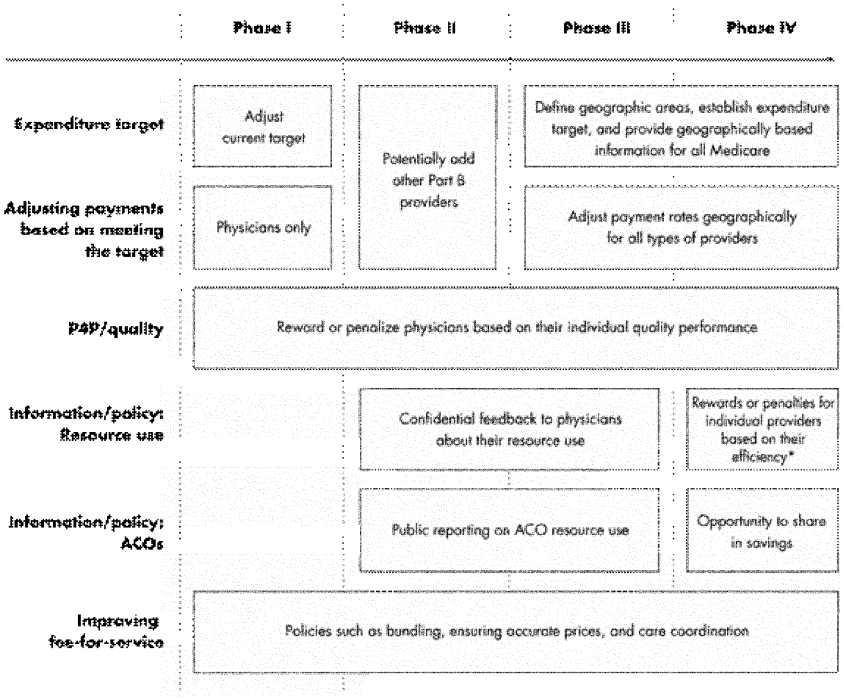
Path 2

The second path would pursue the approaches outlined in path 1 but would also include a new system of expenditure targets (Figure 2). As policymakers grapple with the budgetary consequences of volume and expenditure growth, the presence of an expenditure target may prompt more rapid adoption of the approaches in path 1, since it will put financial pressure on providers to change. If the Congress determines that a target is necessary to ensure restraint on fee increases, the Commission has concluded that such a target should embody the following core principles:

- encompass all of fee-for-service Medicare,
- apply the most pressure in the parts of the country where service use is highest,
- establish opportunities for providers to share savings from improved efficiency,
- reward efficient care in all forms of physician practice organization, and
- provide feedback with the best tools available and in collaboration with private payers.

In keeping with these principles, the expenditure target should not be borne solely by physicians. Rather, it should ultimately be applied to all providers to encourage different providers to work together to keep costs as low as possible while increasing quality. The Congress should also consider applying any expenditure target on a geographic basis, since different parts of the country contribute differentially to volume and expenditure growth. If an expenditure target reflects the limits of what society wants to pay, the greatest pressure should be applied to those areas of the country with the highest per beneficiary costs and the greatest contribution to Medicare expenditure growth.

Figure 2. Timeline for path 2



Note: P4P (pay for performance), ACO (accountable care organization).
*Providers receive rewards or penalties if they are not part of ACOs.

Geographically adjusted targets, even if applied at the level of metropolitan statistical areas, are still too distant from individual providers to create appropriate incentives for efficiency. Creating proper incentives for improved performance—whether for physicians or other providers—will require much more targeted incentives. Rewards and penalties must be based on the performance of provider groupings that are small enough for the providers to be able to work together to improve. Therefore, within each geographic area, measurement of resource use would show how physicians compare with their peers and would reveal outliers. The comparisons could show the resource use of individual physicians and of groups of physicians belonging to ACOs, such as integrated delivery systems, multispecialty physician groups, and collaborations of hospitals and physicians. ACOs, in turn, would have to meet eligibility criteria but would then be able to share savings with the program if they furnish care more efficiently than the trend in their area. Episode groupers and per capita measures are tools for measuring resource use, and they could become tools that define payment adjustments for physicians who remain committed to solo or small practice outside the confines of larger organizations.

This expenditure target system would address three goals simultaneously. First, it would address geographic disparities in spending and the volume of services. Second, by departing from the existing national SGR and allowing providers to organize into ACOs, it would improve equity and encourage improvements in the organization of care. Third, providers would receive actionable information to change their practice style.

Improving Medicare's value

Medicare should change payment incentives by:

Linking payment to quality by basing a portion of provider payment on performance. The Commission has found that two types of physician measures are ready to be collected: structural measures associated with information technology (such as whether a physician's office tracks patients' follow-up care) and claims-based process measures, which are available for a broad set of conditions. To implement pay-for-performance, CMS must be given the authority to pay providers differentially based on performance. Such a program should be budget neutral, with monies set aside redistributed to providers who performed as required.

Encouraging coordination of care and use of care management processes, especially for chronic care patients. There are a number of care coordination and care management models Medicare could implement. For example, beneficiaries with chronic conditions could volunteer to see a specific physician or care provider for the complex condition that qualifies them to receive care coordination/care management. That physician would serve as a sort of medical home for the patient. Payment for services to coordinate care would be contingent on negotiated levels of performance in cost savings and quality improvements.

Ensuring accurate prices by identifying and correcting mispriced services. CMS should reduce its reliance on physician specialty societies to identify misvalued services so that overvalued services are not overlooked in the process of revising the physician fee schedule's relative weights. CMS should also update the assumptions it uses to estimate the practice expenses associated with physician services. Further, CMS should initiate reviews of services that have experienced substantial changes in volume, length of stay, site of services, practice expense, or other factors that may indicate changes in physician work.

Allowing shared accountability arrangements, including gainsharing, between physicians and hospitals. Such arrangements might increase the willingness of physicians to collaborate with hospitals to lower costs and improve care.

Bundling services. Bundling puts providers at greater financial risk for the services provided and thus gives them an incentive to furnish and order services judiciously. Candidates for bundling include services typically provided during the same episode of care. Bundling the hospital payment and the physician payment for given DRGs could also increase efficiency and improve coordination of care.

Promoting primary care, which can lower costs without compromising quality. Medicare should create better incentives for providers to furnish primary care (e.g., by ensuring accurate prices for primary care services) and for beneficiaries to seek it (e.g., by changing Medicare's cost sharing structure).

Rethinking Medicare's cost-sharing structure and its ability to steer beneficiaries to lower cost and more effective treatment options.

Medicare should collect and disseminate information by:

Measuring physicians' resource use over time and sharing results with physicians. Physicians would then be able to assess their practice styles, evaluate whether they tend to use more resources than their peers (or what available evidence-based research recommends), and revise their practice styles as appropriate. Once greater confidence with the measurement tool was gained, Medicare could use the results for payments—for example, as a component of a pay-for-performance program that rewards both quality and efficiency. CMS could also use the measurement tool to flag unusual patterns of care that might indicate misuse, fraud, and abuse.

Encouraging the development and use of comparative-effectiveness information to help providers and patients determine what constitutes good quality, cost-effective care. Comparative-effectiveness information could also be used to prioritize pay-for-performance measures, target screening programs, and prioritize disease management initiatives. Given the potential utility of this information to Medicare, and given concerns about the variability in methods and the potential bias of researchers conducting clinical- and cost-effectiveness research, a public-private partnership may be warranted. For example, the federal government could help set priorities for research, while funding could come in part from drug manufacturers, health plans, and pharmacy benefit managers.

Improving Medicare's Value (*Continued*)

Medicare should improve program integrity and provider standards by:

Using standards, where appropriate, in physician offices to ensure quality. MedPAC has recommended that CMS impose quality standards as conditions of payment for imaging services. Other types of services may be candidates for standards as well.

Continuing to improve program integrity, capitalizing on the opportunity presented by administrative contractor reform. Contractor reform may also provide an opportunity for Medicare to enhance its ability to measure performance, improve quality of care, and encourage coordination of care.

Chairman STARK. Thank you, Glenn. You intertwine in your recommendations and throughout your report issues like efficiency and quality and behavior in terms of overutilization, I suspect, in those sorts of areas. Can a payment policy address all those issues or are we to bifurcate this and just say, look, we'll have to deal with quality and limitation, overutilization, those sorts of things, in separate regulations and just deal with the pay system without regard to that?

Mr. HACKBARTH. Yes. Well, we think that using payment policy to change behavior, both to reduce cost and improve quality, makes sense. That's not to say that it's an easy thing to do, but it makes sense, and we think that there's abundant evidence that providers respond to payment policy and change their behavior accordingly. We've got 25 or 30 years of experience that shows just how dramatic those changes can be particularly in terms of reducing cost.

Using payment policy to increase quality is admittedly a newer endeavor where we don't have the same track record, but in fact we think it could be useful there as well.

Chairman STARK. As I said, I don't have a question except ones that I think you don't want to answer. We are—as you know, you and I have discussed this and these alternatives at some length.

The easy way out is to deal with this just for next year and hope that the reimbursement fairy puts the plan under our pillow sometime between now and 2008, also partly I suppose, to kick some of it back to CMS. I would ask, are there—how much can they do administratively toward resolving this?

Mr. HACKBARTH. So, the question is?

Chairman STARK. Does CMS have a lot more latitude to make, in your opinion, administrative decisions that will resolve some of the volume quality problems that we should be after them to take as opposed to trying to solve all of this in a legislative way?

Mr. HACKBARTH. Well, if you look at that agenda that's on pages 17 and 18 of my testimony, there are important parts of that agenda that CMS does have the authority to do by regulation. An example of that is improving pricing accuracy, as we call it.

We believe that there are some services within the physician fee schedule that we're paying too much for. Since we pay too much for them there is a profit opportunity that's attracting capital, attracting effort on behalf of physicians, and we're increasing expenditures without a commensurate increase in value for patients.

So, that pricing agenda, which really doesn't apply just to physicians; it applies to hospitals and post-acute providers. Those are areas where CMS can work largely on its own. Going to new payment approaches that encourage and reward coordination of care like the medical home idea as one example, those would generally require legislative changes. So, our agenda for improving efficiency of value is a mixture of regulatory and legislative actions.

Chairman STARK. Following on that, I believe that MedPAC has suggested that we are under-funding CMS for the increasingly complex nature of their work and the volume involved. Do you want to comment on that?

Mr. HACKBARTH. Yes, I do. That's very important from the perspective of the commission. This agenda, laid out on pages 17 and 18, is a complicated agenda. There is no silver bullet for these problems. At the same time, the clock is ticking financially with the retirement of the Baby Boom Generation, so the fiscal pressures facing the program are about to escalate dramatically.

We think that the pace of improvement needs to accelerate dramatically and we don't think that the pace is slow right now because CMS is just sort of sitting back with their feet up on the table. We think there are real issues about their capacity to develop, implement and refine new payment systems, so we need to expand that bottleneck so that we can move some of these ideas from concept through demonstration to implementation and ongoing refinement much more quickly than we do right now.

Chairman STARK. Thank you. Dave.

Mr. CAMP. Thank you, Mr. Chairman. The March 1 report, MedPAC report says that Medicare access to physician services remains stable, but I'm hearing different things from my constituents in mid- and northwestern Michigan, in rural areas particularly. How will a new physician payment system safeguard access and enhance access, frankly?

Mr. HACKBARTH. Well, a couple points. From a national perspective, we believe that access to care for Medicare beneficiaries remains good, and we draw that conclusion based on both surveys of physicians and of patients.

Having said that, it's also clear to us that there are pockets, areas within the country where there may well be acute problems, but on a national basis, we don't think that there is a big problem.

To assure ongoing good access to care for Medicare beneficiaries, we need to, of course, assure that the basic payment rates are adequate, and we fear that continued cuts of the sort that are now mandated by the SGR would threaten access to care. In addition to that, we think that by refining our payment systems we can help assure access. A particular concern in some parts of the country is access to good primary care, and we think that in fact in important respects Medicare may be underpaying for good primary care, and that's an important part of the agenda that is in my testimony. So, that is also important in retaining access.

As you know, Congress, in addition to that, has taken a number of targeted actions directed at payment for rural physicians where there are special additional payments for shortage areas, a limit on the geographic adjuster—floor under the geographic adjuster and

so on, and those sorts of targeted measures can be part of the response as well.

Mr. CAMP. Physicians just began reporting quality information this year. That's a major step in policy change. What other steps could be taken, at least in the interim, to ensure that we get the right information?

Mr. HACKBARTH. Well, the reporting obviously is a critical step for examining the quality of services provided by physicians. Are you talking more generally about information in the program?

Mr. CAMP. Information, what other steps we might take.

Mr. HACKBARTH. To get additional information on performance?

Mr. CAMP. Well, and also to ensure that we're getting quality care and not simply volume as well. It's really two sides to it.

Mr. HACKBARTH. Well, another path that the commission thinks is important to explore is information on the effectiveness of alternative treatments that could in turn guide both physicians and patients. Important, albeit a small step, was taken in that direction with the MMA funding, as I recall, $15 million for comparative effectiveness research. We think that's small compared to the magnitude of the task at hand, and we think that a much larger investment in what is truly a public good, information about what works, is called for, and the Federal Government ought to take a lead in doing that.

MedPAC will be looking at some ideas on how such an effort might be structured, where it might be housed, and hopefully we'll be making some recommendations on that in the future.

Mr. CAMP. In follow up to what Mr. Stark mentioned, it seems as though some of this could be done administratively by CMS. In particular, your comment that we're paying too much for some services, that seems to me that's not an issue for the Congress but that's an issue for CMS to address. Why have we not seen more proposals from them?

Mr. HACKBARTH. Well, in fairness to CMS, there have been some proposals. As you know, an important part of the process is a regular reevaluation of the relative values built into the physician fee schedule, and there is a periodic review of those relative values.

Just this past year, some changes were made that resulted in increases in relative payment for evaluation and management services. We believe that there are some design issues in that process that we've made recommendations to CMS on that could help advance that agenda still further.

Generally speaking, CMS has been receptive to recommendations of that sort, but again there's a question of resources and how many different things they can work on at one time.

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

Mr. DOGGETT. Continuing on this same line of questioning, is it a matter of resources at CMS or do we need to give them greater legislative authority?

Mr. HACKBARTH. More discretion, more latitude? Is that what you mean, Mr. Doggett?

Mr. DOGGETT. Well, this issue of whether it could resolve this problem internally or whether we needed to act each year has come up again and again, and I'm just trying to get a more general understanding of whether they lack all the statutory authority they need to address this problem or it is, as you were just telling Mr. Camp, more a matter of resources.

Mr. HACKBARTH. Well, if the issue is the relative values, I think that they have the discretion that they need. It may be more of an issue of resources than discretion. As you well know, issues like the payment update for physicians and other providers are generally set by statute. CMS and the Secretary do not have discretion on that score. Whether giving them discretion would advance the cause or not, I think there's no clear right answer to that. There are pluses and minuses.

In terms of developing and implementing new payment systems, I think that there's an interesting, important process ongoing with the Medicare Health Support Pilot Project, which was established under MMA. This is to help manage patients with chronic illnesses. What I want to focus on is not so much the merits of the design but the fact that it was set up as a pilot. So, here's an idea that Congress wanted to explore; let's test it in a systematic way, and then, if it works, give the Secretary the authority to move toward implementation as opposed to coming back through the legislative process again.

I think that pilot model may have a lot to recommend it.

Mr. DOGGETT. You indicated to Mr. Stark and in your written testimony that there was a determination that some types of services we're paying too much for already.

Mr. HACKBARTH. Right.

Mr. DOGGETT. What are some examples of those?

Mr. HACKBARTH. Well, an area that has been of concern to the commission is imaging services. It's fairly technical, arcane stuff, but the process by which those prices are set that Medicare pays we think may have some bad assumptions in it and as a result specific services may be overpriced and therefore unusually profitable.

We've recommended to CMS that they institute a process for an ongoing systematic review of those relative values. There's certain indicators that they could look at to detect a possibility of overpayment like changes in technology, the practice expense.

When a new service is implemented often it comes in with a relatively high value, but physicians learn by doing it over time. The price ought to come down over time, but it doesn't; it stays at the high value.

So, there's some indicators that we think CMS could look at to systematically identify potentially overvalued services to be adjusted.

Mr. DOGGETT. You've indicated in the recommendations that we need to incorporate the concept of payment on performance.

Mr. HACKBARTH. Yes.

Mr. DOGGETT. How might a system that moved more toward pay for performance work in practice for the average family physician?

Mr. HACKBARTH. The commission has made a series of recommendations on pay for performance, applying not just to physi-

cians but hospitals, dialysis facilities, Medicare Advantage plans and the like. In some respects, pay for performance for physicians is more complex, more challenging than say, for hospitals or Medicare Advantage plans.

It's more challenging and complex for a couple reasons. One is there are so many more physicians than hospitals, for example. They tend to be much smaller units. We have, as you well know, many solo practices and small group practices. They have weaker informational infrastructure than the institutional providers and the like.

So, we think that it's important to move ahead with pay for performance for physicians but to do so carefully and select measures that we have reason to believe could have a particularly important quality benefit for Medicare beneficiaries.

Let me just speak for myself here as opposed to the whole commission. I'm a little concerned about a willy-nilly process for developing new measures for physicians: More is automatically better; we've got to have more measures for every physician type, without any attention being paid to the benefit for patients of changing performance on a particular measure or the cost associated with collecting the information.

So, I think some care needs to be taken with physician pay for performance in particular that we get a good benefit-to-cost ratio as we choose and implement new measures.

Chairman STARK. Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

You said in your statement that things were happening far too slow in the system and yet your indications are that you don't want to go with any top speed to any of these changes. One of the things I'd like you to talk about is for years we've been saying that the information that's available out there is not accurate and they're working with 2- or 3-year-old data. They refuse to go to the private system for upgraded data.

Now can you talk to that issue for me?

Mr. HACKBARTH. Not to that specific issue, Mr. Johnson. Certainly, I agree with the premise that too often the Congress and MedPAC for that matter work with outdated information, but I'm not aware of CMS's response.

Mr. JOHNSON. You all didn't even look into that in your study?

Mr. HACKBARTH. Not in this particular report, but we've looked into it in the past.

Mr. JOHNSON. So, you can't talk to it? How do we fix it?

Mr. HACKBARTH. In terms of how you revamp the system?

Mr. JOHNSON. Yes.

Mr. HACKBARTH. That is a technical question that is beyond the expertise of a commission like ours. That's an operational question for operational experts. We are consumers of that information.

Mr. JOHNSON. But you like to deal with old information, is that true?

Mr. HACKBARTH. That's precisely the opposite of what I said, Mr. Johnson. We have repeatedly said that it's a problem that much of the information we use is outdated.

Mr. JOHNSON. We've been dealing with this for 10 years at least. Now tell me why no one has figured out how to get current data.

Mr. HACKBARTH. Well, MedPAC is a group of part-time commissioners. We meet seven times a year. We don't run the Medicare program. That's a question best directed to CMS.

Mr. JOHNSON. You made the statement also that imaging was a high expense item. You mean, is it more expensive because we have to hire it out to get it done nowadays instead of having it in the doctor's office for immediate activity?

Mr. HACKBARTH. I don't know that that makes imaging more expensive. I think that there can be a case made in some instances for having in-office imaging as we've said in previous reports. We are concerned however that that can lead to overuse, and we've also expressed concern about the quality of the imaging that results.

Mr. JOHNSON. Yes, I understand that it's more expensive for the patients, too. They have to travel.

Let me ask you one more question. Can you differentiate—you suggest that maybe geographically inferences should be made to control expense and yet I remember we used to have that, precisely that. In the area of Dallas that I'm from we have two counties right next to each other, both of them highly metropolitan and yet one of them was a metropolitan area and the other was a rural area. As you know, the payment schedule was totally different.

How are you going to avoid that if you go back to metropolitan areas for example? New York city is going to get all the money; New York and Los Angeles.

Mr. HACKBARTH. Let me distinguish between two things. Medicare's payment systems for physicians, hospitals, all over providers, include geographic adjustments. They include geographic adjustments to try to match the payment level to the underlying cost of delivering the care. That continues today. That's not old news; that's current news.

What is suggested in the SGR report is something different, which is to look at the total expenditures per Medicare beneficiary on a regional basis. The thinking there is that there are some parts of the country that contribute more to Medicare's cost problems than others.

There's a dramatic variation in Medicare costs per beneficiary, and so the proponents of a geographic system—and they are a subset of the full commission, not the entirety—the proponents of such a system say, if we've got a Medicare cost problem, we ought to apply more pressure on the high cost areas than the low cost areas; that's only fair.

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

Chairman STARK. Mr. Thompson like to inquire?

Mr. THOMPSON. Thank you, Mr. Chairman. I do.

Thank you for being here.

I'd like to talk a little bit about the issue of expenditure targets. If in fact we go to a different type of expenditure target, how do we avoid getting into the same situation we're in now with the targets that we have? Any advice on it?

Mr. HACKBARTH. Well, the crux of the problem right now is that we have a target, in this case for physician services, of the gross domestic product (GDP), that is totally disconnected from the reality of healthcare delivery. So, we establish a target, lift payment updates to that target without a plan for how we would actually change utilization patterns to get them in line with the target goal of growth with GDP.

When the SGR was established, the growth trend was higher than GDP. It's not enough to legislate a lower target. You've got to change policy to try to bring the curve down.

Mr. THOMPSON. My concern is if we change those policies, establish a new type of target, we run into the same problems. What do you recommend we do to avoid running into that?

Mr. HACKBARTH. Yes. So, even the proponents of expenditure targets within the commission believe that the agenda that's laid out in my testimony, pages 17 and 18, you've got to do that in addition. You can't expect expenditure targets by themselves to solve the problem. You've got to go through Medicare's payment systems for physicians and all the others and change them and change the incentives if you want to change the long-term trend. Targets by themselves will not do that.

Mr. THOMPSON. Thank you. The other thing I wanted to talk about is the idea of the group practice model. Do you think this is accurate? Is this a good way to deal with providing services and at the same time controlling expenses?

Mr. HACKBARTH. Well, I'm hardly unbiased on this question. I used to be the CEO of a very large multi-specialty group. I'm frankly a believer in multi-specialty group practice as a way to improve quality and efficiency. Having said that, it would only be fair to say that it's not just a group practice, per se, that we want to encourage. It's not a legal form. It's not an organizational structure. What we want to encourage is particular results.

So, rather than just promoting group practice, the commission's view is let's reward the results; let's reward higher quality; let's reward better coordination of care.

Mr. THOMPSON. The multi-specialty model would get you there is what you're saying?

Mr. HACKBARTH. Many multi-specialty group practices are very good at those things, but not all.

Mr. THOMPSON. So, how do you use that model or that theory in areas such as mine, rural areas where it's harder to put that, to identify those sub-specialties and putting them together?

Mr. HACKBARTH. That's precisely why, a good example of why the commission didn't say, well, multi-specialty group practice is the answer for Medicare. There are many parts of the country where it wouldn't work well, we don't have the provider infrastructure for that model to work well, we don't have the patient volume for that model to work well.

So, could it work well in some places but not others? In a rural area, potentially hospital medical staff could serve as an organizing element. Medicare might at least give the opportunity for rural providers to coalesce around a hospital or a small hospital system and have that as an organizational structure for payment.

Mr. THOMPSON. But there was that understanding that in some areas it's difficult if at all possible?

Chairman STARK. Mr. Ramstad. He's not here? Mr. English, would you like to inquire?

Mr. ENGLISH. Thank you, Mr. Chairman. I would.

Mr. Hackbarth, stipulating one of the suggestions you presented here as a path that replaces the SGR with a new system of expenditure targets, it's obvious from your presentation that there was not an agreement within MedPAC on the issue, so obviously there might be some resistance from stakeholders as well.

I wonder though, in any system of expenditure targets, how much we should be worried about ultimately creating a system where there is rationing. How do you assess that risk? Given the challenges facing Medicare in the out years, what should we be prepared to do to position the Medicare system and specifically SGR to limit that risk?

Mr. HACKBARTH. We think an important part of the response is to invest more in understanding the effectiveness of different treatments and the ability to actually compare different treatments. The way the system works now, all too often we almost—not just pay for but pay even more for something because it's new without a clear understanding of whether in fact it is bringing additional benefit to patients and certainly without an understanding of whether the additional benefit is equal to the added cost.

That's a luxury that's going to be increasingly difficult for the program to afford as the Baby Boom Generation retires and all the demographic forces shift dramatically in a different direction. So, as to avoid sort of blind rationing of healthcare, what we need is more information to guide thoughtful decisions about appropriate utilization.

So, in the case of an expensive new treatment, rather than just saying, well, we can't afford new stuff, it may be that that new treatment is useful or has a high benefit applied to a particular subset of the patient population. If we have the right information we can target those expensive new initiatives on those patients who will benefit and help assure that they're not applied more indiscriminately in increased costs without commensurate benefit. So, information is a key part of the solution.

Mr. ENGLISH. Also a key element of information is the sorts of quality standards that are implicit in any system of pay for performance. Judging from your presentation, you feel pay for performance is a significant part of the solution in repositioning the Medicare system.

When it comes to paying physicians, I've focused on pay for performance in some other areas of the Medicare system. Do you believe that with the range of specialties, with the range of services that we're trying to reimburse here, that pay for performance can be developed to a degree to be sensitive enough to provide really the right incentives. Is this a system that we will be able to develop to the degree necessary to achieve real benefits?

Mr. HACKBARTH. Yes. I believe the answer to that is yes, it can. Although as I said earlier, I think that the task is markedly more complex for physicians for reasons that we've talked about. Therefore it's important to proceed with care and thoughtfulness,

focus on areas for example where we think that there would be a particularly large benefit to the Medicare population. If we can improve care for certain types of illness, the gains could be significant. If we could improve coordination of care between physicians and hospitals to avoid unnecessary admissions and readmissions, there could be a substantial benefit for that. So, a targeted, thoughtful approach for physicians is what I think is called for.

Chairman STARK. Mr. Becerra.

Mr. BECERRA. Mr. Hackbarth, thank you for being here with us. Let me ask you to give us a little bit more information about your sense, MedPAC's sense about how CMS can implement and operate within this new world that we may ultimately devise. Does CMS, in your mind, have the resources and capacity to take this to a new level, a different place with what it currently has or will it have to reorganize some, bring in new folks, change certain concepts, get new technology and equipment, what will they have to do to get us to a point where they could actually make this whatever it is work?

Mr. HACKBARTH. Well, as I said earlier, a significant investment is required. The information infrastructure would be a very important part of that.

Mr. BECERRA. Let me stop you there. "Significant," define "significant?"

Mr. HACKBARTH. We are really not the right people to try to provide all the estimates on that. What you would need to do is do a very detailed review of the agency, its existing operations, where the greatest opportunities are.

Mr. BECERRA. By using the word "significant," that implies that the way things are right now in CMS will not cut it?

Mr. HACKBARTH. In our view, doing more of the same will not cut it. You are going to have two former administrators here who have more recent experience than I do.

Mr. BECERRA. I am hoping to ask them as well, maybe they will give me more specifics on the actual numbers.

Mr. HACKBARTH. They will probably be able to do that.

Mr. BECERRA. In your opinion, have we established within CMS the type of expertise that can guide us in the direction that we need to go and will give us the expertise to try to help implement whatever we do?

Mr. HACKBARTH. Well, again, Bruce and Gail can probably address that better than I. I am concerned that we do not have all the right expertise within the agency and that over time perhaps we have had a drain of expertise from the agency. It is not an easy place to work these days, the expectations are enormous, the resources are not growing equal to the expectations, it is a tough place. When you create that environment, it can be difficult to recruit and retain the sort of people you need to make a program work. So, there are complicated issues there. As I said, they are well beyond MedPAC's specific expertise. What we see is we are customers of their product much as you are, and see good people working hard to do their best for the program, for the Congress but often lacking necessary resources.

Mr. BECERRA. In this effort to get away from the cookie cutter approach that we currently live with, invariably we are going to

run into the tensions that exist between the various interests involved. I know that coming from southern California, where you have a very high cost ratio for anything, not just medical services, health care services, that it is going to be important to know that we do a better job of determining what are costs really are, but that, as I said, invariably implies that you are going to have the tensions between those who are currently getting reimbursement rates that they like to try to help adjust for those who are not getting what they like. Your sense of whether or not we can actually parcel this down to a point where we do a better job of targeting the reimbursement dollar to those who are providing a quality service, is it, given this political environment that we are in, possible to get those stakeholders who are currently in the system to make adjustments that will allow us to try to more appropriately direct the dollar?

Mr. HACKBARTH. The politics of change is a whole different dimension. I have sort of focused on the technical aspects of developing and implementing new payment systems. To the extent that you are changing payment systems, often you are redistributing money, redistributing incomes, shifting resources geographically. As is obvious from your question, you have experienced first-hand how difficult and painful that can be. I would not be doing this if I did not tend to be an optimist about the ability to make improvements over time. The progress is not always a straight line, but I do think that in general we make progress, but Bruce Vladeck and I were talking before the hearing about the difficulty of improving things like the hospital wage index. We can come up with ideas for how that could be a better index that more accurately reflects costs in different communities. A lot of the problems right now are political. It is not that we cannot figure out how to do it technically, it is how to make it happen politically.

Mr. BECERRA. You have left a lot for Bruce and Gail to answer.

Mr. HACKBARTH. Yes, and they will be good at it.

Mr. BECERRA. I thank you for your time. I yield back, Mr. Chairman.

Chairman STARK. Thank you. Mr. Hulshof?

Mr. HULSHOF. Thank you, Mr. Chairman. I think he is a great set-up man, isn't he, Xavier, for our next panel. Mr. Hackbarth, what is interesting is scattered throughout the capital complex, and I guess even at Walter Reed itself, there is a lot of attention being paid to quality of care in the Veterans Administration and, of course, a natural reaction given the revelations about substandard out-patient care, we have similar challenges looking down the road, Medicare, perhaps falling plaster and mold, but the fact that we are going to have nearly 80 million senior citizens living longer, the Baby Boomer generation's retirement is imminent, the first Baby Boomer reaches 62 in just about 300 days, and so the challenges, and we have talked about them, we have talked around them some as well, the challenges are monumental, although a bit different than of course what is being discussed in the VA system. I want to kind of piggyback on what my friend from California, and I mean no disrespect by this as far as the geographical alternatives and the proponents. I presume that the idea would be that Congress would provide CMS with additional rulemaking authority.

The reason I make that presumption is because when the Chairman gaveled this hearing to order, I noticed my good friends from Las Vegas, Los Angeles, Saint Helena, and Freemont Hills, obviously the West would be well-represented, my friend from Fargo, and with due respect to the gentleman from Austin, having lived through a BRAC commission and seeing the politics of the base realignment system, how do we take politics out of it? I think that is sort of a generic comment, and I think you were nodding along. I presume then CMS, looking at the cost per beneficiary would be—and allowing CMS then to establish this formula as is current law, as you pointed out to Mr. Johnson?

Mr. HACKBARTH. Well, let me begin by reminding you that this is a sub-set of MedPAC——

Mr. HULSHOF. I understand.

Mr. HACKBARTH (continuing). Is interested in the idea of geographic expenditure target. The issue about exactly how you operationalize it is not one that we have delved into in detail. We have done, both in this report and in previous reports, is provided data to the Congress on just how much variation there is in Medicare expenditures per beneficiary. Given the complex nature of the task, it might be good to provide some discretion to the Secretary and not to try to write rigid formulas into statute. The SGR experience has illustrated to us when you try to write a formula into statute that is going to run indefinitely into the future, circumstances can change and you may regret what you have written in, but once you write it in, it affects the budget baseline and it becomes very difficult to change. So, introducing some element of secretarial discretion could be a way to take off the sharp edges of such a system.

Mr. HULSHOF. Okay.

Mr. HACKBARTH. But it doesn't have any politics by any stretch.

Mr. HULSHOF. I am intrigued by and I appreciate pages 17 and 18, which are a good summary I think of the entirety of your written statement, and so let me pull the panel a live grenade and if you want to leave that grenade on the table for our next panel, so be it. One of the things that you reference in your bullet points on page 17, again shared accountability arrangements and you mention gain-sharing.

Mr. HACKBARTH. Yes.

Mr. HULSHOF. Specifically, physicians collaborating with hospitals. Then the next bullet point down as well, bundling services, bundling both the hospital payment and the physician payment for a given DRG. Again in the pure policy vacuum of course that is helping to increase efficiency. Without naming names of members of this panel, there have been some that have made some strong statements about each of those and both of those. So, just the remaining time I will give you what comments about the bundling or the collaboration suggestions you give us?

Mr. HACKBARTH. The objective behind both of those is to get physicians and hospitals to work together to find ways to reduce costs and improve quality. On the Commission, we have got hospital executives and physicians, people that have a lot of experience with that interaction and there is a real sense of distress about how the payment system is often sort of a wedge between pro-

viders. Far from encouraging collaboration, they actually discourage it. At the extreme, what we end up with is things like physicians going into competition with hospitals and not collaborating in the interest of patients but let's look at this as competing businesses and each maximize our share of the pie. In the long run, that is not good for patients, that is not good for Medicare. So, we are trying to find ways to bring physicians together with hospitals to improve care. We see gain-sharing and bundling of hospital and physician payments as potential paths to get that team work back into the program.

Chairman STARK. Mr. Pomeroy.

Mr. POMEROY. Thank you, Mr. Chairman. Well, continuing on that thought just expressed, do you think Congress should extend the moratorium on physician specialty hospitals?

Mr. HACKBARTH. MedPAC, I guess it is 2 years ago, as you know, Mr. Pomeroy, did a report and we did not recommend continuation of the moratorium. We did make a number of other recommendations, importantly changing the payment system so that we pay more accurately for some of the services that are most popular, popularly provided through physician-owned hospitals. To be blunt about it, to take away what we think is an inappropriate profit opportunity in some services, some cardiac services, for example. CMS has taken some initial steps in that direction but not really as far as we recommended in our report. We think that is a better approach to dealing with specialty hospitals, fair pricing. We also think we ought to give physicians and hospitals some ways to collaborate together and share in the savings. Right now, if physicians have a better way about how to deliver hospital care, the program says to them, "Well, go out and start your own hospital and then you can share in the profits." If you collaborate with the hospital administration, you cannot share in those efficiency gains. So, the system is skewed toward let's go compete physicians against hospitals as opposed to let's collaborate together in the interest of better care for our patients.

Mr. POMEROY. I am going to say Sam Johnson's comments hold true for me as well, there is a little bit of frustration here from my part anyway relative to utter lack of guidance from MedPAC. You are saying that integrated systems produce more beneficial and cost-effective results and yet you are not for continuing the moratorium. Take a look at the SGR problem and think it needs to be fixed, maybe should there be a target, maybe there should not be. It sure would be good if we had pay for performance but you do not have that fleshed out. To me, it reminds me really of what the Secretary of Health and Human Services when he said he sure looks forward to working with us on a long-term fix and there is not a nickel in the budget past a 1 year patch for a long-term fix. Everyone is just kicking this thing down the road and not getting around to any meaningful effort to get their hands around it. I think what you have said relative to the strength that integrated delivery systems flies in the face of MedPAC's position against extending a ban on specialty-owned hospitals, and I find that disappointing. Out in the rural areas that I represent, we have achieved something quite remarkable for Medicare and that is high quality at low cost. We have done it because the clinics and the

hospitals have become single entities and it has produced I think a superior result on the metrics that MedPAC has developed itself to evaluate these things. What might you offer us in terms of guidance for incentives that we can put forward to drive this kind of cost effectiveness. You mentioned one, whack the reimbursement for certain specialty items. Do you have pay scales that you would advance for us to consider in passing those recommendations on to the Secretary, how do we begin doing that? Secondly, what else do you offer?

Mr. HACKBARTH. Well, again, the summary version of what we are proposing is on pages 17 and 18. Behind each of those points there is a lot of detail, including in many instances past MedPAC recommendations. I would be happy, Mr. Pomeroy, to sit down with you and go through it in as much detail as you would like. I do not think that it is true that we have not made specific proposals. It is true that we have not come up with a single silver bullet but that is the nature of the problem. Anybody who tells you that they have got a solution for this frankly is not being honest with you. It is not one change, it is a lot of changes and a lot of changes over time.

Mr. POMEROY. I am new to the Subcommittee and I am late to this hearing so I have a little more homework to do. At the same time, I think it is just critical we redouble our efforts here and look forward to the Chairman's leadership in terms of as we try and draw the most out of MedPAC that we possibly can for near-term legislative action. Thank you.

Chairman STARK. Well, I guess I would just respond and let Mr. Camp respond for himself, I do not know of I think any very objective group or institution that really has suggested a solution to the SGR. I do not think either Dave or I have determined what we can do. You add into that the budgetary constraints that we face and you compound it. So, MedPAC I am sure will be glad to evaluate anything we would propose that may differ or be a combination of the solutions they suggest. I think that the fact that they are split, I do not know as I have ever asked Glenn how you are split out of the 17, how are you split out of the 17, 10 to 7?

Mr. HACKBARTH. I am only sure of the expenditure targets. It is pretty much down the middle, Mr. Chairman.

Chairman STARK. I rather suspect that that is what you would find among of all of our colleagues on both sides and how you come together with a way to meet budget targets. My theory is that when everybody in the room is scowling, you have got the right solution and you drop the gavel. If anybody is smiling like you are, you got away with something from North Dakota, and I am not sure that Mr. Becerra is going to let you take that out of Los Angeles so that is what we are faced with. I am quite sure at least that it is minimally partisan. So, I think we have to look to MedPAC as a good example of what we will face, all the divisions in the provider community, most all of the interests that are represented in MedPAC by the commissioners. We have plenty of time for a quick second round for anybody who wants it but then we will hear from two people who have worked on this from before. We can come around again, sure.

Mr. CAMP. Well, thank you, Mr. Chairman, I appreciate those comments. The letter we have in our materials from the acting director of the Center for Medicare Management kind of goes through this problem and talks about the significant growth in volume and intensity of Medicare physician services and then says, "We have not been able to come to a conclusion as to the causes of this sustained increase." So, they have not even come to an agreement as to how and why it is happening, much less come to an agreement over a solution here, which makes it very difficult for a legislative body to act. It really does help if we can get that.

Mr. HACKBARTH. Can I just pick up on that, Mr. Camp, because I think that is really the crux of the matter? The growth in health care services and spending in general, as well as physicians specifically, is a complicated phenomenon. A lot of it is good. Some of it is due to wonderful new technology that leads to better outcomes for patients, and we for sure do not want to discourage that. On the other hand, what you find there is a lot of stuff that is expensive, low value, and done principally because it is high profit. So, that underlying trend is not either good or bad, it is some of each.

We talked, Mr. Chairman, about the split in the Commission. One way to think about that split is we get half the Commission that says the underlying trend has a lot of good stuff in it, we do not want to use therefore the meat ax approach that might damage that good stuff. We need much more targeted adjustments, refined adjustments and payment policy so that we do as well as we can to encourage the good stuff and penalize the bad stuff. The other half of the Commission says, yes, there is good stuff and bad stuff in that underlying trend but the problems facing the Medicare program, the fiscal challenges facing Medicare, and the Congress more broadly, are so great that we need to run some risks and use more of a heavy-handed approach, if you will. That is a risk worth running. I suspect you talked to other groups of "experts" if we can be called that, and you will find we are split. Some people say the cost problem is so urgent, dramatic action is required and dramatic action would be a total cost Medicare expenditure limit. Other people do not see it that way. It is because this underlying trend has good and bad stuff.

Mr. CAMP. Well, I do think this sort of sawtooth that providers and physicians have been subjected to for the last few years has really not been acceptable, where we go up to the eleventh hour and finally come up with a solution. It is ultimately, being a physician is running a business as well and they do need some certainty. I think it is certainly a very difficult issue but the current process that we have been under for the last few years just doesn't seem to be acceptable but again I do not have any clear answers for what direction to take, but I want to thank the Chairman for the opportunity to question again.

Chairman STARK. Mr. Thompson had a solution, he assured me but he left before he shared it with me.

Mr. CAMP. I think some of that depended on administrative help that did not come our way.

Chairman STARK. Mr. Becerra?

Mr. BECERRA. Mr. Chairman, just briefly. Mr. Hackbarth, it is a comment and a question. The comment is I know there are politics even within your group and it must have been difficult but the politics get really tough once you get over here to this place. It is almost a little discouraging, Mr. Chairman, that even within MedPAC the differences were so intense that we had two alternatives that were presented to us, which of course means that we will turn it into eight or who knows how many others. So, I do not know how it can be made any easier but you all are considered the experts on this policy-wise and technically, and I think it really would help as much as possible to get as clear a voice from MedPAC, and I know it is tough but that is the comment.

The question is this, as much as we may think we have come up with a silver bullet for this problem that we face within Medicare, to some degree we fool ourselves, don't we, if we do not take care of all of the other issues in health care generally because Medicare is one component of health care and providers are providing health care to recipients of Medicare but they are also providing it to folks who do not have access to Medicare, do not have access to any health insurance, and we do not really resolve it for all health care providers simply by addressing the problems we have with reimbursement rates under Medicare. So, a question for you, how do you see all that fitting into the greater issue of how we deal with the global issues of health care?

Mr. HACKBARTH. Yes, a couple of points. I think unanimously the commissioners, the people who choose to be on MedPAC and devote their time to it out of busy schedules, they are believers in Medicare and want to see the program succeed, believe in its mission, and are willing to donate a lot of time to that end. So, we are all believers. I must say though that there are a lot of commissioners who worry about the impact of Medicare on the broader health care system and whether through our payment policies in Medicare, we encourage a way of delivering health care, a style of medical practice that is increasingly unaffordable for the average American. So, when we have debates within the Commission, we have debates all the time about how we slow the increase in Medicare costs and make the program more efficient, increase the value, a sub-text in that is we need to do that not just for Medicare but for the broader health care system. The path we are on is unsustainable. We can be certain that more and more Americans are going to be without insurance coverage and have diminished access to care each year if we continue on this path. So, we need to improve Medicare not just for the beneficiaries but for the American people as a whole.

Chairman STARK. I want to thank you, Glenn. I guess we will see you again tomorrow for some more enlightenment and look forward to that. Thanks for spending a long day here on the Hill. We will now have our second panel, people that many of us have worked with over the years, Bruce Vladeck, who is addressed here as the president. I notice that we are just 2 days short of celebrating your first birthday as interim president of the University of Medicine and Dentistry. So, happy first anniversary. Are you still interim?

Mr. VLADECK. I am still interim.

Chairman STARK. You are still interim but you are just waiting and on the 8th of this month they will announce that you have been interim long enough. Welcome back. Gail Wilensky, who has long been associated with Project Hope and a variety of other policy and research organizations, who served also as head of what was then HCFA. I am going to call on you according to the order that you are listed here and let Bruce go and then we will hear from Gail. I am sure you are going to find many interesting comments and suggestions that they will make. Go ahead.

STATEMENT OF BRUCE C. VLADECK, PH.D., INTERIM PRESIDENT, UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY, NEWARK, NEW JERSEY

Mr. VLADECK. Thank you very much, Mr. Chairman and Mr. Camp, Members of the Subcommittee. It is a great pleasure and a privilege to be back before this Subcommittee. Again, I must start out with the necessary disclaimer though that I appear not as my role as interim president of a large Medicare provider but as the former administration of the HCFA, who spent four and a half years grappling with many of the same problems you are addressing today. I am not sure I can claim substantially greater success. In observation of your rules about time, let me just summarize very quickly a few of the points I sought to make in my written testimony.

The Medicare physician payment is now 15 years old and some of its deficiencies are increasingly apparent. Obviously, the SGR itself has left you in the possible situation of having to choose every year between reductions in physician fees, which might eventually imperil beneficiaries' access to physician services and modest increases, which reward the profligate and parsimonious alike and which have a particularly adverse effect on an already difficult enough Federal budget process. The problems with the SGR arise and turn, to at least some extent, from the extraordinary growth in procedural services, especially diagnostic procedures, being provided to the Medicare population, a rate of growth which many observers think is probably not clinically optimal.

In my view, however, the principal shortcoming of the payment system as it is now operating is the way in which it has been reinforcing the continuing erosion of primary care in the distribution of medical services in many communities. One of the principal goals of the Congress and the executive branch when the system was first created was to provide incentives to increase the supply of primary care services to the Medicare population and to communities in general by shifting payments away from diagnostic and surgical procedures to so-called cognitive services. For the first few years of the new payment system that desired goal seemed to be met, but in more recent years, the erosion of primary care availability has accelerated due at least in some part to the effects of the SGR itself as MedPAC's report notes, as well as to the inadequate characterization and price setting for primary care services in the fee schedule. This was not just a matter of taste, I don't believe. Many of the most serious problems in the performance of the health care system, particularly for Medicare beneficiaries with their higher burden of chronic illness and multiple medical prob-

lems, can be attributed, at least in part, to the inadequate availability of and economic pressures on family practitioners, general internists, geriatricians and other primary care providers. If you look at all the nations of the world which perform better than we do in terms of controlling health care costs well, having universal access to healthcare, and which have older populations than we do in the United States, you see one of the few characteristics that they have in common is a higher ratio of primary care providers to specialty providers than we have in the United States.

In my view, it is impossible to do everything at once in so complex an area as physician payment policy, as is evidenced by the MedPAC report itself, so we should focus on meeting a few key objectives. My priority would be to focus on reform of the payment system until we address the balance between primary and specialty care by doing the following: One, going back to the basic coding scheme and weighting for evaluation and management services. Second, then replacing the SGR with a formula similar to the Volume Performance Standards, which existed prior to the SGR, of which I think Dr. Wilensky was responsible for some of the original formulation in which we established separate growth targets for evaluation and management services and other kinds of procedures and encourage the faster growth of those services at the expense of others. I would also support expanded experimentation with additional case management or care coordination fees for primary care and adoption of economic incentives for the further development of multi-specialty group practices, which tend to internalize cross-subsidization of primary care services.

Given how complicated both the Medicare payment system is and physician services are out in the communities, I do not think there is a single set of changes that are likely to solve all of the problems with the current system, nor are we likely to get everything right the first time or the second or the third, but I believe that adoption of the proposals I have suggested would at least begin the process of turning around and moving us back in the right direction toward ensuring that primary care services will be the central building block of a more accessible and effective system of care for Medicare beneficiaries.

Again, I am honored to have the opportunity to be back before you today, and obviously I would be happy to respond to any questions after Dr. Wilensky's comments.

[The prepared statement of Mr. Vladeck follows:]

Statement of Bruce C. Vladeck, Ph.D., President,
University of Medicine and Dentistry of New Jersey, Newark, New Jersey

Mr. Chairman, Mr. Camp, Members of the Subcommittee, my name is Bruce C. Vladeck. I am Interim President of the University of Medicine and Dentistry of New Jersey, but I appear before you today not as a representative of that institution, but as a former Administrator of the Health Care Financing Administration who spent four and a half years grappling with the issues before you today. I very much appreciate the opportunity to share with you my views on the Medicare Physician Payment System and the report of the Medicare Payment Advisory Commission (MedPAC), which I believe has done its usual exemplary job of laying out the key issues and reporting the critical facts in an insightful and balanced way. Uncharacteristically, however, the members of MedPAC were unable to come to consensus on a single approach to the problems they addressed, which I believe reflects the complexity and difficulty of the problems we are facing.

The system by which Medicare pays for physician services obviously has a number of significant problems. Total expenditures are growing at a rate that poses an increasing burden on Medicare beneficiaries, in the form of out-of-pocket costs, Part B premiums, and Medicare Supplemental premiums, while also producing an excessive strain on the federal budget. At the same time, it is far from clear that those expenditures are buying anything like a proportional improvement in the accessibility or appropriateness of physician services beneficiaries are receiving. The ability of Medicare beneficiaries to receive physician services when they need them appears to be holding its own, except perhaps in a few specific markets, but not improving dramatically; the overall quality of physician services received by beneficiaries is probably improving, but not fast enough in the view of many experts and commentators; and the critically important problem of inadequate coordination among multiple providers of care appears, if anything, to be getting worse. More specifically, the Sustainable Growth Rate (SGR) formula, the focus of MedPAC's report and of today's hearing, has created a situation in which the Congress must, every year, either let stand an unacceptably large reduction in Medicare physician fees, or cobble together an arbitrary fix which, under the peculiar rules of the Federal budgetary process, have a particularly severe impact on the overall budget, and thus on the availability of funds for other pressing public priorities or for deficit reduction.

In my testimony today, I would like to make a few general observations about Medicare physician payment; offer a few general guidelines, based on years of often difficult experience, about payment systems, what they can and can't accomplish, and what is reasonable to expect from them; and then offer my own suggestions about the direction of future policy. In doing so, I would emphasize that these are extremely difficult problems, that we are unlikely to get everything right the first, second, or third time around, and that a certain humility on the part of all participants in the policy process would be entirely appropriate, given our historical experience.

Paying Physicians Under Medicare

This year marks the fifteenth anniversary of the implementation of the Medicare Physician Fee Schedule, but in my view physician payment still constitutes the most difficult and problematic aspect of Medicare reimbursement policies. Physician practice in this country remains enormously diverse: in the relative supply of physicians, the ways in which they are organized, historical patterns of both fees and utilization, as well as practice patterns. The role and significance of multiple specialties is critically important, and also varies considerably from one community to another. Physician fees, in and of themselves, account for less than one quarter of all Medicare expenditures, but physician decisions drive almost all of Medicare utilization and thus Medicare spending. Since both underutilization and overutilization are significant problems, often in the same communities and sometimes in the same practices, getting the incentives right is a Herculean and perhaps impossible task. Moreover, medical practice is extraordinarily, and perhaps increasingly, dynamic, as the impact of new procedures and new technologies is reinforced by competition among suppliers, hospitals, and physicians themselves. In that regard, it's impressive that the Fee Schedule works as well as it does, as is evidenced by the fact that most private payers, lacking plausible alternatives, now piggyback their own payment systems on Medicare's.

Yet it's important to remember that one of the major objectives of the reform in Medicare physician payment adopted by the Congress in 1989 was to redress the then-perceived imbalance between primary care and specialty services, by implementing a resource-based fee schedule that would increase the relative prices for cognitive services at the expense of procedural ones. In this regard, the early experience of the new system was quite successful, as it shifted literally billions of dollars from procedures to cognitive services, increased the relative incomes of office-based practitioners at the expense primarily of surgical specialists, and helped contribute to a modest shift in the development of more primary care resources in many communities.

Obviously, that trend did not continue, and the SGR itself may be partially at fault. As the MedPAC report documents so well, procedural services have fueled the growth in Medicare physician spending over the last decade, and because the SGR formula responds to disproportionate growth in one category of services by reducing future fees for all physicians, it in effect suppresses the growth in fees for cognitive services for which utilization is growing at a slower rate. Whatever the cause, the ratio of procedural to cognitive services is back to pre-fee schedule levels, and the proportion of young physicians entering primary care practices has fallen dramatically.

This is not just a reimbursement problem. In my view, almost any analysis of the shortcomings of the health care delivery system in this country leads back, sooner or later, to the relative shortage of primary care. Those nations whose health systems produce better outcomes than ours at lower costs are almost all characterized by a far higher ratio of primary care practitioners to specialists than the United States. In general, communities or health care systems with higher ratios of primary care providers to specialists are less expensive, and frequently provide care of higher quality. The significant problems of care coordination and continuity which MedPAC discusses in its report, and which are a major and increasingly-recognized source of problems in health care quality, are integrally connected to the interrelated shortage of primary care practitioners and contemporary economics of primary care practice. And this imbalance has particularly baleful effects for Medicare beneficiaries, with their higher burden of chronic illness, their multiple medical conditions, and their frequent difficulty in navigating an increasingly complex health care system. In my own view, then, no physician payment system can accomplish every objective one might desire for it, but if we focus on increasing the availability of primary care while simultaneously shrinking the specialty sector, we can achieve some of the most important objectives, including cost deceleration and greater care coordination.

Some General Observations About Payment Policy

In evaluating the MedPAC report, and thinking about what steps the Congress should take to address some of the problems caused by the SGR and more generally affecting Medicare physician payments, it may be helpful to consider some generalizations about what works and doesn't work more generally in Medicare payment policy. I offer the following observations, based both on my own experience in developing and implementing such policies and the broader literature.

First, you can only do so many things at once. If Medicare physician payment policy could insure adequate access for beneficiaries and reasonable cost containment, while not exacerbating the trends towards erosion of primary care and more procedure-oriented medicine, that would be a significant accomplishment. Other worthwhile goals for public policy, including improvements in quality of care, reductions in overutilization of selected procedures, and greater alignment of incentives between physicians and other providers, can be addressed through mechanisms other than the payment system, as the MedPAC report itself correctly emphasizes.

Second, you're never going to get everything exactly right the first time, so it's important to build the capacity to learn from actual experience and make appropriate changes in a timely way into policy design. I know it's somewhat heretical to suggest this in this setting, but that implies that the Congress might give serious consideration to giving more discretion to CMS in the operation of payment systems, rather than legislating rigid formulae like the SGR. Any resulting decisions which the Congress considers unacceptable can always be overruled legislatively.

Third, it's important not to overestimate how "scientific" the rate-setting process is, or can ever be. MedPAC, in its report, criticizes the pre-SGR Volume Performance Standards because it maintains separate targets for different categories of services. Over time, that produced different conversion factors which, according to MedPAC, "distorted" the initial weightings of those services, which were derived from resource-based relative values. But those weightings themselves were heavily colored by pre-existing practice patterns, not from any scientific formula. And the weighting methodology itself, due to a range of practical limitations, was hardly flawless. As the experience in trying to weight practice expenses in the fee schedule further bears out, when the data is poor and the preexisting status quo less than optimal, policy and political concerns are appropriate considerations, especially since they're likely to eventually dominate the decision-making process anyway. One should therefore be careful in arguing that one policy alternative is less "scientific" or technically defensible than another.

Similarly, it's an illusion to believe that complex payment systems can be extremely precise. Adjustments for regional variations, differential input prices, or changing technologies can never be as accurate as the theorists would desire. Rough justice is preferable to no justice at all.

Finally, since the world is extremely complicated and responses to new payment systems are not always predictable, more experimentation is often desirable. The MedPAC report calls for systematic testing of a number of alternatives to current payment methodologies, and I would wholeheartedly endorse such an approach.

Implications

Given all these considerations, I would offer the following personal recommendations, which are different from, but with a few exceptions not inconsistent with, the MedPAC recommendations:

- First, I would encourage a systematic re-evaluation of the relative weights assigned to Evaluation and Management services by replacing the current CPT codes for such services with any of several preferable alternatives. There's a school of thought that the major flaw in the Medicare fee schedule is its continued reliance on an obsolete and often misleading coding system, and the gruesome experience providers and payers alike have had with attempting to arrive at correct coding for E&M services suggests there has to be a better way. More accurate reporting of such services would, in my view, do more than anything else to redress the existing disincentives for primary care.
- At the same time, I would urge a return to the differential limits for different kinds of services that was embodied in the VPS, but abolished by the SGR. MedPAC's major objection to such an approach appears to be that it introduced "distortions" into the relative weighting system of the RBRVs, but as noted above, I think that objection is far from compelling. Policy and political considerations invariably creep into the process of weighting individual services; it might be far healthier to address them openly and explicitly.
- To further encourage the provision of primary care services in the Medicare program, I would strongly support MedPAC's recommendation for experimentation with the payment of additional fees for case management and care coordination. We actually have some experience with such mechanisms in programs of Primary Care Case Management in Medicaid, and while the circumstances surrounding such programs were radically different from the way in which the Medicare program generally operates, techniques for implementing such a program are well-established. In the interim, the literature on primary care suggests that some improvements in care coordination and case management will occur anyway as a result of increased reliance on primary care services themselves.
- I would also support MedPAC's recommendation that we experiment with incentives to encourage further growth in multi-specialty group practices. The difficulty of organizing and sustaining such practices in most communities is reflected in the fact that they still employ only 20% of practicing physicians, despite the demonstrated benefits in both quality and cost-effectiveness such practices display. Appropriate payment incentives may be necessary to overcome the apparent barriers to further development.
- Finally, I would argue that other worthwhile objectives for Medicare policy towards physicians, such as discouraging overutilization of selected services, redressing imbalances in physician supply and distribution, and—most importantly—improving quality of care, are best addressed by administrative and organizational mechanisms other than payment policies. MedPAC correctly notes that CMS possesses other administrative tools, often underutilized because of resource shortages or the general fixation on payment policy, to address such issues. Adequate consideration of each of these issues would require extensive analysis and discussion, presumably at another place and another time, but I would contend that, precisely because these are such important concerns, they should be addressed frontally, rather than as epicycles to an already too-complex process of calculating appropriate physician fees.

In summary, I would suggest that we replace the SGR with a modified form of its predecessor—a service-specific reinvention of the VPS formula, which prospectively adjusts conversion factors by major service categories. At the same time, we need to reevaluate the weighting of cognitive services, while exploring other means of encouraging greater care coordination and the evolution of multi-specialty group practices.

It is, again, a privilege and a pleasure to have the opportunity to appear before you, and I'd be happy to try to respond to any questions or comments you might have.

Thank you very much.

Chairman STARK. Thank you and with that, we will hear Dr. Wilensky's comments.

STATEMENT OF GAIL R. WILENSKY, PH.D., SENIOR FELLOW, PROJECT HOPE, BETHESDA, MARYLAND

Ms. WILENSKY. Thank you, Mr. Chairman, Mr. Camp. It is a pleasure to be back here. As you noted, I am currently a senior fellow at Project Hope and also, which many of you may not know, co-chairing a congressionally mandated Task Force on the Future of Military Health Care. I have somewhat broader experience with regard to Medicare, having had the privilege to be the administrator of HCFA but also chairing the Physician Payment Review Commission and then subsequently for four years the Medicare Payment Advisory Commission, and my views are shaped by those complex set of experiences.

I think we all agree on the goals of what we are trying to accomplish, which is moderate spending, maintain access, and encourage quality and efficiently provided services by the provider community. The spending goal is quite clear, I am definitely one of those who are extremely worried about the future sustainability and the financial impact on beneficiaries that not maintaining some control on Medicare spending will have for the Federal budget and for the country as a whole. I agree with Glenn Hackbarth's assessment that nationally access is not currently a problem in any systematic way but it is something we need to monitor as we go forward in the future, particularly if we try more aggressively to attack the spending problem.

When it comes to the provision of appropriate, efficiently provided quality care, there we do have a problem and it is not just Medicare's problem. We have many indications in terms of medical errors and patient safety statistics. If you look at the assessment of the likelihood of receiving appropriate care, when a person is a patient in a hospital, the average is about 55 percent, large variations in Medicare spending with very little to show at the high side for it. So, we have many signals that when it comes to appropriate, efficiently provided quality care, Medicare has a problem as does the rest of the health care system.

In general in trying to moderate spending, Medicare moved away from historic charges to administered pricing and with it to a bundling together of services. That has had a lot of impact, much of it good, in terms of trying to moderate spending without having to resort to expenditure targets. The history of the physician payment reforms, as you know, has had a different history. I would give Mr. Stark much more credit for the introduction of the Volume Performance Standard. I was the administrator who got to implement the Resource-Based Relative Value Scale and the Volume Performance Standard. Relative to the problems that occurred in the past, it attempted to solve many of those problems, increased payment for primary care, redistribute payments across urban and rural areas, and slow down what had been very rapid growth in spending when only the MEI had been used for the update. There were some anticipated problems with regard to volatility and the Volume Performance Standard was replaced with a SGR in the Balanced Budget Act (P.L. 105–217). We can debate whether or not that has actually changed the volatility much, there still is a lot of volatility.

When you look at the SGR or the Volume Performance Standard, it is clear that spending limits will limit spending if they in fact

are invoked, which as you know for the SGR has not been the case since 2002. The problem though is that it does not affect the volume and intensity behavior at the individual physician level and that is where the problem is that drives the Volume Performance Standard (VPS) or the SGR. Neither the Relative Value Scale nor the VPS nor the SGR encourage or reward physicians for efficiently produced high-quality care and that is a problem because we do have evidence that financial incentives can change behavior.

We have two paths that have been identified by MedPAC, repealing the SGR and trying to change the payment or putting the SGR everywhere. I actually regard them more appropriately as being sequential. I think you need to change the payment mechanism to move to more of a bundling of payment, and you can think about that on many dimensions, and I would go for almost any of them. When I was the administrator, we had the Coronary Artery Bypass Graft (CABG) demonstration where Part A and part B payments were bundled into a single payment. That seemed to have some good outcomes. I am a proponent of gain sharing, getting hospitals and physicians to work together and share the savings. I like the disease management demos. I think pay for performance has a lot to say for it, although it will work a lot better in integrated systems than with individual practices. Realigning incentives is critical, but I have also as of late been focusing on one other area and that is the need for better information. I believe if we are going to have smarter spending, which is critical, we need to allow payers and clinicians and the public to understand better what works when, for whom, under what circumstances, and that means a significant investment, and I even have some ideas about what that significant investment might be if we are going to go forward. The bottom line is we need to know more and we need to pay for it better. If this does not slow down Medicare spending, then I suspect we will move to an across-the-board expenditure cap for Medicare's future because we do need to moderate spending or we will have major problems for both the Federal budget and the American public.

Thank you.

[The prepared statement of Ms. Wilensky follows:]

Prepared Statement of Gail R. Wilensky, Ph.D.,
Senior Fellow, Project Hope, Bethesda, Maryland

Goals of Medicare: moderate spending, maintain access, encourage quality and efficient use of resources by providers.

Spending goal is clear: question of future sustainability and financial impact on beneficiaries. Access is not currently a problem. Provision of appropriate, efficiently-provided, quality care is—but not just a Medicare problem.

In general, Medicare has moved away from historic charges to administered pricing, prospective payment and "bundling" of services. Bundled services are updated with a "bottoms-up" approach and concerns about volume/intensity increases have been limited.

Physician payments have had a different history: can be characterized as a disaggregated fee schedule and a "top-down" updating strategy. When physician spending continued to grow rapidly in the 1980's, even with the introduction of the MEI, expenditure targets were introduced. The VPS was introduced in 1992 and the SGR after 1997. Both produced more volatility than expected and since 2002, scheduled fee reductions haven't been implemented.

The SGR will limit total spending by physicians but doesn't affect the volume/intensity of individual physicians and may even exacerbate their incentives to in-

crease services. Neither the RBRVS nor the VPS encourage or reward physicians for efficiently-produced, high-quality care.

MedPAC has identified two paths: repeal the SGR and focus on developing payments reforms for physicians or don't repeal the SGR and extend it to the rest of Medicare.

Possible to view these choices as sequential. Medicare needs to improve the value of what it buys, encourage the efficient provision of services and incent quality improvement and care coordination, in any case. For physicians, this means moving to a more aggregated fee schedule and this could mean eliminating the SGR. Creating the right bundles is hard and will mean difficult power shifts. Lots of interesting demos that may help: CABG demo, gain-sharing demos, disease management demos, Premier hospital payment demo, etc.

Realigning incentives is important but better information is also needed. Creating a comparative clinical effectiveness center to provide credible, objective data should also be considered.

Bottom line: Need to know more and pay for it better. If this doesn't slow down Medicare spending, across-the-board expenditure caps could be in Medicare's future.

Mr. Chairman and Members of the Subcommittee, thank you for inviting me here today to testify on strategies to moderate physician spending and alternatives to the sustainable growth rate (SGR). My name is Gail Wilensky. I am currently a senior fellow at Project HOPE, an international health foundation that works to make health care available to people around the globe. I have previously been the administrator of the Health Care Financing Administration, now known as the Center for Medicare and Medicaid Services, and also the chair of the Physician Payment Review Commission and the Medicare Payment Advisory Commission. I am here today to share my ideas on strategies to moderate physician spending under Medicare based on my views as an economist and my experiences in these various positions. My testimony reflects my personal views and should not be regarded as reflecting the views of Project HOPE.

My testimony reviews Medicare's attempts to moderate spending on physician services, the differences between strategies for physicians and other areas of Medicare, the successes and problems with the SGR as well as other strategies the Congress should consider in order to achieve its various goals for the Medicare program: moderating spending, maintaining access to quality care for beneficiaries and rewarding quality and the efficient use of resources by providers.

Moderating Spending on Medicare Services

Finding ways to moderate spending on Medicare services is clearly an important goal for the Congress to pursue. Numerous studies have indicated the long term problems regarding Medicare's fiscal sustainability and the pressures that Medicare and other entitlements will place on the Federal budget if ways aren't found to moderate the growth in Medicare spending. A third volume in the Brookings series on "Restoring Fiscal Sanity" devoted entirely to health care, including a chapter on Medicare that I have authored, will be released later this month, reinforcing this message.

In addition, rising Medicare expenditures, particularly for Part B, affect the beneficiaries of the Medicare program in at least two important ways. Part B premiums, currently set to cover 25% of Part B costs, increase with increased physician spending. Because of rapid spending in Part B, even with the SGR in place, Part B premiums have doubled from 1998 to 2006, increasing from $43.80 per month to $88.50. Secondly, each of the services carries with it a 20% co-insurance payment. Thus, increased spending affects the amount the beneficiary has to spend on co-insurance payments as well as on premiums.

While the importance and desirability of moderating Part B expenditures is readily apparent, the difficulty is finding ways that do so without negatively affecting beneficiary access and that also encourage the provision of high quality care. MedPAC reports regularly on what is known about access, largely from survey data, and to date, there does not appear to be any systematic problems with beneficiary access. That does not mean that access problems won't arise in the future and concern about potential future access problems presumably is the major reason that Congress has not implemented the reductions in physician fees that have been required by the SGR every year since 2002.

Unlike access, the information on the quality of care that is being purchased is more troublesome, although definitely not a Medicare-only issue. A series of studies by the Institute of Medicine, beginning with its 1999 report, To Err is Human, indicates that medical errors and quality in general, are a serious problem in the U.S., with as many as 100,000 lives lost annually because of patient safety and medical error issues. In addition, studies by Beth McGlynn from the Rand Corp. and others

have indicated that, on average, patients receive only 55% of the care regarded as appropriate for their medical condition.

Medicare's History in Moderating Spending

Implementing strategies to moderate spending in the Medicare program has been a focus for the agency administering Medicare and the Congress for at least the last three decades. Although initially reimbursement followed historical charges, that changed for hospital payments with the introduction of the prospective payment system in 1983 and the introduction of the Medicare Economic Index (MEI) for physicians in 1984.

In general, Medicare has used a system of administered pricing to set the reimbursement required for an efficiently produced service. Using administered pricing requires a methodology both to set the reimbursement and also to update it. For most services in Medicare, the movement has been increasingly towards "bundled" payments. This movement began with inpatient operating hospital services but has been extended to capital payments in hospitals, outpatient services, home care and nursing home payments. To update the reimbursement for bundled payments, Medicare uses a "bottoms up" strategy. In other words, estimates are made for the components in the bundle that are thought to be associated with increasing costs over time—an inflation measure for these components is specified usually in the form of an industry-specific input-price index called a "market basket"—and an adjustment is also made for productivity.

There has traditionally been less concern about potential volume increases for services that are paid as part of a bundle, either because "induced demand" for a bundled service is considered less likely or because gaming is more difficult. This is not to say there have been "no concerns" about volume increases and the effects that they could have on Medicare spending but the view has been that the aggregate nature of the bundled payment make volume changes less of an issue and that protections against "gaming" can be put in place. An example of such a protection is not paying for readmissions for the same DRG within a 30-day period of the discharge.

Physician payments have had a different history. Unlike the increasingly aggregated payments for most other services in Medicare, the fee schedule used to pay physicians is very disaggregated, involving more than 7,000 CPT codes. Also, unlike most other parts of Medicare, updates to the fee schedule are driven by a "top-down" strategy and since 1992 have been controlled by a spending target, initially the volume performance standard (VPS) and then after changes in the Balanced Budget Act, the sustainable growth rate (SGR).

Initially, physician fees were based on historical charges as were other parts of Medicare. This first period of physician payment under Medicare lasted for 20 years, from 1965 to 1984 and was associated with rapid increases in both charges and volumes of services. The second period of physician payments, from 1984 to 1991 used the Medicare Economic Index (MEI) to increase fees and was also associated with rapid growth in spending.

The experience from these two periods of physician payment strategies made clear that controlling fees alone with a disaggregated fee schedule like the one used for physicians is not a very effective way to control spending. During the decade of the 1980's for example, spending for physicians grew at an annual rate of 13.7% while spending for all services grew at a rate of 11.1%—not that an 11% growth rate should be regarded as much of a goal.

Physician Fee Schedules and Expenditure Targets

The legislation passed in late 1989, with an implementation date of Jan. 1992, affected physician payments in a number of significant ways. The most important of these was the abandonment of a charge-based payment system, the limitation on balanced-billing liabilities that beneficiaries could face, a redistribution of payments across procedures and geographic areas and the introduction of a direct link between the volume and intensity of services in a base year and the update in fees in a subsequent year.

The fundamental change to the physician fee schedule itself was the adoption of a resource-based, relative value system (RBRVS) in place of the charge-based system. Payment rates under the RBRVS are calculated by adding together three different weights that reflect the relative costliness of the most important inputs to a physician service—physician work, practice expenses and professional liability expenses. The relative weights are adjusted to reflect relative costs in the local market where the service is provided. Multiplying the weights by a conversion factor translates the weights into dollars.

The RBRVS changed the relative payments across procedures and across geographic areas but does not address concerns about potential changes in volume and intensity that could result. Given the experience with the previous use of a disaggregated fee schedule, this concern was not without cause and produced a lot of heated discussion about the appropriate "behavioral offset" to assume. In many ways, assumptions about potential changes in volume and intensity became irrelevant because the 1989 legislation also included the VPS, which directly (subject to a two-year lag) tied the update to changes in the volume and intensity of services provided by physicians. As a result, overspending or under-spending, relative to the target set by Congress, was reflected in a reduction (or increase) in the update two years later. To some surprise, volume and intensity relative to targets declined initially which resulted in larger than legislated changes for a period. But because the VPS was also based on historical changes in volume, it resulted in adjustments that were unexpectedly volatile. During the period between 1992 and 1998, the MEI increased between 2.0% and 3.2% while the annual updates increased from 0.6% to 7.5%.

Concerns about the volatility with the VPS led the Congress to replace it with the SGR as part of the Balanced Budget Act. Under the SGR, the expenditure target is tied to the growth in the economy—the inflation adjusted growth in GDP per capita, to be more specific. The SGR also is designed to reflect cumulative spending relative to the target.

As is frequently the case, the substitution of the SGR for the VPS solved some problems but created others. Initially the increase in fees was quite substantial since the economy was growing rapidly in the late 1990's and volume of services was not. That changed by 2002, when the economy had slowed down and volume and intensity of services had started growing more rapidly. Since 2002, physician fees have been scheduled to decline each year as a result of spending growth that exceeded the inflation adjusted growth in per capita GDP. In 2002, fees declined as scheduled by 3.8%.

Since 2002, Congress has been under enormous pressure not to implement the 4% to 5% fee reductions that the SGR would otherwise have required each year and indeed, Congress has either frozen fees (2004 and 2005) or provided for small increases in fees in the years since 2002. Meanwhile, spending has been rising rapidly during this period (12 to 15% a year), again making it clear that controlling fees is very different from controlling expenditures.

Problems with the SGR

The SGR, if followed, will limit aggregate spending on physician services but there are several serious analytical issues that have been raised about the SGR. Congress has also indicated concerns about repeated fee reductions and in fact, has only once implemented the fee reductions produced by the SGR. Spending targets can control spending but only if there is the political will to invoke them although it has been suggested that their presence puts an important restraining influence on any fee increases that do occur.

The primary problem with the SGR is that while it controls *total* spending by physicians, it does not affect the volume and intensity of spending by *individual* physician*s*. In fact, there is some concern that it may actually exacerbate the incentives for individual physicians to increase the volume and intensity of services they provide. The reason is that nothing that they do as individuals is likely to affect the overall spending level for physician services. This has led to serious questions about what the current Medicare fee schedule is and is not rewarding. While some tradeoffs are inevitable because multiple goals may not be entirely compatible, the incentives associated with an SGR, particularly one applied only to one segment of Medicare spending, (that is physician spending), have been viewed by many as being perverse.

What are the Alternatives

MedPAC has identified two major choices for the Congress. The first is to repeal the SGR and focus on the development and adoption of payment reforms that would improve incentives for physicians to provide high quality services at lower costs. The second is not to repeal the SGR but to extend spending limits across all of Medicare, perhaps with targets differing across regions to reflect the well-known variations in spending by region.

While I don't disagree with the basic dichotomy that has been laid out—repeal the SGR or extend the concept to all of Medicare—I would phrase the choices slightly differently. As MedPAC has also noted, Medicare needs to institute policies that improve the value of the program and that rewards providers for the efficient use

of services as well as creating incentives to improve quality and care coordination—no matter what it does about expenditure targets.

Moving in this direction for physicians will require, among other things, the use of a less disaggregated fee schedule and the use of a less disaggregated fee schedule should make it possible to do away with the SGR for at least a period of time. Care coordination and the focus on better treatment for chronic conditions which is where so much of Medicare spending occurs anyway, is unlikely to work well when physicians are being reimbursed on a micro unit basis. Figuring out how to create the right bundles and recognizing the significant power shifts that could result will be difficult and time-consuming but there are interesting demonstrations that are already started or at least being developed that should provide some assistance.

The Coronary Artery By-Pass Graft (CABG) demonstration that was started when I was at HCFA bundled for all Part A and Part B expenditures into a single payment and although not conclusive appeared to result in lower costs and as good or higher quality for the participating groups. A gain-sharing demonstration is starting that would allow physicians and hospitals, that are not financially at-risk, to work together and share savings that result from better care of complex cases and chronic care patients. Other demonstrations are attempting to show the effects of disease management or better care coordination in a fee for service system.

MedPAC has recommended elsewhere and as co-chair of the IOM subcommittee that was responsible for the recent release of the IOM report on Pay for Performance, I concur with the idea of adopting payment strategies that reward institutions, and when we can put in the proper measurement systems, clinicians who provide high-quality, low cost care and to do so in at least a budget neutral manner. The early results from the Premier demonstration are consistent with conventional wisdom that increasing quality can be associated with lower costs but this is just one small example. As the IOM report makes clear, however, moving to a system that realigns incentives will require a lot of changes and a lot of difficult decisions, not the least of which is a uniform, national performance set of measures.

I regard Pay for Performance or Results-Based Payment as *part* of the process to begin realigning incentives in Medicare so that the payments that are made are more in line with the objectives of the Medicare program—but only that—part of the process. Many changes will need to be made to restructure the payment system so that it encourages more of what we want produced (i.e., high-quality, efficiently produced appropriate care) and that recognizes that much of the care needed by an aging population will have to focus on the needs of individuals with multiple chronic conditions.

As important as it is to realign incentives, it is also important to provide both payers and providers with better information on the relative clinical effectiveness of alternative medical procedures and technologies. A number of other countries have been involved with the concept of comparative clinical effectiveness but generally only for new pharmaceuticals and medical devices. Similar information needs to be available for medical procedures as well since among other things, that's where most of the money is spent. Even if incentives are appropriately aligned, we can hardly expect to "spend smarter" if clinicians and payers (and patients) don't know "what works when, for whom, under what circumstances." Getting such information will require a significant investment and take several years to develop but in a sector that is now spending $2 trillion, it is hard to explain why that type of investment would not be appropriate.

The bottom line: "we need to know *more* and pay for it *better*."

If that doesn't work to slow down Medicare expenditures, we had better be prepared to introduce expenditure targets across the board in Medicare but recognize it will be hard not to exacerbate problems with medical silos in a world that really needs better coordination across medical boundaries.

Chairman STARK. Well, thank you both. As, Gail, you will remember when we wrote the first reimbursement plan, my counterpart on the other side was Senator Durenberger, who has in the interim become the Garrison Keillor of the medical delivery and he comes up on my email right after the Viagra ads about once a month with his Commentary from Dave. I thought I would just quote one of his latest newsletters, he talks about another friend of ours and he says, I quote here, "Doctor Uwe Reinhardt tells me of his recent challenge to a Canadian health economist to explain

why there are so many cues in the Canadian system. 'Simple,' says the Canadian economist. 'It is the sign of a much more efficient health system passing on avoided excess capacity costs you Americans love to Canadians in much less expensive health care.'" Only Uwe I suppose could come up with that, but I want to ask each of you a question about issues that have concerned me. Bruce, you talk about primary care and your concerns there, and I share those that I hear anecdotally that we are getting fewer students coming out of medical school and it is pretty easy, in California $100,000 a quarter for a family physician to start and in Indianapolis, a radiologist can make $500,000 a year and at least they have enough math in medical school so they can figure that one out with their shoes and socks on as to how much more quickly they can pay back the loans that you have given them at I hope an excessive interest rate.

My theory is that one of the things we could do, and I share this idea of disease management on Medical Home, and rather than let these commercial companies that are out there develop this and sell it to us, that we somehow empower the primary care doctors to take on that responsibility and get paid for it, whether they use physician's assistants or I don't care, bill collectors to call me and remind me to take my Zocor or whatever they do, but it occurs to me that we have a chance there, I am not sure I like the idea of there being gatekeepers, but as I say to manage and be responsible for our beneficiaries in particularly those areas where you don't have enough population to have a Health Maintenance Organization (HMO) or a managed care plan, they could fulfill this role, what would that do to your graduates into the Medicare system?

Mr. VLADECK. No, I actually think that there would be a lot to be said for it. The problem is with many practices, we would need an up front investment, particularly in the area of information systems.

Chairman STARK. We will get to that in a minute.

Mr. VLADECK. Individuals or small groups of primary care physicians are the most disadvantaged in terms of their systems—and lagging I think the furthest behind. In fact, we have a little bit experience with an approach similar to that under very different circumstances, which was up until the early 1990's, the largest form of Medicaid managed care in terms of enrollment was so-called Primary Care Case Management Programs, which sought to do very similar sorts of things, in a very different kind of environment, a very different setting and with not enough financing, I think, but at least in some areas of maternity care and well child care, I think the track record was encouraging. So, I would be very supportive of that sort of approach.

Chairman STARK. The other issue for Gail, and you mentioned it in your last bullet here, you talk about the need to know more, and I have been concerned—well, as you remember, Bill Gradison and I were talking about outcomes research 15 years ago, and without any kind of a database, you cannot get much outcomes research. So, you wouldn't know what to advise a woman in terms of where to go for breast cancer, which is the best procedure. There are good schools around the country, good centers of excellence, each of which would use a different procedure. When Bruce gets

prostrate cancer, he is going to get the same answer at Hopkins as he is going to get in Austin and maybe the procedures are equally efficacious but you really do not know with some kind of statistical certainty which is better, and I think we can know that. My solution is, and this is by way of asking for your comment, that I do not think we are going to be able to build a universal database, which obviously would have to take advantage of information technology and some kind of uniform reporting or records keeping unless or until probably Medicare drops the hammer and says you will not get paid if you do not keep your records, hospital, medical school, doctor, in this format and the sanitized information on each patient goes into a I don't care, National Institutes of Health, Bruce's medical school, some place where it is kept and nobody gets the name unless there is a need to know but researchers can use the data to build the kinds of things, pay for performance, how do we know that performance—you give an aspirin to Cheney as a blood thinner, I know that. You certainly do not want to pay doctors for anything I know. So, my thought is, one, somebody has to mandate it. Two, it has to be universal. Nobody will like it, I am convinced that whatever system is picked, 90 percent of the providers are going to hate it because it isn't their system, but we will be improving one system and the third part is that in spite of the complaints I have heard about the Stark laws, the Federal Government is going to have to pay for it. We are going to have to pay over five years say and front-end load it. That means people who already are in the system get their money back. The doctor who has not bought his laptop yet gets the money. So, we go 10, 8, 6, 4, 2 and out, but I somehow think we will not get to all these good things we want to get to unless we bite hard on that bullet and mandate a system that will collect the information to build the database. Do you want to sign on?

Ms. WILENSKY. Well, I will sign on to pieces of it. Let me share where I agree and where at least my thinking has gone in a different direction. I am a very strong proponent of the need to build a center for comparative clinical effectiveness. I had a recent paper that was released, and I have been spending a lot of time thinking about where it should be housed and how to fund it. I see that as somewhat separate, although the information that could come from experiences in Medicare and patient records would help that. I actually see a combination of data from randomized clinical trials combined with administrative record analysis combined with consensus information. So, I see that as somewhat different, but the question of how to try to get consistent information and to what extent you rely on electronic records is a very important one. If you believe in pay for performance or pay for results, which I do, it requires having uniform measurement systems. It will be made much easier with support from electronic medical records.

I do not know whether I think you need to actually pay for them directly, and the reason is we do not pay directly for the construction of cath labs or open heart surgery centers, but we have many of them. We pay for them by how we reimburse.

Chairman STARK. I guess that is what I am talking about, an increase on a procedure payment over a period of time to compensate.

Ms. WILENSKY. To the extent that we pay for the kind of results that you can get with electronic medical records, that is a different way than paying for it explicitly. You can drive behavior, we have a lot of cath labs, we have a lot of imaging centers and it is probably the best signal we have of our skewed reimbursement system. To the extent we pay more for the kinds of things that you can get easily with information systems, you can do the same thing. I worry a bit about whether we are going to step backwards to a cost-based reimbursement system if you pay directly for electronic medical records.

Chairman STARK. I am thinking of something Graduate Medical Education (GME), just an addition that every provider gets and those who already have it, get their money back, those who don't have it, get the money to go out and buy it.

Ms. WILENSKY. I think what we are trying to do is similar, and we could debate exactly which of the strategies would work best, but I do not disagree with what you are trying to do. I also do not have a problem with saying you do not have to participate in Medicare but if you want to participate in Medicare, this is how you have to submit your bills. As I recall, the Congress has been reticent in the past to require electronic submissions for physician reimbursement because of concerns in rural areas, but if you had a payment system that looked like it would make that more feasible, that concern may go away. So, again, there are certainly areas of overlapping interest.

Chairman STARK. Thank you. David?

Mr. CAMP. Thank you, Mr. Chairman. Thank you very much both of you for your testimony. I am interested in the idea of giving more discretion to CMS in the operation of payments systems. Dr. Vladeck, I think that was in your testimony. Could you just elaborate on that a bit?

Mr. VLADECK. Well, again, and I do not know what the CBO would do with it, but——

Mr. CAMP. Probably not good.

Mr. CAMP. In fact, if you look at the way in which hospital updates have been done under the prospective payment system for hospitals and Medicare and compare that with a rigid formula like the SGR, there is a lot more wiggle room in terms of historically the way the updates were set until they become part of a reconciliation process every year. You could dampen some of the volatility that Gail and Glenn talked about. You could maybe set multi-year kinds of targets rather than doing it every single year, things of that sort. So, I think in other settings, historically in the Medicare program and other payers, you can set a target as a range or set a target with multi-year adjustments or things of that sort rather than writing in a formula that is as rigid as the SGR, achieve some of the same effects in doing it, certainly send very much the same signals to the provider community but without locking yourself into the kinds of mess frankly that the SGR has now produced. Now what CBO does with that, I don't know but it would certainly be worth just getting away from some of the rigidities of these things.

Similarly, I would argue that some of the criticisms of the old VPS formula that were both in the MedPAC report and that Gail referred to in terms of volatility was in part because the basic

structure of those categories were established statutorily. If you gave CMS the opportunity to set some targets, we are really worried about imaging this year, we are going to put a separate cap on certain categories of imaging, we are really trying to encourage this kind of category, we are going to put in the bucket that we are going to accept a larger rate of growth and so forth, you might be able to get away from some of the rigidities that the current formulas tend to create.

Mr. CAMP. Well, I think one of the things that have happened as the formulas get more complex, the distortions in the formulas do not get any less. I think SGR was viewed as a proposal that would even things out even more, yet the complexity of these formulas makes it very difficult as well.

Mr. VLADECK. I do not disagree. On the other hand, I would say part of the problem is that complexities accumulate and you are never going to get it right entirely in any one year any way, and so we are now in a position where in order to change a formula that is not working well, the Congress has to legislate a new formula. If there were somewhat—and I do not know exactly how to do it, somewhat broader and vaguer legislative authority for CMS to set targets or for the Secretary to set targets that gave them more administrative flexibility. The fact is that every few years, you probably need to try something new because nothing is ever going to work perfectly. Some of the complexity is because you do learn from prior mistakes. The system is not set up very well to learn because it requires legislative action with significant budgetary implications in order to change.

Mr. CAMP. All right, thank you. Thank you very much, Mr. Chairman.

Chairman STARK. Mr. Becerra?

Mr. BECERRA. Thank you to the two of you for your testimony. I have to make one comment, Mr. Hackbarth is still here so either he lost his ride or he really is interested in what is going on because you are the first witness I have ever seen who stayed beyond his or her time. So, glad you are still here.

Dr. Vladeck, you mentioned primary care and how we need to try to re-emphasize that and then you talked about some of the countries in the world who do a better job in that area. I am wondering if you could give me your sense, as we look around the world at other systems, health care systems, and I guess if we try to compare apples with apples, developed countries, first world countries, are there any countries that are having the type of difficulty we have, and I guess here we are talking about the segment of the population that receives Medicare so it is principally the elderly population, are there any countries in the world comparable to us who are having the same kind of money problems we are having when it comes to trying to provide health care to its elderly population?

Mr. VLADECK. Well, I think everybody is having money problems in the sense that health care costs are going up in many instances more quickly than government revenues. The population is getting older everywhere.

Mr. BECERRA. In fact, they are probably having an aging out problem more than we are in some cases.

Mr. VLADECK. My understanding is, if I remember the data correctly, that of the nations of the Organization for Economic Co-operation and Development (OECD), which is a good sub-set of the industrial nations of the world minus some of the newer ones in Asia, we are tied with Australia and New Zealand for having the youngest population of the OECD countries. So, many of them have substantially older populations. They all have problems with health care cost inflation but they are not as severe as ours, and they start from lower bases. So, the average of say Western Europe countries is about, dollar adjusted and so on, is a third to 40 percent less than ours. I think there is an increasing amount of data that suggests that is not the result of significant queuing for services in many of those countries. It is not the result of less utilization of services. The Germans use imaging services like crazy, but it has to do with, one, systems that are much more organized around primary care in which their ratio of services provided by primary care practitioners to the services provided by specialists is a lot higher than it is in the United States. Two, lower prices for things that are partially a result of that differential balance between primary and specialty services.

Mr. BECERRA. Tell me if I am wrong in this, and Dr. Wilensky, please feel free to chime in, my sense is that those principally European countries start off with far lower costs, which in some ways would be difficult for us to try to emulate because in this country, you are better off if you are doctor than the general—far better off than you are in the general population. You make more money, it is a more lucrative career even those days a lot of physicians will tell you it is still not as good as it used to be. So, in Britain or other countries, you are probably making less if you are a physician, which obviously keeps some of your costs down, certainly some of your expectations as well, but at the same, as you mentioned I think Dr. Vladeck, they are more organized and they are more organized around giving care at the beginning than say at the end. So, is there some way to pair what we have, which is very high quality in some areas but disparately proportioned, with the need to have more organization within our system and focused at the beginning stages?

Mr. VLADECK. Let me just say very quickly I think it is a complicated question, and Gail may want to add something to this, but I only say 15 to 20 years ago when most of the specialty and subspecialty societies strictly limited the number of residency slots and the opportunities to enter those, we all accused them of anti-competitive behavior, we all told them they were unfairly monopolizing economic opportunities for people. We accused them of making it impossible to get sub-specialists in the rural communities or in under-served urban communities, and we frankly beat the hell out of them to open up the areas of economic opportunity and the availability of sub-specialists in smaller and less populated geographic areas. So, part of the reason we are more expensive is just because we are so big and it is so far from one place to another in a lot of communities, and we have rejected regionalization in most of the country as a policy, which prevails in many of these other countries, but I think, again, one of the things that they do elsewhere is very significantly limit the supply of specialty physicians

through the educational system, which we used to do through the American Medical Association and the specialty societies used to do for us, and we all decided was unacceptable abuse of private power.

Ms. WILENSKY. Yes, your question is quite complicated but other countries tend to limit specialists and they tend to limit the expense of specialized support for the specialists in terms of equipment and specialized hospitals or the beds that are supporting specialized hospitals. The good news in terms of having a high base of spending per capita is that we have a lot of one off savings potentials if we could begin to get a more efficiently driven health care system. Most of these countries actually have more similar spending growth rate problems to ours and it is really the absolute level that is so different. They are very similar kinds of problems. You and I have spoken in the past about using loan forgiveness as a way to drive more people into primary care. I continue to think that it is an excellent way given the levles of indebtedness that people coming out of medical school are carrying now, saying that we will waive your medical school debt if you go into any one of the primary care areas that are in short supply. Loan forgiveness has not been very popular, I think because of the lack of success in the 1970's when it was first tried but incomes were high and growing and medical school tuition was low and not growing so rapidly and these have now reversed. You are also quite correct in saying that the relative differential in terms of income for physicians versus other workers in this country relative to most other countries is much greater here. I don't know that you want to directly try to take that on as much as trying to do things that shift the balance by changing the mix in terms of specialty and primary care physicians. That seems to me an easy way to start.

The issue about regional variations is complicated. Maybe we can use them to drive toward higher quality, if we monitor and reward those groups that provide high quality, efficiently produced care. These groups are frequently either in integrated settings or are focused in particular areas and it is why I am very much supportive of the strategy that Glenn Hackbarth had raised. Rather than kill off specialty hospitals, pay them right, which would be less than a community hospital which has to be available 24/7 and also provide a lot of poorly reimbursed services like burn care. It is possible specialty hospitals can actually provide care better or do it cheaper but they certainly shouldn't get reimbursed at the average rate that they are now getting reimbursed. So, I think we need to think about ways of how can we try to target or reward places, clinicians, institutions that do it better and do it cheaper. I don't mean it just as an add-on, Mr. Stark. I also mean it at the very least as budget neutral and maybe even a budget savings.

Chairman STARK. I thought you were going to add Medicare Advantage Plans into the line-up.

[Laughter.]

Ms. WILENSKY. No.

Mr. BECERRA. Mr. Chairman, I have tons of other questions but——

Chairman STARK. Well, we may have some votes in a couple of minutes, and I wanted to give Earl a chance to support the rural health care delivery system in this country.

Mr. POMEROY. Mr. Chairman, I will get to that some other day, I am just finding this to be a thoroughly enjoyable discussion and one that I feel like I am re-entering the health policy discussions having met each of you when I was a State insurance commissioner and been kind of away from the action and now this Committee is letting me get back into the action. I am eager to get back in. Glenn, maybe I was a little hard on you earlier, I am just frustrated, and I will look forward to discussing this further with you tomorrow night. Bruce, I thought your comments were very interesting in terms of how maybe now the SGR issue is actually accelerating the departure from primary care medicine. Just in North Dakota, we have made exhaustive efforts to get a 4-year medical school, which for a population of our size is a real undertaking. It is family practice-oriented, primary care residencies, and they are having trouble filling some of those primary care family practice residencies, and I think the student debt load has a lot to do with it but maybe there are some other things as well. Gail has presented well some of the positive things we can look at maybe to try and put this back, to try and reinvigorate the attractiveness of primary practice residencies. Bruce, you talk about how the way the SGR is working now, it seems to be advancing the disincentive, you mentioned it in your testimony, I would like you to just spend the rest of the time with this question elaborating on that?

Mr. VLADECK. Well, I am happy to respond although in all honesty I got it right out of the MedPAC report and their explanation of the phenomenon, but essentially if you have a single cap on the rate of fee increases but the cap is a function both of fees and volume, and if the volume of your radiology procedures is going up way fast and your volume of evaluation and management services (E&M), is going up very, very slowly but you have one cap, and then what that does is it caps the fees of everybody in the same way even though you probably are paying too much for those diagnostic radiology services and too little for the E&M services. Over time it compounds that effect. Part of the problem always with designing these systems has been that if the service consists primarily of a physician or other health professional interacting with another human being by doing a physical, by taking a history, by counseling or whatever, there is only so much more volume that you can produce and this is the underlying problem with primary care. If you are taking pictures, first of all, you are the radiologist, you are not taking pictures at all anyway, you are the technician and every year you can get an additional computerized thing that is going to screen them more quickly for you so if you used to read 100 mammograms a week, you can now read 200 or whatever. So, if you impose a cap on total Medicare physician spending, as MedPAC notes, and the stuff that you do not want to encourage more of, like the imaging is growing faster than the stuff you want to encourage more of, you have a sort of perverse effect of taking a double whammy at the stuff that you may be underpaying for. That is the phenomenon they note and that I also note. I think that is the problem with a single cap.

Ms. WILENSKY. It is the problem really with the cap altogether. Even among the radiologists, for example you probably have some that are very conservative in their practice style and others that

are very aggressive. The cap is a very crude instrument. It will limit spending but it makes no distinction between the physician that is very careful and conservative from the very aggressive ones. There has been some mention of looking more seriously at outliers, and I think that is something that CMS ought to be encouraged to do. We know that there are some physicians or some practices that are very aggressive in what they do. Maybe they really do have sicker patients but that is the kind of thing where some analysis of the top 1 percent, 5 percent of the most resource-intense practices might find either reassurance that their patients really are sicker or a very different practice style and thinking about how to try to change this type of behavior through various strategies. We know concentration in health care spending is a problem. It is a different way to look at the concentration problem but giving CMS more discretionary authority in this and other areas I think really might help them be more aggressive in going after some of the aggressive spending practices.

Mr. POMEROY. That is very interesting. I think your outlier idea deserves some further discussion in this Subcommittee. Blue Cross/Blue Shield in North Dakota was one of the last bastions of really unfettered fee-for-service medicine and as they started to get a consumer majority on the board, it started to crank down just a bit. Looking at outliers was one of the early steps and it was pretty successful.

Mr. VLADECK. If I can just say this also gets back not only to the discretion issue but to some extent the resource issue for CMS because they do not do nearly the kind of analysis of patterns of claims, of just basic statistical analysis for these purposes that the most sophisticated private insurers do and to a large extent that is just because they do not have the money and the resources to do it. They do not have the in-house data processing capability and there is not enough money left over in the contractor budget. So, again, I think it is a relatively modest investment relative to the cost of the program that could be put to very good use in this and other ways.

Mr. POMEROY. Database outcomes and the analysis have all been under discussion since my insurance commissioner days. It is really astounding given the percentage of the national budget going this way and the accelerated growth of spending in this area that we have got so little built in analytical capacity.

Ms. WILENSKY. It happens because the benefits come out of the entitlement fund and the administrative support is a direct appropriation. That means that every time there is consideration for administrative increases, it is competing against all those other areas of appropriations, although with regard to Medicare fraud, there was a trust fund type of mechanism that was set up. This might be a way to model it so that if aggressive use of claims, auditing or practice assessment would in fact produce savings, at least its funding doesn't have to be competing against low income education support and all these other things that come out of the appropriations process.

Mr. POMEROY. I thank the panel and yield back. Nice to see you again.

Chairman STARK. I want to thank both of you for continuing to take the time. I would ask Gail, I think I know how Bruce would answer, I hate to ask questions I do not know the answer, but do you think it is important to continue Medicare as an entitlement?

Ms. WILENSKY. I would like to see some changes in how it is structured but Medicare basically as a program for the over 65 population will continue and I think should continue. I personally am more comfortable with having the contributions that the Government make range more by income than it does but it actually has been moving that direction in a number of ways.

Chairman STARK. But on the other hand it is already perhaps the most progressive tax, if you figure that somebody makes $10 million in salary, pays the same Medicare tax as somebody at the minimum wage but they both get the same benefit and then to add on, sort of insult to injury, and I have always worried that we would create a sense of turning it into a welfare program by discouraging those among us who are more well to do. I wouldn't mind if they want to adjust the tax, which is the same way of getting there I guess.

Ms. WILENSKY. Yes, and I worry that it be made into a welfare program. I think it is possible through a combination maybe of tax changes and other changes on the benefit side to reduce some of the government's contribution, but I share your concern. I actually am more concerned about not doing enough for individuals who are just above the Medicaid cut off.

Chairman STARK. You serve on the Maryland——

Ms. WILENSKY. Yes, I am actually at the moment their acting chair.

Chairman STARK. Is that the commission that sets rates for Maryland hospitals?

Ms. WILENSKY. It decides the Certificate of Need. There is a separate rate setting commission that is the sister agency right next door.

Chairman STARK. That sets rates, which gives them the all payer?

Ms. WILENSKY. Right.

Chairman STARK. How would that work? I think the history of that is that when it was organized or formed, I think it is a good system for reimbursing hospitals, it takes all the gaming of quantity discounts and major purchasers from getting special discounts and giving the hospitals fits, but I cannot sell it to my California hospitals, but I still think it is good, but at the time it was propounded, the physicians screamed and yelled and stayed out of it. Would that kind of a system work for physicians?

Ms. WILENSKY. Well, the rate setting goes on for physicians under the Resource-Based Relative Value System.

Chairman STARK. No, but I am talking about in Maryland with the all payer system.

Ms. WILENSKY. Well, the all payer system affects the hospitals, it does not affect——

Chairman STARK. I know that, but if you included physicians in that kind of a—that type of a rate setting system rather than what we are doing now?

Ms. WILENSKY. The part—I think fundamentally we need to bundle the physician services. The question is about how to do that. Remember the physician Diagnostic Related Groups (DRGs) that were under consideration in the 1980s, I guess it would have been shortly after DRGs were introduced, or some other way of bundling payments using the medical staff. You have got to bundle services in some way to get around the problems of the SGR. The SGR or the VPS was put in place because with a very disaggregated fee schedule, we had abundant evidence that spending would go up even more rapidly than other areas in Medicare without a spending limit, and we shouldn't ignore that past. So, the way to try to figure it out is what is the best way to try to bundle services? Is it by chronic care so that you bundle care for a diabetic patient or for congestive heart failure? Is it to try and do for things that go together, puts A and B together so for the bypass surgery, putting the physicians that care for a patient together with the hospital costs and do that bundle? The answer may be that there are different kinds of bundles that would make sense, chronic care having one type, primary care maybe having another, and that which is related to surgery doing more part A and B bundling so you have crossed medical silos. The way you get around that really micro-level of fees. That is the killer. That is the part that drives you to using a spending limit, which then puts you back into penalizing the good guys, the conservatively practicing physicians. So, that is the basic direction that needs to be taken. To me, almost anything that you gives you more bundling is moving in the right direction. Now, there are power shifts implied with bundling. That was really what I think stopped the physician DRGs—a recognition that one group or entity was going to be the holder of all the money and that will be difficult. Up until now, the groupings have all been voluntary. Figuring out how to have groups form so you can bundle the services is the key. That is the direction of the answer to the SGR issue.

Chairman STARK. Would you like to further inquire, Dave? We have some time.

Mr. CAMP. Yes, I am interested in that concept because, as we know, there are 700,000 physicians with 700 million claims in Medicare alone and the 7,000 system of codes that they have to deal with, a lot of sevens here but it is not workable anymore. The idea of bundling, could you just describe a little bit more how that would work?

Ms. WILENSKY. Well, let me show you. There are different ways. We already have bundling for surgical fees because there is a flat fee that includes the actual surgery plus the pre-care and the post-care.

Mr. CAMP. Yes, for the event.

Ms. WILENSKY. For the event. So, you have that limited bundling that goes historically on just in the nature of how it has happened. When we had this CABG demo, the demonstration in the early 1990's, physicians and hospitals came together and negotiated with HCFA saying here is what we used to charge all separately but we are going to come together and propose a lower reimbursement. It will cover all the physicians that drop in on the patient while the patient is having the bypass procedure or the valve

replacement and also include the hospitalization. It was less money and as best we could tell, as good or higher quality care. It eliminated some of the various specialists who used to come by as consultants for whatever. Those numbers went down substantially. You had a more integrated group for what was a complicated procedure. Some of our NIH consultants said, "Not only that, you will have better outcomes because you will drive the various physicians who are working together on this complex case to work together more effectively." Bundles will require sitting down to look at for chronic care, which by its nature, is not a single visit, that is the nature of the chronic care disease, and deciding how to bundle the payments of the primary care physician that is taking care of the complex diabetic or the congestive heart failure patient. This way the physician gets a payment and then Medicare doesn't have to bug them for every individual test they do in between. It is why you do not have to bug hospitals anymore for all the little things they order, once you have got the DRG, it's their problem and it is not Medicare's problem.

Mr. CAMP. Well, if CMS could guide that is because the last thing you want us to do is to be trying to understand these procedures and it seems as though they have the authority to——

Ms. WILENSKY. I am not sure about that.

Mr. CAMP (continuing). Or at least begin some of that.

Ms. WILENSKY. They can do—what they can do is demonstrations. The only frustration is demonstrations, even successful ones, do not have a good track record of making it into legislation. I believe, although I am not a lawyer so I may be wrong on this, I think ultimately they would need the legislative authority to reconfigure payment but you would not want to put in statutory language exactly what all these bundles look like.

Mr. CAMP. Exactly, right. Yes, Dr. Vladeck, you have something to say?

Mr. VLADECK. Just very quickly, some of what we talked about in terms of demonstrations with case management fees or care coordination fees are a halfway step toward episode bundling or an annual bundling for certain chronic care patients. I would just put the caveat on that my geriatrician friends would tell me about that they are unfortunately relatively few Medicare beneficiaries with only one chronic disease. So, there is a lot more research and investment that needs to be made in figuring out how to do those bundles, but I think that is the right direction going over time.

Ms. WILENSKY. We do have some experiences, as Bruce had said, the primary care case management system for well-baby care and pre-natal care in Medicaid has had a pretty interesting history. South Carolina, which was normally not the place for a lot of innovations in Medicaid, has used this as a very successful model. Figuring out what the right bundle is will take some intellectual capital and horsepower, but when you think about how much goes into maintaining this incredibly complicated area, this would be time so much better spent.

Mr. CAMP. Well, and many physicians complain about the administrative burden of the coding system, if that could be—you would have a lot of savings there as well.

Ms. WILENSKY. Absolutely.

Mr. CAMP. That could be addressed. Thank you, Mr. Chairman.

Chairman STARK. Thank you both. I guess we will see Gail tomorrow, but thanks, Bruce.

Mr. VLADECK. Thank you, Mr. Chairman.

Ms. WILENSKY. Thank you.

[Whereupon, at 4:20 p.m., the hearing was adjourned.]

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