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to the
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SUMMARY OF KEY POINTS

- The Sustainable Growth Rate formula should be repealed.
- Fundamental changes in the fee-for-service system are necessary in order to control the growth of Medicare spending and to improve the way care is delivered to Medicare beneficiaries. Congress will have limited success in controlling Medicare spending and providing truly high-quality care to Medicare beneficiaries if it merely uses quality-based pay-for-performance or shared savings programs built on top of the dysfunctional fee-for-service system. Fortunately, there are better ways of paying physicians that can enable them to make more significant improvements in patient care and achieve greater savings for Medicare.
- Accountable payment models need to be designed and implemented as quickly as possible in ways that will work for every specialty and every part of the country. To do this, Congress should establish a new, bottom-up approach to payment reform, whereby physicians, provider organizations, medical specialty societies, and regional multi-stakeholder collaboratives are invited to develop payment models that will work well for individual physician specialties in the realities of their own communities. This process should include the following elements:
  - New payment models should be able to be proposed to CMS at any time, with no limit on how many different proposals can be approved as long as they will improve care and reduce costs. Proposals must be reviewed quickly and CMS should have the obligation to approve a proposal if it is specifically designed to improve patient care and save Medicare money.
  - There should be frequent opportunities for physicians to apply to participate in already-approved payment models. Every physician should be permitted to participate in an accountable payment model whenever they are ready to do so. If a physician is participating in such a model, they shouldn't be subject to threats of SGR-type payment reductions.
  - Physicians need to be given access to Medicare claims data so they can determine where the opportunities for saving are, how care will need to be redesigned to achieve those savings, and how payment will need to change to support better care at a lower cost.
  - Once a physician is participating in an accountable payment model, they should have the ability to continue participating as long as they wish to do so if the data show that the quality of care is high and Medicare spending is being controlled.
  - Funding should be made available to medical specialty societies and multi-stakeholder Regional Health Improvement Collaboratives to provide technical assistance to physicians.
- To help new payment models be as successful as possible, Congress should ask Medicare beneficiaries to designate which physician(s) they want to be in charge of care for each of their conditions, so that there is no need to use complicated, inaccurate statistical attribution methodologies to determine which physicians are accountable for which patients.

Mr. Chairman and Members of the Subcommittee on Health:

I commend you for working to repeal the Sustainable Growth Rate formula and to reform physician payment systems, and I appreciate the opportunity to provide input to your deliberations.

The Need to Repeal the Sustainable Growth Rate

Patients' lives depend on having good doctors who are paid adequately to deliver good quality care. We will not be successful in transforming our healthcare system to deliver higher-quality, more affordable care if physicians have to wonder every year whether the major payment cuts required by the Sustainable Growth Rate formula will go into effect or not.

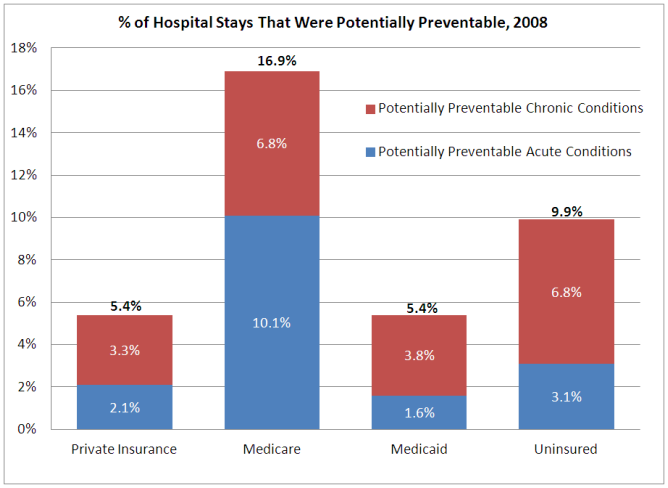
There is no other industry in the U.S. where the key professionals on whom that industry depends are told that their pay will be cut by 27% at the end of the year regardless of whether they are doing a good job or not. We shouldn't do that with physicians in the healthcare industry, either.

Temporary fixes aren't enough. The law has never made sense, and it needs to be repealed.

Controlling Medicare Spending Without Harming Beneficiaries

The broader challenge that Congress faces is controlling the growth in Medicare spending without harming beneficiaries. The way to do this is remarkably simple: tens of billions of dollars in Medicare spending could be saved every year by avoiding unnecessary tests, procedures, emergency room visits, and hospitalizations, and by reducing infections, complications, and errors in the tests and procedures which are performed. For example:

- **Millions of hospital stays, costing billions of dollars, are potentially preventable.** AHRQ data show that 17% of hospitalizations of Medicare beneficiaries are potentially preventable.[1] The frequency of these preventable hospitalizations can be dramatically



Source: *Potentially Preventable Hospitalizations for Acute and Chronic Conditions, 2008.* AHRQ HCUP Statistical Brief #99

reduced; for examples, studies have shown that rates of emergency room visits and hospitalizations for many patients with chronic disease and other ambulatory-sensitive conditions can be reduced by 20-40% or more through improved patient education, self-management support, and access to primary care.[2] If the 2.4 million potentially preventable hospitalizations for Medicare beneficiaries each year were reduced by 25%, Medicare savings would range from $3 billion per year (assuming spending of only $5,000 per hospitalization) to nearly $10 billion per year (based on more typical total spending of $15,000 for an episode of hospitalization for chronic disease, including post-acute care, readmissions, etc.). Bigger reductions in hospitalizations would lead to even greater savings.

- **Hundreds of thousands of infections, complications, and errors occur every day, costing billions of dollars.** On average, in every minute of every day, 3 new avoidable errors, infections, and complications occur somewhere in the U.S. A study a few years ago estimated the cost of those problems at $20 billion per year for all payers.[3] Although progress is being made in reducing the rate of these complications, far more can be done. Work pioneered by the Pittsburgh Regional Health Initiative and replicated in other parts of the country has proven that such events can be dramatically reduced or even eliminated through low-cost techniques.[4]

Medical Error	# Errors (2008)	Cost Per Error	Total U.S. Cost
Pressure Ulcers	374,964	$10,288	$3,857,629,632
Postoperative Infection	252,695	$14,548	$3,676,000,000
Complications of Implanted Device	60,380	$18,771	$1,133,392,980
Infection Following Injection	8,855	$78,083	$691,424,965
Pneumothorax	25,559	$24,132	$616,789,788
Central Venous Catheter Infection	7,062	$83,365	$588,723,630
Others	773,808	$11,640	$9,007,039,005
TOTAL	1,503,323	$13,019	$19,571,000,000

Source: *The Economic Measurement of Medical Errors*, Milliman and the Society of Actuaries, 2010

Reducing avoidable hospitalizations and improving the quality of the remaining hospitalizations not only can save money for Medicare, they improve outcomes for patients, too. Too much time is spent debating whether to deny patients coverage for expensive treatments in order to reduce spending, when our focus should be on how to keep patients healthy, avoid unnecessary hospitalizations, and reduce the infections, complications, and readmissions which harm patients and cost billions of dollars.

The Fee for Service System is a Major Barrier to Higher Value Health Care

A major reason we're still spending tens of billions of dollars on unnecessary and harmful care is because of the way we pay for healthcare today. The current fee-for-service system makes it difficult or impossible for physicians to help Medicare take advantage of these opportunities to improve care for patients and reduce healthcare spending. For example:

- **Many of the types of services that have been shown to prevent emergency room visits and hospitalizations are not paid for adequately or at all**. Medicare does not pay primary care practices for care coordination services for complex patients, to engage in shared decision-making processes with patients facing important choices about tests or procedures, or even to answer a phone call from a patient. Similarly, specialists are only paid for seeing patients in person, not for advising primary care physicians on care management, for time spent coordinating services with the primary care physician, or for responding to patient calls for assistance. A physician who deals with an urgent patient problem over the phone isn't paid even if that call prevented an unnecessary emergency room visit. A physician who hires a nurse to assist with patient education typically cannot be reimbursed for the cost of that nurse, even if the nurse helps the patient avoid a hospitalization. All of these things limit the ability of physicians to flexibly design services to best meet a patient's needs, resulting in unnecessary illnesses, treatments, and spending.
- **Physicians and hospitals can be financially penalized for reducing unnecessary services and providing better quality services.** For example, reducing errors and complications during hospital stays can not only reduce both physicians' and hospitals' revenues, but also reduce hospital profits and their ability to remain financially viable.[5] Physicians lose revenue if they perform fewer tests and procedures, even if their patients are better off without the tests or procedures.
- Perhaps most fundamentally, under the fee-for-service payment system, **physicians don't get paid at all when their patients stay well.**

Pay-for-Performance and Shared Savings Won't Solve the Problem

Although there is widespread agreement now that the fee-for-service system is broken, it is essential to understand the specific problems with fee-for-service payment described above in order to

ensure that payment reforms actually *solve* these problems. In fact, most so-called "payment reforms" don't solve the problems because they don't actually change the fee-for-service system.

For years, health plans and Medicare have been trying to fix the problems of the fee-for-service system by adding bonuses and penalties on top of it. However, most pay-for-performance (P4P) programs have had very little impact, and the reason is simple: a small P4P bonus or penalty can't overcome the significant weaknesses of the underlying fee-for-service payment system. Merely tying payment to a large number of quality measures doesn't necessarily result in better quality care, since you can't expect healthcare providers to measure, report, and improve on a large number of quality measures if the quality measures demand changes in care that aren't paid for under the current payment system.

Although "shared savings" sounds like an innovative new approach to payment, in reality, it is nothing more than a new form of pay-for-performance. Shared savings programs and similar payment reform efforts will likely have limited impact because they leave the current, broken fee-for-service system in place, and in particular, they force physicians and hospitals to lose money when they help Medicare reduce spending. For example:

- Pay-for-performance and shared savings programs don't change the fact that Medicare pays physicians only for office visits, not for phone calls or for hiring a nurse to help patients manage their conditions. If a physician can respond to a patient's health problem over the phone, thereby avoiding the need for the patient to make a visit to the office, the physician will still lose revenue. If the physician hires a nurse to help the patient, the physician's costs will increase but he or she will receive no additional payment. Giving the physician a small bonus or reimbursing the physician for a portion of the lost revenue through a shared savings program still penalizes the physician's practice (recouping only a portion of the loss still results in a loss) and also creates a cash flow problem, since pay-for-performance and shared savings payments typically aren't made until a year or more after the losses occur.
- If better coordination of a patient's care can avoid an emergency room visit or hospital admission, the hospital will lose all of the revenue for that visit or admission, but it will still have to cover the costs of having the emergency room or hospital bed available. Giving the hospital a bonus or shared savings payment for lower admission rates can still penalize the hospital, since the portion of the lost revenues offset through the shared savings payment may be less than the fixed costs the hospital must continue to cover.

Congress will have limited success in improving the quality of healthcare for Medicare beneficiaries and controlling the growth in Medicare spending if it merely adds more pay-for-performance programs, shared savings programs, or "value-based purchasing" programs on top of the current fee-for-service system. The fee-for-service system must be replaced.

Accountable Payment Models Can Help Improve Quality and Lower Costs

Fortunately, there are better ways of paying physicians than fee-for-service that give them the flexibility to both improve patient care and reduce Medicare spending *without* having to take financial losses themselves. *Accountable payment models* can:

- give physicians the *flexibility* to deliver the type of care that patients need without having to worry about whether that particular combination of services is going to be reimbursed adequately.
- give individual physicians *accountability* for the *kinds of costs they can control or influence*, not for things they *cannot* reasonably affect.
- separate insurance risk and performance risk, so that *physicians are not penalized financially for taking care of sicker patients* or those with unusually complex conditions.

Building Blocks of Accountable Payment Models

Accountable Payment Models are created using one or more of the following building blocks:

- **Bundled Payment:** Instead of paying physicians and hospitals separately for each service associated with the hospitalization or procedure, a bundled payment gives them a single amount for the procedure that they can divide up on their own. Under bundled payment, if a physician helps a hospital reduce the cost of a procedure, the physician can share in the savings the hospital achieves, and both the hospital and physician can then offer a lower price to Medicare for the newly redesigned care.
- **Warrantied Payment:** Under a warrantied payment, the physician is paid more for a procedure than they are today, but they are no longer paid more for treating any infections or complications related to the procedure that the patient experiences. The physician is thereby rewarded for providing safer, higher-quality care, and Medicare saves money by not having to pay to treat expensive complications.

- **Condition-Based Payment:** Bundled payments and warrantied payments can help improve the quality and efficiency of care for a particular procedure, but they don't remove the disincentives for reducing unnecessary procedures. A condition-based payment solves that problem by paying for care of the patient's health condition, regardless of what procedure is used.

BUILDING BLOCKS OF PAYMENT REFORM	HOW IT WORKS	HOW PHYSICIANS AND HOSPITALS CAN BENEFIT	EXAMPLE
Bundled Payment	Single payment to two or more providers who are currently paid separately (e.g., hospital + physician)	Higher payment for physicians by reducing costs paid by hospitals	Medicare Acute Care Episode (ACE) Demonstration
Warrantied Payment	Higher payment for quality care, no extra payment for correcting preventable errors and complications	Higher payment for providers with low rates of infections and complications	CMMI BPCI Geisinger ProvenCare
Condition-Based Payment	Payment based on the patient's condition, rather than the procedure used to treat the condition	No loss of payment for providers who use fewer tests and procedures	ACC SMARTCare BCBSMA AQC

The advantage of all of these payment approaches is that they give physicians greater flexibility to decide which services should be provided to a patient (rather than being restricted by the services specifically authorized under a fee-for-service system) and they remove the disincentives to eliminate unnecessary services, so that Medicare or other healthcare payers spend less money to get higher-quality care for their patients.

These approaches – a single payment for a complete product or service, with a warranty to correct defects at no charge – are how most other industries are paid for their products and services, and it makes sense to use them in healthcare, too.

Creating Accountable Payment Models Using Different Combinations of the Building Blocks

Most of the successful payment reforms you typically hear about are simply combinations of these building blocks. "Episode payments" include some combination of bundled payment and warrantied payment. "Risk-adjusted global payment" is, in effect, a broad set of condition-based payments, each with elements of bundling and warranties.

Thinking in terms of the building blocks of payment reform is important because there is no single "best" way to define an episode payment or global payment. The CMS Innovation Center has recognized this, and so its Bundled Payments for Care Improvement (BPCI) Initiative is offering four different payment models for 48 different patient conditions. Each model has a different combination of bundling and warranties; some apply to conditions and others apply to particular procedures.

But despite this diversity – as many as 144 different payment models in total – the BPCI doesn't go nearly far enough, because *all* of the BPCI payment models *are limited to patients who have been hospitalized*. Although we certainly want to improve the quality and efficiency of hospital care and to reduce the high cost of complications, readmissions, and post-acute care for patients who are hospitalized, patients should not have to be hospitalized in order to get better quality care. **We also need to have payment reforms that help to keep patients healthy and avoid needing to go to the hospital in the first place.**

Examples of Successful Accountable Payment Models Using the Building Blocks

Where these building blocks have been used to create appropriate accountable payment models, providers, payers, and patients have all benefited. For example:

- in the Medicare Acute Care Episode (ACE) Demonstration, which "bundles" physician and hospital payments (i.e., it makes a single payment to both providers, rather than separate payments to each), Medicare has saved money, physicians have received higher payments, hospitals have been able to reduce their costs and improve their operating margins, and patients have received better care at lower cost.[6]
- the Geisinger Health System in Pennsylvania, through its ProvenCare[SM] system, provides a "warranty" that covers any follow-up care needed for avoidable complications within 90 days at no additional charge. The system was started for coronary artery bypass graft surgery, and has been expanded to hip replacement, cataract surgery, angioplasty, bariatrics, low back pain, perinatal care, and other areas.[7] Offering the warranty led to significant changes in the processes used to deliver care, and Geisinger has reported dramatic improvements on quality measures and outcomes.[8]
- The Alternative Quality Contract implemented by Blue Cross Blue Shield of Massachusetts in 2009 defines a single payment to a physician practice or health system for a group of patients to

cover all care services delivered to those patients (including hospital care, physician services, pharmacy costs, etc.). The payment amount is determined based on the health conditions of the patients, not based on what tests or procedures the providers use. The physician practice or health system can earn a bonus payment for achieving high performance on clinical process, outcome, and patient experience measures. Evaluations of the early results show that participating healthcare providers achieved better quality, better patient outcomes, lower readmission rates, and lower utilization of emergency rooms.[9]

Accountable Payment Models Are Needed for Every Specialty

To date, most payment reform efforts have been focused narrowly on a subset of physicians, particularly primary care physicians and surgeons, or they have required physicians to participate in large health systems or Accountable Care Organizations that are willing to take accountability for the total costs of care for a population of patients. These initiatives are desirable, but insufficient. **If we are going to successfully control healthcare costs and improve the quality of care for all patients, we need to make payment reforms available to every specialty and to independent physicians as well as those who are part of large systems.**

There are many examples of significant improvements in the quality and cost of care that could be achieved by paying individual specialties under accountable payment models. For example:

- **Coronary Artery Disease.** A condition-based payment for coronary artery disease would enable cardiologists (potentially in collaboration with cardiac surgeons and/or primary care physicians) to redesign the way care is delivered to patients with newly diagnosed coronary artery disease, regardless of what type of treatment is used (medical management, PCI, or CABG) or where the treatment is provided (hospital, ambulatory surgery center, or office).
- **Congestive Heart Failure.** A condition-based payment for patients with congestive heart failure (CHF) would enable cardiologists and/or primary care physicians to provide better care management for patients and reduce the rate of emergency room visits and hospitalizations for exacerbations of their CHF.
- **Chronic Obstructive Pulmonary Disease.** A condition-based payment for patients with chronic obstructive pulmonary disease (COPD) would enable pulmonologists and/or primary care physicians to provide better care management for patients with COPD and reduce the rate of ER visits and hospitalizations for exacerbations of their COPD or for pneumonia.
- **Inflammatory Bowel Disease.** A condition-based payment for inflammatory bowel disease would enable gastroenterologists (potentially in collaboration with primary care physicians) to better manage all of the care needs of patients with this condition, reducing unnecessary hospitalizations and emergency room visits.

- **Epilepsy.** A condition-based payment would enable neurologists (potentially in collaboration with primary care physicians) to better manage all of the care needs of patients with epilepsy, including their preventive care.
- **Colon Cancer Prevention.** Gastroenterologists (potentially in collaboration with oncologists) could receive a global payment for colon cancer screening and treatment of colon cancers within a population of patients. More effectively targeted, high quality colon cancer screening would be designed to reduce the frequency of late stage colon cancer treatments, while eliminating unnecessarily frequent colonoscopies.
- **Transient Ischemic Attack and Stroke.** An episode payment would enable neurologists and vascular surgeons to provide the most effective short-term management and treatment of patients who experience a transient ischemic attack (TIA), regardless of what type of treatment is used (e.g., endarterectomy, tPA, antiplatelet therapy). A longer-term condition-based payment could be made to neurologists and cardiologists to support comprehensive strategies to prevent both strokes and myocardial infarction in patients who have experienced a TIA.
- **Childbirth.** A single payment to obstetricians/gynecologists for labor and delivery would enable the mother and physician to choose the best method of delivery (vaginal delivery or cesarean section) and the best location for the delivery (e.g., a hospital or birth center). The payment could be limited to normal pregnancies in low-risk women, or applied to a broader population with the payment amount risk-adjusted based on the mother's characteristics. This could be very helpful to state Medicaid programs.

In order to move away from fee-for-service, each physician specialty will need payment models that are (a) customized to the specific types of patients they care for and (b) focused on the types of costs they can control or significantly influence. **A weakness of many current efforts at payment reform is that they try to make physicians accept accountability for the total costs of all care their patients receive, even though the physician can only expect to have an impact on a subset of those costs.** Physicians and other healthcare providers are far more likely to be willing to accept responsibility for the utilization and cost of services they deliver or prescribe themselves than services chosen by other providers. (For example, primary care physicians can influence the rate at which their patients go to an emergency room, but not the number of tests that are ordered once the patient arrives; emergency room physicians can influence the number of tests ordered in the emergency room, but not how many patients come to the emergency room for conditions that could have been treated by their primary care provider.) To address this, payment to physicians in a particular specialty should be designed to only include the costs of the services that these physicians control or can significantly influence, while *excluding* the costs of other services. (Medicare would continue to pay for the excluded services on either a fee-for-service basis or through separate payment reforms designed for the other specialties).[10]

Accountable Payment Models Can Also Help ACOs Be Successful

Accountable payment models for each specialty not only can help independent physicians improve care and control costs, they can help create more successful Accountable Care Organizations (ACOs). If every specialty participating in the ACO is paid in a way that enables it to achieve savings of 2% within its own sphere of influence, the ACO as a whole will be far more likely to achieve the minimum 2% savings Medicare is seeking from the ACO than if the ACO tries to achieve a similar amount of savings with a few care improvement programs focused on a small number of patients. Although there are many opportunities to save money in healthcare without harming patients, there are no "silver bullets" that can achieve dramatic savings in any one area.

Accountable payment models will even be helpful for health systems with employed physicians, because they will provide a model for improving the compensation structure for physicians inside the health system. Most physician compensation systems today, even for physicians who are "on salary," are based on fee-for-service, i.e., the physician gets paid in part or in whole based on the number of visits they have or the number of procedures they perform. These compensation structures will need to change if a health system wants to be a successful Accountable Care Organization, and accountable payment models can help them do so.

How an Accountable Payment Model Can Improve Patient Care and Save Money Without Harming the Financial Viability of Physicians or Hospitals

Here is an example of how more accountable payment models can improve care for patients and save money for Medicare without financially harming physicians or hospitals. Assume that during the course of a year, a physician practice or health system sees 300 Medicare patients who have a particular health condition (e.g., heart disease). One approach to treating the condition is an expensive hospital procedure (e.g., placement of a stent in a coronary artery) that could help the patients, but the procedure also carries a risk of infection or death, and it is not appropriate for all patients. The physicians in the practice evaluate the patients to determine whether to do the procedure, and they decide to perform the procedure for 200 of the 300 patients who are evaluated. The physicians are paid $150 for the office visit to evaluate each patient and they are paid $850 for each procedure. The hospital is paid $11,000 for each procedure the physicians perform. In total, Medicare is spending $2.4 million per year on these patients.

Now, assume further that a study shows that 10% of the procedures being performed are either inappropriate or unnecessary. If the physician practice simply reduced the number of procedures by 10%, Medicare would save $240,000, but the revenue to the physician practice would decrease by 10% and the hospital's revenue would also decrease by 10%, causing a financial problem for each of them.

	TODAY		
	$/Patient	# Pts	Total $
Physician Svcs			
Evaluations	$150	300	$45,000
Procedures	$850	200	$170,000
Subtotal			$215,000
Hospital Pmt	$11,000	200	$2,200,000
Total Pmt/Cost	$8,050	300	$2,415,000

But if the physician practice is given a condition-based payment for the 300 patients it is seeing, it can redesign both care and payment in a way that can reduce Medicare spending without financially harming either the practice or the hospital. The payment would no longer depend on what procedures the physicians do or whether they do a procedure at all, so there would be no financial penalty for doing fewer procedures, nor any financial reward for doing more; the focus would be on achieving good outcomes for the patient. Assume that the physician practice works with the hospital and determines that they can jointly give good quality care to the 300 patients with a budget of $2,348,000, which is a 3% savings for Medicare. The physician practice not only redesigns the care for the patients, but it also redesigns the way everyone is paid. The physicians in the practice will now get paid more for the patient evaluation visits, so they have time to spend doing a shared decision-making process with the patients, and as a result, 10% fewer patients decide they want to receive the procedure. The physicians will also get paid more for each procedure, but since they will now be doing fewer procedures, this does not result in a significant increase in revenues for the practice (indeed, they cannot get more revenue than the overall budget allows). The hospital determines what its fixed and variable costs are so that it can be paid enough for each procedure to still cover its costs even with fewer procedures.

CONDITION-BASED PAYMENT:
Ability to Redesign Payment and Care to Save Money
Without Hurting Providers or Patients

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$883	180	$159,000	
Subtotal			$215,000			$219,000	+2%
Hospital Pmt							
Fixed Costs	$6,930	*63%*	$1,386,000			$1,386,000	-0%
Variable Costs	$3,630	*33%*	$726,000	$3,630		$653,400	-10%
Margin	$440	*4%*	$88,000			$89,600	+2%
Subtotal	$11,000	200	$2,200,000	$11,828	180	$2,129,000	-3%
Total Pmt/Cost	$8,050	300	$2,415,000	$7,827	300	$2,348,000	-3%

The net result is that the patients get better care, the physician practice receives slightly more revenue, and the hospital actually sees an increase in its margin, all while saving Medicare money.

Why Shared Savings Won't Achieve the Same Results

This kind of significant redesign of care needs a completely new payment model; it cannot be done under fee-for-service or even in an ACO in the Medicare Shared Savings Program. Under the Medicare Shared Savings Program, the physicians and hospitals are still paid under the fee-for-service system, so they still lose money when they do fewer procedures. The arbitrary formula for awarding shared savings may not provide enough money back to the physicians and hospital to cover their losses, and even if it does, the payment will come a year later, forcing the physicians and hospital to incur losses in the short run. Moreover, there may be no shared savings payment at all if the savings they achieve for this particular set of patients is not enough to allow the ACO to qualify for a shared savings payment.

SHARED SAVINGS:
Shared Savings Payment Is Not Enough To Offset Provider Losses

	Year 0	Year 1	Chg	Year 2	Chg	Cumulative
Physician Svcs						
Evaluations	$45,000	$45,000		$45,000		
Surgeries	$170,000	$153,000		$153,000		
Shared Savings		$0		$17,000		
Subtotal	$215,000	$198,000	-8%	$215,000	-0%	-$17,000
						-4%
Hospital Pmt						
Surgeries	$2,200,000	$1,980,000		$1,980,000		
Shared Savings		$0		$101,500		
Subtotal	$2,200,000	$1,980,000	-10%	$2,081,500	-5%	-$338,500
						-8%
Total Pmt/Cost	$2,415,000	$2,178,000	-10%	$2,296,500	-5%	$355,500
Savings		$237,000		$118,500		-7%

Separating Performance Risk from Insurance Risk

To enable physicians to be successful in accountable payment models and to attract physician participation, the payment models must be structured to ensure that they only require physicians to take accountability for *performance risk*, i.e., for their ability to manage their patients' conditions in a high-quality and efficient manner, but not for *insurance risk*, i.e., whether a patient has an illness or other condition requiring care. In contrast, traditional (non-risk-adjusted) capitation systems transferred *all* cost risk to the provider. Insurance risk is what health insurance is designed to address, and so Medicare needs to retain insurance risk.[11]

There are several ways to structure payment systems to give providers accountability for the costs they can control, without asking them to take on insurance risk that they cannot control: [12]

- **Risk Adjustment:** Higher payments should be made for those patients who have more health conditions or more serious health problems. The payment should only be higher if the patient is sicker, not simply because the provider decides to do more tests or procedures. In the example given earlier, if the physicians and hospital had sicker patients who were more likely to need expensive procedures, then their budget would increase. But this would not mean Medicare

would not still receive savings, because Medicare would have had to pay even more for those patients under the fee-for-service system.

- **Risk Limits:** Since no risk adjustment formula could ever be 100% accurate in predicting legitimate variations in costs, risk adjustment should be supplemented with risk limits, such as outlier payments to cover unusually high costs for specific patients and "risk corridors" that require Medicare to provide additional payments to providers when the total cost of treating a group of patients significantly exceeds the agreed-to payment level. The sizes and cost-sharing parameters for these risk corridors could vary from provider to provider, since larger providers will be better able to manage variation in costs, and the parameters could also be changed over time as providers become more experienced in managing costs.
- **Risk Exclusions:** In some cases, it is clear that certain kinds of costs cannot reasonably be controlled by a provider, and rather than using risk adjustment formulas or other complex calculations to adjust for them, they should simply be excluded from accountability altogether. For example, the costs associated with patients who are seriously injured in accidents could simply be excluded entirely from a global payment model for a small group of physicians, and be paid for separately on an episode-of-care basis or under traditional fee-for-service.
- **Contract Adjustments:** It is impossible for anyone to predict exactly what will happen when Medicare and physicians move to completely different payment models, particularly in the early phases of implementing new payment models. New drugs, new medical devices, and new ways of delivering care are being developed at a rapid pace, and these can either help or hurt providers' ability to control costs and improve quality. Rather than taking years to design and negotiate payment reform contracts that try to anticipate all possible contingencies, CMS should make a commitment to make adjustments to contracts with providers to deal with unexpected events.

Ensuring Quality of Care for Patients

A common concern about payment reforms that are designed to increase incentives for providers to control costs is that they will also create incentives for providers to withhold care that patients need or to deliver lower-quality care in order to reduce costs. It is important to recognize, however, that even fee-for-service payment, with its inherent incentives to deliver more services to patients, does not guarantee the delivery of higher quality care. Implementing the accountable payment models described

earlier will make it easier for physicians and other providers to improve quality because they will remove the barriers and disincentives that exist in the fee-for-service system today. However, no payment system will, in and of itself, guarantee higher quality care unless the quality of care is explicitly measured and mechanisms are established for rewarding higher quality care and/or penalizing lower quality care.

Consequently, accountable payment models should be accompanied by (a) requirements for measurement and public reporting on the quality of care, and (b) bonuses or penalties for the aspects of quality which are not directly encouraged by the payment model itself. Different types of quality measures will be important under accountable payment models than under fee-for-service; for example, if a provider accepts a payment with a warranty for errors, infections, or complications occurring during treatment, there is no need to have a separate quality bonus/penalty for such errors, infections, and complications, because there is a built-in penalty for the provider if such events occur, namely, it has to correct the problems with no additional compensation. In the absence of such a warranty, however, a separate bonus/penalty component would need to be added to the payment system to provide similar incentives. Quality measurement focused on preventive care – where problems will often not manifest themselves until many years in the future – will be important to include in accountable payment models. Fortunately, this is the area where most community-based public reporting programs now focus their efforts.

A more fundamental problem is that most of the measures that are being used by Medicare and other payers today are process measures, not outcome measures, e.g., they measure whether a patient received a specific set of medications, not whether they avoided another heart attack, and they measure whether appropriate surgical procedures were used in the hospital, not whether the patient experienced an infection or was able to walk again. Not only is there evidence that good performance on many types of process measures does not necessarily improve outcomes,[13] process measures could actually impede efforts to reduce costs and improve quality by locking in less-than-optimal approaches to care. **Congress needs to support the development and testing of new quality measures, particularly outcome measures appropriate for the kinds of patient conditions managed by specialty physicians.**

It is desirable to use common, nationally endorsed quality measures and requirements for quality improvement activities wherever possible, but there should also be the flexibility to use different quality

measures and quality improvement programs where appropriate to respond to state and regional priorities. In addition, in selecting national quality measures and requirements for quality improvement strategies, preference should be given to those quality measures and quality improvement strategies that are already being used in multiple regions and states.

How Congress Can Quickly Implement Accountable Payment Models

The nation needs to implement these types of accountable payment models as broadly and quickly as possible, both in the Medicare program and for all types of payers. Every month of delay means that more patients will be harmed, more patients will continue to receive less-than-optimal care, and the federal deficit will be harder to solve.

Weaknesses of the Current Approach for Designing and Implementing Payment Reform

The traditional approach that has been used for payment reform in the Medicare program is a top-down approach, where Congress directs CMS to develop a better payment model, CMS tests one or more alternative approaches, and then it decides on a single approach that has to apply to every physician and every community. This approach is not working as quickly or effectively as we need it to, because it has two fundamental flaws:

- **There cannot be a one-size-fits-all approach to payment reform.** Because the specific opportunities and barriers differ from community to community, and because different physicians have different types of patients and different levels of ability to change care delivery, many different payment reform models will be needed. Any single payment reform model may work for some physicians in some parts of the country, but it will likely not work for others, and that means the impact on cost and quality will be far less than we want or need.
- **We will never be able to "prove" that a payment model works before making it broadly available.** Although it would seem desirable to have "evidence" that a payment reform will be successful before making it broadly available, this will never happen, for two simple reasons. First of all, payment reform itself does not improve quality or reduce costs, physicians do that. Payment reform removes the barriers that fee-for-service payment create for better quality, lower-cost care, but no payment reform will be successful if the physicians being paid that way don't actually use the payment to improve care. Second, because the opportunities and barriers differ dramatically from community to community and provider to provider, the fact that one

physician successfully used a payment reform model to improve care does not guarantee that other physicians will be able to do so. This is particularly true if the payment reform model itself does not incorporate any explicit accountability for cost. For example, even if dozens of studies show that spending is lower for patients who receive care from medical homes that get higher payments, there is no guarantee that future medical home projects will have the same results if they aren't explicitly taking accountability for doing so.

A Bottom-Up Approach for Faster, More Successful Payment Reform

We wouldn't expect centrally-developed solutions in other industries to be the ideal approach, and we can't expect that in healthcare, either. So in addition to the current, "top-down" approach, I recommend that Congress establish a "bottom-up" approach, whereby physicians, provider organizations, medical specialty societies, and multi-stakeholder Regional Health Improvement Collaboratives are invited to develop payment models that will work well for individual physician specialties in the realities of their own communities.

If any of these groups brings CMS a payment model that is *specifically designed to improve patient care and save Medicare money*, CMS should have not only the power, but the *obligation* to approve it and implement it. CMS should then also make that same payment model available to any physician who wants to participate and has the capabilities to do so. Moreover, if a physician is participating in such a model, they shouldn't be subject to threats of SGR-type payment reductions.

This kind of bottom-up approach is not as radical as it might seem:

- For the past two years, the CMS Innovation Center has been inviting providers and other organizations to submit proposals for innovative ways to deliver care and save money, through programs such as the Innovation Awards and the Bundled Payments for Care Improvement Initiative. The fact that CMS received 8,000 applications for the Innovation Awards program demonstrates the broad interest there is around the country in changing care delivery; it also demonstrates the ability of CMS to review large volumes of proposals in a short period of time.
- CMS has implemented significant payment reforms in the past without waiting for evaluation studies to prove that they will work. For example, the Inpatient Prospective Payment System (the DRG payment system for hospitals) was designed and implemented in the fall of 1983, barely a year after it was authorized by Congress, despite the fact that there was no formal

demonstration program to prove it would work. CMS has regularly modified the program to improve it, but it did not wait for the perfect program to be designed before moving ahead to implement it.

There are five things that I believe Congress needs to do to create a truly successful process for developing and implementing new payment models as quickly as possible:

1. **New payment models should be able to be proposed to CMS at any time, and there should be no limit on how many different proposals can be approved as long as they are designed to improve care and save Medicare money. Proposals also need to be reviewed quickly, and CMS should have the obligation to approve a proposal if it demonstrates how it will improve patient care and save Medicare money.**
2. **There should be frequent opportunities for physicians to apply to participate in already-approved payment models. Every physician should be able to participate in an approved accountable payment model whenever they are ready to do so.**
3. **Physicians need to be given access to Medicare claims data so they can determine where the opportunities for saving are, how care will need to be redesigned to achieve those savings, and how payment will need to change to support better care at a lower cost. Specialty societies and Regional Health Improvement Collaboratives should be empowered to assist physicians to do the necessary analyses of these data.**
4. **Once a physician is participating in an accountable payment model, they should have the ability to continue participating as long as they wish to do so if the data show that the quality of care is high and Medicare spending is being controlled. Most innovative payment models today are explicitly time-limited, and no physician or other healthcare provider is going to make significant changes in the way care is delivered if they might be forced to revert to traditional fee-for-service payment within a few years. *We need to stop doing demonstration projects and start implementing more broad-based payment reforms.***
5. **Funding should be made available to medical specialty societies and multi-stakeholder Regional Health Improvement Collaboratives so they can provide technical assistance to physicians. Most physicians don't have either the time or training to determine whether and how a new payment model will work for them. If organizations that they trust can**

help them analyze data and redesign the way they deliver care, they are far more likely both to embrace new payment models and to be successful in implementing them.

CMS could give priority to reviewing payment reform proposals from communities that have already developed multi-payer payment reforms involving all or most of the commercial insurance plans in the community and Medicaid programs. The biggest problem the physicians who are participating in these programs have faced is that Medicare does not participate, meaning that 30-40% or more of a physician practice or hospital's patients are not included in the payment reforms. If Congress creates a process through which these communities can bring these payment approaches to CMS and have them approved, the providers in those communities will be better able to change care, and the Medicare program will be able to quickly achieve savings.

The Need to Engage Beneficiaries

Payment reforms will be far easier to implement and far more successful if Congress also takes steps to encourage Medicare beneficiaries to be actively engaged with their physicians in managing their care. One simple change would make a huge difference: asking beneficiaries to designate which physician they want to be in charge of care for each of their conditions.

Most payment reforms that are being implemented in traditional Medicare or in commercial PPO insurance plans are forced to use complicated statistical attribution methodologies to determine which physicians are accountable for which patients. These methodologies are *retrospective*, i.e., Medicare looks back over the claims it paid for the patient over the past year or two to identify which providers the patient actually saw, uses statistical analyses to determine which, if any, physician delivered the majority of the patient's care, and if there is such a physician, assigns the patient to that physician. But using *retrospective* statistical attribution rules to assign patients to providers means that neither the provider nor the patient knows they are part of the new payment system until after the care is delivered, potentially a year a more later.[14] If providers and payers only find out *retrospectively* that they are in a new payment system, it will be difficult for them to work together *prospectively* to change care and prevent unnecessary costs from occurring.

The problems caused by retrospective attribution go far beyond mere uncertainty by providers and patients regarding whether they are in a payment model or not. The attribution models actually reinforce the problems of the fee-for-service system. For example, in various medical home programs,

the primary care physician gets an additional, non-visit-based payment for each patient who is attributed to him or her based on whether the patient made a billable office visit to the PCP. But PCPs who redesign their practices to reduce the emphasis on office visits for healthy patients in favor of phone calls and emails, while providing longer office visits for more complex patients, will be harmed financially under this system, since they will not only lose fee revenue by having fewer office visits, they may also not receive any additional payment for the patients who do not have the recent office visits that are required to trigger the attribution calculation.

Attribution systems also make physicians reluctant to participate because if the attribution rules assign patients whose care the provider cannot influence, the provider can be inappropriately penalized when costs for those patients increase (or inappropriately rewarded if costs decrease). If the attribution rules fail to assign a patient even though the provider was responsible for improving the efficiency of care for that patient, the provider would fail to receive credit for the savings or quality improvements they achieved.[15]

There is an easy solution to this: Simply ask beneficiaries to designate which physician(s) they want to be in charge of care for each of their conditions. Asking patients to designate who their physicians are does *not* mean that the patient has to be "locked in" to those physicians or that any physician must serve as a "gatekeeper" for the patient's care (i.e., that Medicare will not pay for the patient to receive care from any specialist or other provider that is not approved in advance by the physician). It merely means that the patient needs to *choose* their physicians and *notify* both the physicians and Medicare about that; if they wish to change physicians at any point, they would be free to do so, as long as they notify the physicians and Medicare about the change.

Do We Need Incentives or Penalties to Get Physicians to Participate?

Some people have suggested that we need to make the fee-for-service system less attractive, e.g., by cutting payment levels, in order to encourage or force physicians to engage in new payment models. I think this is both unnecessary and inappropriate.

Most physicians will find a properly designed new payment model to be more attractive than the fee-for-service system, because it will give them the flexibility to redesign care for their patients, the opportunity to be rewarded for delivering higher quality care, and the ability to help the nation control healthcare costs in a way that doesn't harm patients or cause financial problems for their practice.

Under the fee-for-service system, physicians typically lose money themselves when they change care in ways that generate savings for Medicare. However, Medicare payments to physicians represent less than 20% of total Medicare spending. Since physicians prescribe, control, or influence most of the remaining 80% of spending, under a properly designed payment model, physicians can help Medicare reduce spending significantly without cutting their own revenues.

Making fee-for-service less attractive in order to get physicians to participate in new payment models implies that the new payment models are *worse* than fee-for-service, which is simply not true. Moreover, since not every specialty or physician will be able to participate in an appropriate payment model right away, making fee-for-service more onerous will penalize physicians who have no other alternative available to them.

I find that most physicians are frustrated with the current fee-for-service system and want to participate in better payment models. However, many physicians have been burned in the past by payment changes that are badly designed, e.g., by shifting unmanageable levels of risk to them, demanding better quality care without giving them the resources or flexibility to deliver it, or cutting payment levels below the achievable cost of care. If Congress and CMS can offer physicians payment models that avoid these problems and provide the help they need to succeed, I believe physicians across the country will not only participate voluntarily, but enthusiastically.

How Congress Can Help Ensure the Success of New Payment Models

Many people believe that the only way that physicians can succeed under accountable payment models is to work for large integrated health systems. Nothing could be further from the truth. Experience has shown that small, independent physician practices can also use better payment models to deliver higher-quality, lower-cost care. For example, the earliest known example of someone offering a warranty in healthcare was not a large health system, but a single physician. In 1987, an orthopedic surgeon in Lansing, Michigan collaborated with his hospital to offer a fixed total price for surgical services for shoulder and knee problems, including a warranty for any subsequent services needed for a 2-year period, including repeat visits, imaging, rehospitalization, and additional surgery. A study found that the payer paid less and the surgeon received more revenue by reducing unnecessary services such as radiography and physical therapy and reducing complications and readmissions.[16]

In many cases, small physician practices may need to join together through Independent Practice Associations (IPAs) or other structures to achieve the necessary economies of scale to manage accountable payment models. However, physicians do not need to be employed by hospitals or join large group practices in order to do so. There are many examples of how physician practices, including very small practices, are successfully managing these new payment models.

Just like in every other industry, where small businesses are often the innovators, small healthcare providers can be more efficient and innovative than large systems, if we give them the opportunity to do so without imposing unnecessary and expensive regulatory requirements.

However, physicians, particularly those in small practices, will need help both to design and implement new payment models. As noted earlier, two kinds of assistance are particularly important:

- Access to Data and Analysis on Cost and Quality
- Training and Coaching in Process Improvement

Access to Data and Analysis on Cost and Quality

It is impossible for physicians, hospitals, and other providers to identify where opportunities for cost reduction exist or how to capitalize on them without access to Medicare claims data. Physicians need information on current utilization patterns and analyses of the likely impact of interventions in order to construct a feasible business case for the investment of resources in new care processes and to evaluate the feasibility of participating in a new payment model.

For example, in order for a physician practice or health system to accept an episode of care payment for the type of treatment it delivers, it needs to know about all of the services that those types of patients have been receiving from the hospital, other physicians, and post-acute care providers, how much all of those providers are being paid, the frequency with which adverse events occur, and the extent to which any of those elements can be changed. Differences in the types of services needed for patients with different types of health conditions need to be identified, and the impacts of risk adjustment and risk limits need to be determined. Medicare will need to have matching data so it can be sure the total episode price is lower than the average amount being paid today.

Once a physician practice is participating in an accountable payment model, timely access to data is critical if the practice is going to be held accountable for costs and quality, particularly if this includes services delivered by hospitals or other providers.

It is not enough simply to have access to data or even to traditional quality measures that are produced by Medicare and commercial health plans; physicians need useful *analyses* of those data to identify where opportunities exist for quality improvement and cost reduction.

Medical specialty societies and Regional Health Improvement Collaboratives can provide this kind of assistance to physician practices, but they will need financial support to do so. In particular, there is currently no federal funding program that provides support for the work that multi-stakeholder Regional Health Improvement Collaboratives do to analyze data or do public reporting of quality measures.

Training and Coaching in Process Improvement

Data can show where opportunities exist to reduce utilization and costs, but physicians also need training and coaching in how to restructure their practices in ways that can take advantage of these opportunities. Not only is this re-engineering not taught in medical school, it is hard for physicians to do it and still keep up with the demands of ongoing patient care. Moreover, it will be challenging for physicians and other healthcare providers who have been operating under the fee-for-service payment system for many years to suddenly switch to operating under accountable payment systems that require greater accountability for cost and quality.

Physicians cannot change the way they deliver care unless payment systems are implemented that support those changes. However, once a better payment model is made available, they will need to change care delivery in order to succeed. Here again, medical specialty societies and Regional Health Improvement Collaboratives can provide assistance to physician practices, but they will need financial assistance to do so. Successfully transforming local healthcare delivery will require many years of persistent effort, and so reliable, multi-year funding will be needed to support these efforts.

Thank you again for the opportunity to testify. I would be pleased to provide any additional detail about these recommendations that would be helpful.

Sincerely,

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[6] For more information on the ACE Demonstration, see http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations-Items/CMS1204388.html . Although no formal evaluation has been released yet, presentations by participating hospitals and physicians at various conferences have documented the benefits that Medicare, physicians, hospitals, and patients have received.

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[15] For example, if a patient is admitted frequently to the hospital during the year for various problems, but makes his first visit to the PCP near the end of the year, the patient could be attributed to the PCP for the entire year, thereby making the PCP accountable for all of the hospital visits that occurred before the patient first saw the PCP.

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