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REFORMING SGR: PRIORITIZING QUALITY IN A MODERNIZED PHYSICIAN PAYMENT SYSTEM

WEDNESDAY, JUNE 5, 2013

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Burgess, Shimkus, Rogers, Murphy, Blackburn, Gingrey, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Barton, Upton (ex officio), Dingell, Capps, Schakowsky, Green, Barrow, Christensen, Castor, Sarbanes, and Waxman (ex officio).

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

Staff Present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Mike Bloomquist, General Counsel; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Steve Ferrara, Health Fellow; Julie Goon, Health Policy Advisor; Sydne Harwick, Legislative Clerk; Sean Hayes, Counsel, O&I; Robert Horne, Professional Staff Member, Health; Katie Novaria, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Krista Rosenthall, Counsel to Chairman Emeritus; Chris Sarley, Policy Coordinator, Environment & Economy; Heidi Stirrup, Health Policy Coordinator; Lyn Walker, Coordinator, Admin/Human Resources; Alli Corr, Minority Policy Analyst; Amy Hall, Minority Senior Professional Staff Member; Elizabeth Letter, Minority Assistant Press Secretary; and Karen Lightfoot, Minority Communications Director and Senior Policy Advisor.

Mr. Pitts. The subcommittee will come to order. The chair will recognize himself for an opening statement.

On February 7th and April 3rd, 2013, the Energy and Commerce and Ways and Means Committee Republicans released a three-phased outline for permanently repealing the Sustainable Growth Rate, the SGR, and moving toward a Medicare reimbursement system that rewards quality over volume. Stakeholder feedback followed each release and has been integral to the development of this policy, culminating in the draft legislative framework released on May 28th.

[The information follows:]

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Mr. Pitts. This discussion draft took into account the conversations and work of the Energy and Commerce majority and minority staffs, as well as the long collaborative relationship we have had with the Ways and Means Committee.

It was also not a complete reform proposal. Rather, it was designed to be a partial release that allows for input from stakeholders and members of this committee. Again, we are seeking substantive feedback on ways to complete this draft, and I would encourage all interested parties to submit their comments to the committee by June 10th.

The committee has sought to accomplish SGR reform through an open and transparent process with consideration given to all relevant stakeholders. To briefly summarize the draft legislation, Phase I repeals the SGR formula and provides a period of payment stability. During this time, providers will work with the Secretary to identify quality goals and methods of measurement. Phase II will build upon the work of Phase I, tying quality measurement to fee-for-service payment. Provider input will be essential to defining quality medicine during Phases I and II. Any time throughout Phase I and II providers may voluntarily opt out of fee for service by participating in an alternate payment model.

These models will be flexible. Some exist today, such as medical homes, while new and innovative models may also be created and adopted.

Some specifics, such as the duration of payment stability, or the methods of assessing providers on quality measures, have intentionally been left open in our discussion draft. We look forward to input on these and other topics from today's witnesses and the stakeholder community at large with the goal of achieving meaningful Medicare payment reform and designing the best possible system for patients and providers alike.

From the beginning of this process, there has been one clear goal: to remove the annual threat of looming provider cuts by permanently repealing the flawed SGR and replacing it with a system that incentivizes quality care, not simply volume of services. If we are to succeed in getting reform to the President's desk during this Congress, reform must be bipartisan and bicameral. It must also be fully offset and fiscally responsible. However, we are not making the mistake that has sidelined SGR in years past by having the pay-for discussion before we know what we are paying for.

The commitment to exploring bipartisan reform from Mr. Pallone, Mr. Waxman, leaves me hopeful that bipartisan reform is indeed possible. In addition, our longstanding and continuing relationship with Chairmen Camp and Brady from the Ways and Means Committee underscores the commitment that the House has to reforming SGR this Congress. I look forward to working with all parties in the coming weeks and months with the goal of getting SGR reform to the President's

desk. And I look forward to hearing the views and opinions of our witnesses today, and I would like to thank each of them for appearing before this subcommittee.

Thank you. And I yield the balance of my time to the vice chair, Dr. Burgess.

[The prepared statement of Mr. Pitts follows:]

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Dr. Burgess. Thank you, Mr. Chairman.

This hearing is all about momentum. For 10 years I have been here in this committee. On both sides of the dais we have all agreed that the SGR needs to go, and then we get to hear from some really smart people from Washington think tanks to tell us what the brave new world should look like, and then nothing happens. And we all pat ourselves on the back because we agree that the Sustainable Growth Rate makes some unrealistic assumptions about spending inefficiency, but really doesn't move the needle.

Now, this morning, in spite of what you read in the newspapers, today is different. It is different in two respects. First, last week the committee released the first draft of legislative language to eliminate the SGR and move Medicare to a program that more aligns with the private sector in both model development and linking payment to quality. The draft continued the trend of soliciting more provider feedback than at any point in history, and I pledge to all Medicare providers that your feedback, if provided to the committee, accompanied by helpful guidance, will be given the full attention of the committee, and we will work with you.

Yes, this is a first draft, a very rough first draft. Nothing is sacrosanct except the original paragraph which repeals the Sustainable Growth Rate formula. We have got to catch Medicare up with what is happening in the real world. We have to allow every practice

modality that is out there to flourish. Yes, that includes fee for service. But we have got to catch up with what is happening in the real world, and that is what this morning's hearing is all about.

I thank the chairman for calling the hearing, and I will yield back the balance of my time.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Dr. Burgess follows:]

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Mr. Pitts. And now turns to the gentlelady from Virgin Islands, Dr. Christensen, who is filling in for the ranking member today. Recognized for 5 minutes.

Dr. Christensen. Thank you, Mr. Chairman, and I want to thank you and Ranking Member Pallone, who had to return home for the funeral of our beloved Senator Lautenberg, for holding this hearing today. We have come together many times to discuss this issue, and I hope that today's discussion finally puts us on a path to real and broadly implementable solutions that focus on quality, improved patient outcomes, fairer provider reimbursement, efficiency, and lower cost.

Replacement of Medicare's SGR payment system is something that we all agree needs to happen. And I think we also all agree that the healthcare delivery system itself is dysfunctional. It, too, needs to be fixed, and several provisions in the Affordable Care Act -- to pilot new payment models and models of care, to innovate and to help guide the best treatments -- can both improve care, help us to reform and replace the current payment system, and lower costs.

As a family physician, the concept of medical home is not a foreign one to me. And as a community health doctor in the public sphere in a small community I know the value of teamwork to patient outcome, as well as satisfaction. But because the system was not set up to support a team approach, it added time and efforts that could have better been spent caring for more patients, enhancing our knowledge, or quality

time with our family.

We are fortunate that some healthcare providers and systems have begun to do the reforms we are attempting to create nationally through the Affordable Care Act and that they can share their journeys' successes and recommendations, based on experience with us today, and I want to thank the panelists for being here, and I look forward to their testimonies.

As we highlighted in our last hearing on this issue, innovation is key to improving healthcare delivery and payment system. However, moving forward it is important for us to encourage innovation while also ensuring that the benefits of innovation reach all communities. Historically, innovation in health care has improved outcomes for those who are insured or are more affluent much faster than for those who are low income or uninsured, exacerbating existing health disparities.

It is also important that the efforts to reform and replace the SGR take into account those providers who currently work in communities and treat patients who have long been underserved by the health system. These patients are adversely affected by many social determinants of health, have less reliable access to quality care, and ultimately suffer poorer health outcomes as a result. I look forward to hearing how pay for performance and value or outcome-based reimbursement can address this particular concern.

Today, we have a lot to focus on, as the background memo for this

hearing indicates. My colleagues on the other side of the aisle have released two sets of draft frameworks, together with their colleagues on Ways and Means. They have also released draft legislative language, and this hearing is intended to get feedback on the legislative language released and, more importantly, to help inform our Members on the committee process moving forward. And there are some gaps that this hearing I think can probably help to fill.

I also look forward to working with my colleagues on this and the Ways and Means Committee, and other colleagues, as well as the provider and patient advocacy organizations, to continue the efforts of our panelists and others and those of the Affordable Care Act for reform. Our Medicare patients need and deserve it.

Is there anyone who would like the balance of my time? And if not, Mr. Chairman, I will yield back.

Mr. Pitts. The chair thanks the gentlelady.

[The prepared statement of Dr. Christensen follows:]

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Mr. Pitts. Now recognize the chair of the full committee, Mr. Upton, 5 minutes for opening statement.

The Chairman. Thank you, Mr. Chairman.

You know, today we are building upon the significant progress that the committee has made during the past couple years and take a very important step in permanently repealing the flawed Sustainable Growth Rate, otherwise known as SGR or the doc fix. The legislative framework that we released last week, the review of which is the purpose of our hearing today, includes invaluable feedback from so many stakeholders.

However, this legislative framework is not etched in stone. And rather, it is an opportunity for the committee to continue working closely with Members and stakeholders towards a permanent repeal of SGR. It also doesn't contain a pay-for, as we intend to avoid the error made in years past of discussing how to pay for reform before the policy is actually developed. But make no mistake, SGR reform will be offset with a real and responsibly paid-for item when it comes to the floor of the House for a vote.

When Chairman Camp and I began the push towards reform earlier this year and in the last Congress, it was with common purpose and mutual support. Our friendship and working relationship have never been stronger. Both committees, working closely together and with careful attention to public input, have been able to transform the initial February outline that we jointly released into a solid policy

framework. There remains much more work to be done for sure, including the hope for bipartisanship, but we would not be where we are today without our good friends on the Ways and Means Committee, and that collaborative effort will continue.

Over the past several weeks Energy and Commerce Republicans and Democrats have labored hand-in-hand to explore whether bipartisan reform might be possible. And while the release last week was done without their names attached, the language it contained did reflect our talks and collaborative efforts with committee Democrats. I want to particularly thank Mr. Waxman and Pallone for their leadership and continued interest in exploring SGR reform.

And while we stand today at a point far beyond any reform efforts of the past, much work still remains. SGR is one of the most complex issues confronting the Congress and, not surprisingly, difficult policy questions remain to be answered. Today's testimony will help answer some of those questions.

The committee has been dedicated to making reform a transparent process. Such transparency has already given this committee insightful recommendations from multiple stakeholders that culminated in the legislative release last week. We look forward to continuing that process in the weeks to come.

So SGR reform is vital to ensuring economic stability for physicians, access to care for seniors, securing the future of the

Medicare system. I want to conclude by sharing my sincere optimism that, in fact, we will achieve a bipartisan bill, one that represents the work of both sides of the aisle, and in the end the best chance for SGR reform to work its way to the President's desk is through that bipartisanship.

So let's not be satisfied with the unprecedented progress that we have already made. Let's continue working until we have solved the problem for not only our physicians, but certainly for our seniors.

And I yield the balance of my time to Dr. Cassidy.

[The prepared statement of The Chairman follows:]

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Dr. Cassidy. Thank you Mr. Chairman.

The recent CBO projection reducing the cost of repealing the SGR to $138 billion gives us an opportunity to reform this flawed payment formula. We should see this and provide reform that puts us on a financially sustainable path, incentivizing quality health care to individuals and certainly to physicians. I think we all agree on that.

In this process we must be careful to not sacrifice the independence and autonomy of the independent physician practice, and as a doc I am very sensitive to that. Mr. Chairman, I have working on a proposal that would ensure the independent physician and the small group is protected. I will be discussing it during my questions, and hope we can work together as we move forward with reform.

In addition, I would like to commend the chairman for including a process for alternative payment models in the committee discussion draft. I understand that this is an issue the chairman wishes to further develop. I fully support this approach, and, again, I look forward to working with the committee to develop it further.

I yield back to Mr. Upton or to Dr. Gingrey.

[The prepared statement of Dr. Cassidy follows:]

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Dr. Gingrey. Dr. Cassidy, thank you for yielding.

Mr. Chairman, as a physician, I am pleased and excited that we are at this moment today. We are addressing the flawed SGR system, seeking to give doctors more certainty over reimbursement. By using specialty societies and other professional groups to create quality measures that will be used to promote best practices, we will see better patient outcomes and a more efficient -- a much more efficient payment system.

I do have a concern that the quality measures associated with payment reform may lead to unwarranted court claims. Government payment reform should not have any effect on a doctor's liability. During debate, then Chairman Waxman submitted comments for the record which stated that it was not the intent of the President's healthcare bill to, quote, "create any new actions or claims based on the issuance or implementation of any guideline or other standard of care," end quote. Nor is it to supercede, modify, or impair any State medical liability law governing legal standards or procedures used in their medical malpractice cases.

Mr. Chairman, there is bipartisan agreement that the intent of our Federal healthcare laws is to promote quality, not to create new avenues for medical malpractice claims. I look forward to working with the subcommittee to address this potential loophole as we work toward physician payment reform.

Thank you for your indulgence, and I yield back.

Mr. Pitts. The chair thanks the gentleman.

[The statement of Dr. Gingrey follows:]

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Mr. Pitts. That concludes the opening statements. We have one panel today. I will introduce our panel at this time.

First of all, Dr. Cheryl Damberg, senior policy researcher and professor of the Pardee RAND Graduate School. Secondly, Mr. William Kramer, executive director for national health policy, Pacific Business Group on Health. Thirdly, Dr. Jeffrey Rich, immediate past president of the Society of Thoracic Surgeons, director at large, Virginia Cardiac Surgery Quality Initiative. And finally, Dr. Thomas Foels, executive vice president and chief medical officer, Independent Health.

Thank you all for coming. You will each have 5 minutes to summarize your testimony. Your written testimony will be placed in the record.

Dr. Damberg, you are recognized for 5 minutes for your opening statement.

STATEMENTS OF DR. CHERYL L. DAMBERG, PH.D., SENIOR POLICY RESEARCHER, PROFESSOR, PARDEE RAND GRADUATE SCHOOL; WILLIAM KRAMER, EXECUTIVE DIRECTOR FOR NATIONAL HEALTH POLICY, PACIFIC BUSINESS GROUP ON HEALTH; JEFFREY B. RICH, M.D., IMMEDIATE PAST PRESIDENT OF THE SOCIETY OF THORACIC SURGEONS, DIRECTOR AT LARGE, VIRGINIA CARDIAC SURGERY QUALITY INITIATIVE; AND THOMAS J. FOELS, M.D., M.M.M., EXECUTIVE VICE PRESIDENT, CHIEF MEDICAL OFFICER, INDEPENDENT HEALTH

STATEMENT OF CHERYL L. DAMBERG

Ms. Damberg. Thank you for inviting me here today. As the committee considers ways to revise the physician fee schedule so that payment policy supports the delivery of high quality, resource-conscious health care, there are important design features related to structuring performance-based incentive programs that I want to call to your attention. Thoughtful incentive design can ease the transition process for both physicians in the Medicare program and enhance the likelihood of program success. Due to limited time I will touch on only a few of the important design issues. More details can be found in my written testimony.

First, encourage improvement among all physicians by using a continuous payment incentive approach. A continuous incentive

approach pays physicians additional incentive payments for each increment of improvement they achieve. A continuous approach avoids the cliff effects that are common in incentive structures that tie payments to a single all-or-nothing cut point, setting up a large number of providers who will receive nothing despite making actual improvements and investments to improve. Paying more per increment of improvement at the beginning and the middle part of the continuum than toward the top strengthens incentives to physicians at the lower end who are making investments to improve.

Second, use fixed performance thresholds to make it clear in advance to physicians what level of performance is required to achieve an incentive. Over the last decade many performance-based incentive programs used tournament-style relative thresholds that create a competition among providers. Relative thresholds create a great deal of uncertainty and can lessen the response to the incentive, particularly for those physician who are a distance from the anticipated threshold. Instead, physicians should compete against a fixed national benchmark where all who improve and hit the designated targets win. Avoiding competition between physicians for a limited number of winning positions will help to foster sharing of best practices among physicians.

Third, make payments meaningful to generate the desired response. The experiments of the last decade in pay for performance generally

found weak results in part because incentive payments were relatively small, on the order of 1 percent. Physician leaders indicate that incentives of 5 to 10 percent are required to be meaningful. In the beginning, while physicians are learning how to participate, incentives could be relatively modest. However, over time, and in the near term, rather than the long term, the size of the incentives should be increased.

Begin the transition now for primary care by leveraging measures used in Medicare Advantage and other private payer programs. Much work has gone on over the past decade to advance the development of performance measures, particularly for care delivered by primary care physicians. These measures have been widely deployed by private payers, Medicaid agencies, and Medicare in the context of performance measurement, accountability, and incentives, both in managed care and fee for service. The committee and Congress need to understand that a majority of primary care physicians in the United States have already been exposed to these programs. And they could start by working with the Medicare Advantage star rating program and in the process align measurement activities already targeting ambulatory providers.

Fifth, for many clinical subspecialties measures are completely lacking or few are available that could be readily deployed. As such, concerted effort and Federal investment is needed to develop and bring measures to market. CMS should identify and focus development efforts

on 10 to 12 clinical subspecialty areas that contribute to a significant portion of Medicare spending and utilization, and they should work with measure development experts and clinical specialties to identify performance gaps and develop those measures.

Sixth, allow physicians to opt out if they can demonstrate that they have moved to other value-based purchasing models that incentivize cost and quality. Some providers have already started to migrate toward alternative payment models such as ACOs, bundled payments, and medical homes. To the extent that these models contain performance-based incentives for cost and quality they should be considered acceptable opt-out arrangements. For physicians who do not participate in new payment models, they should minimally demonstrate that they are able to perform parallel functions to deliver high-quality, efficient care.

Seventh, rather than simply imposing this change on physicians, Medicare should work in partnership with physicians to support their improvement. Creating an environment where physicians can succeed should include such things as building support structures with local community partners to work on improvement and redesign, facilitating sharing of best practices and learning networks, providing meaningful, timely data feedback, and continuing to advance the health IT infrastructure.

In summary, the ability to move successfully forward with new

performance-based payment models is predicated on having a robust set of measures, a good incentive design, and a support structure that can help physicians participate and succeed in the program. Thank you for the opportunity to appear here today, and I would be happy to take your questions.

Mr. Pitts. The chair thanks the gentlelady.

[The prepared statement of Ms. Damberg follows:]

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Mr. Pitts. And now recognize Mr. Kramer for 5 minutes for an opening statement.

STATEMENT OF WILLIAM KRAMER

Mr. Kramer. Thank you, and good morning. My name is Bill Kramer from the Pacific Business Group on Health. I would like to express our deep appreciation to Chairman Joe Pitts, Vice Chairman Dr. Michael Burgess, as well as to Ms. Donna Christensen on behalf of Ranking Member Minority Member Frank Pallone, for convening today's hearing. I want to applaud the committee for stepping up to the challenge of finding a solution to this very important issue.

PBGH represents large employers who want to improve the quality and affordability of health care. PBGH consists of 60 member companies with employees in all 50 States that provide healthcare coverage of up to 10 million Americans and their dependents. Our members include many large national employers, such as GE, Walmart, Boeing, Tesla, Disney, Intel, Chevron, Wells Fargo, and Safeway, as well as public sector employers.

The basis for my testimony today is our members' significant experience in designing and implementing innovations in provider payment and care delivery. We believe the lessons learned in private sector purchasing can be applied to Medicare.

There are three key points I want to make in today's testimony. First, businesses have a big stake in how Medicare works. Second, large employers want to see physician payment tied directly to the value of the services that are provided. And third, we need new and better performance measures to support a new physician payment system.

First, why should businesses care about how Medicare works? For decades, large employers have been frustrated by the rising cost and inconsistent quality of health care. They know we need to change the way we pay providers. Large employers have supported innovative approaches to physician payment, such as the intensive outpatient care program piloted by Boeing and adopted by many other large employers.

We know, however, that these innovations do not have the scale to drive system-wide change and improve health care across the Nation. We need America's largest healthcare purchaser, the Federal Government, to work in alignment with us and join our efforts and apply its purchasing strategies as purposefully as our businesses do.

Second, large employers want to see physician payment tied directly to the value of services that are provided. We need to replace Medicare's current fee-for-service system over time with payment based on performance with a goal of achieving measurable improvements in quality and affordability. The new physician payment system should encourage individual as well as group accountability.

Although team-based care is often very effective, in many

situations patients are most concerned about the performance of individual physicians. I recently had surgery to repair a broken bone in my face, an injury resulting from an elbow to the eye during a pickup basketball game. While I was pleased to know that I would receive care within a large, high-quality healthcare system, what I really wanted to know was the track record of that surgeon. What was his success rate? How many infections or surgical complications did the patient have. By far the most important thing to me was that surgeon's performance record.

Third, we need to develop more and better performance measures. Among the nearly 700 measures endorsed by the National Quality Forum, the large majority are clinical process or structural measures. While these can be valuable for quality improvement initiatives by physicians, they do not provide information about the things that patients and employers care most about. We strongly recommend that Congress provide support for the rapid development and use of better performance measures, including patient-reported outcomes, patient experience of care, care coordination, appropriateness of care, and total resource use. The selection of these measures should be based on input from physicians, but ultimately be determined by those who receive and pay for care.

In summary, first, businesses have a big stake in how Medicare works and Medicare should adopt successful purchasing practices from

the private sector. Second, large employers want to see physician payment directly tied to the value of services that are provided. PBGH and its member companies strongly support the replacement of the SGR as long as the new payment system results in significant improvements in healthcare quality and affordability.

Third, Congress should invest in the development of new and better performance measures to undergird the new payment system. The selection of these measures must meet the needs of those who receive and pay for care -- patients, employers, and taxpayers.

Our Nation desperately needs to improve its healthcare system, and the SGR replacement is a rare opportunity to give it a shot in the arm. PBGH applauds the committee's efforts to get it right, and we offer our real world experience and expertise to you in advancing this important initiative. Thank you, and I am happy to answer any questions from the committee members.

Mr. Pitts. Thank you.

[The statement of Mr. Kramer follows:]

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Mr. Pitts. The chair thanks the gentleman, and now recognizes Dr. Rich 5 minutes for an opening statement.

STATEMENT OF JEFFREY B. RICH

Dr. Rich. Thank you, and good morning. Chairman Pitts, Representative Christensen, and distinguished members of the committee. Thank you for the opportunity to present my testimony today on the behalf of the Society of Thoracic Surgeons.

I come to you wearing many hats. As mentioned, I am the immediate past president of the Society of Thoracic Surgeons and an active participant in our national database, one of the longest running, most robust clinical outcome data registries in existence. More importantly, or as importantly, I am the former director for the Center for Medicare Management at CMS. In other words, I ran the Medicare fee-for-service system in the last years of the prior administration and was involved very much in value-based purchasing and also physician reform initiatives.

I am a founder and director of the Virginia Cardiac Surgery Quality Initiative. I am now a practicing cardiac surgeon at Sentara Heart Hospital and president of the Mid-Atlantic Cardiothoracic Surgeons, so I have an active clinical practice and understanding of payment and payment reform.

The Society of Thoracic Surgeons represents more than 6,000 surgeons, researchers, and allied healthcare professionals who are dedicated to providing patient-centered high-quality care to patients with chest and cardiovascular diseases, including heart, lung, esophagus, transplantation, and critical care. The STS National Database was established in 1989 as an initiative for quality assessment, improvement in patient safety among cardiothoracic surgeons. The fundamental principle underlying the STS database initiative has been that engagement in the process of collecting information on every case, robust risk adjustment based on pooled national data, and feedback of this risk-adjusted data to the individual practice and institution will provide the most powerful mechanism to change and improve the practice of cardiothoracic surgery for the benefit of patients and the public. And I might add that the database will serve as a platform in all phases of reform, I, II, and III.

The Virginia Cardiac Surgery Quality Initiative was founded in 1994 by myself and others with the expressed purpose of improving clinical quality across an entire State in cardiac surgical programs of all sizes through data sharing, outcomes analysis, and process improvements. All of the Virginia programs participate in the STS National Database and uniformly follow the definitions and measures in its landmark clinical registry.

The database in our State has been unique in that it matches the patient clinical outcome data with each patient's discharge financial data from CMS on an ongoing basis. Each record includes clinical outcomes tied to the cost of each episode of care. In Virginia we have demonstrated that improving quality reduces costs. For example, using evidence-based guidelines, the Virginia Cardiac Surgery Quality Initiative has generated more than $43 million in savings over the last 2 years by reducing blood transfusions in the State. In addition we have reduced atrial fibrillation, a common heart arrhythmia after surgery, and saved another 20-plus million dollars over the last 5 to 7 years. So it has been an effective tool for us not only to improve quality, but to provide cost savings throughout the States.

Since survival and resource utilization information is such an important part of the outcomes for cardiothoracic surgery quality improvement efforts, we urge that steps be taken to ensure these registries have access to administrative or financial data from CMS, and hopefully other payers, both for episodes of care and longitudinal follow-up, as well as outcomes data from the Social Security Administration or another accessible source. It is imperative that SGR reform legislation addresses this foundational issue and gives us a clinical financial tool to create improvement.

STS wishes to commend the committee and your colleagues on the Ways and Means Committee for taking the first steps toward meaningful

physician payment reform. STS has provided substantial comments on the concept document released by the committees on April 3rd that we submit here for the record. Today I would like to highlight a few of our conceptual comments for the committee related to that proposal in a discussion draft just released last week.

STS is particularly grateful to this committee for your recognition of the utility of clinical registries in pursuit of a pay-for-quality physician payment system. To that end, we recognize that Congress faces a challenge in that many specialties do not yet have the ability to collect clinical data, develop risk-adjustive quality measures, and implement physician feedback and quality improvement programs.

That said, we hope that implementation of a pay-for-quality program will not have to wait for all of medicine to be at the same place at the same time. We believe that early innovators who are able to enter into Phase II, or even Phase III, should be able to do so now, while others are trying to play a game of catchup, if you would. For that reason, we recommend that policymakers consider ways to reward providers for incremental steps towards these quality assessment and improvement goals, while allowing those medical professionals whose specialties that already have the requisite infrastructure in place to engage in this new system as soon as possible.

We do believe that it is important to use the STS database for

other uses -- medical liability reform, public reporting. We believe that empowerment of patients with data is important and advancing medical technology.

In conclusion, we wish to thank you for your time and understanding and listening to our plea for engaging with the rest of medicine in clinical data and outcomes assessment.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Dr. Rich follows:]

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Mr. Pitts. And now recognize Dr. Foels 5 minutes for an opening statement.

STATEMENT OF THOMAS J. FOELS

Dr. Foels. Good morning, Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee on Health. On behalf of Independent Health --

Mr. Pitts. Would you please turn the mike on? Thank you.

Dr. Foels. Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee on Health, on behalf of Independent Health I appreciate this opportunity to testify before you today. My name is Dr. Tom Foels. I am chief medical officer at Independent Health, which is a not-for-profit health insurer, serving over 400,000 members in Medicare, Medicaid, and commercial insurance in the Buffalo metropolitan area of Western New York.

Independent Health is nationally recognized for its quality of services and customer satisfaction. We have consistently ranked among the top 10 percent of health plans nationally for quality based on the National Commission for Quality Insurance. Independent Health shares the belief that the replacement of the SGR with a viable Medicare physician payment policy is critical to ensure that the Medicare program will be available for generations to come. We believe that

it is time to replace the fee-for-service system with a system that rewards quality outcomes and efficiency.

Now, while I represent Independent Health, I am also here with the collaborative voice of my colleagues at the Alliance of Community Health Plans, a group of not-for-profit community-based plans dedicated to improving the health of its members, the health of the communities in which they live and work, as well as to ensuring affordability of coverage.

And finally, I speak today as a primary care physician with over 30 years of clinical and administrative experience. For the past 17 years I have held various senior positions at Independent Health, the last four of which as chief medical officer. During that time, I have been deeply involved in our efforts to improve quality and affordability of health care for our community.

My experiences as a physician have taught me that transformational change is difficult, regardless of its merits. I understand the skepticism and reluctance of some physicians because I have, at times, shared it as well. But I have also come to understand that important changes need to be made now that will benefit both physicians and patients and that the transition to a value-based payment system is both desirable and workable.

Our upstate New York community, provider community, is typical of so many communities across the country with an abundance of

independently practicing, non-aligned primary care and specialty care providers and hospitals. Recognizing the desire of physicians to retain their independence, Independent Health has designed its programs in a way that has led to a virtually integrated model of providers. Independent Health has helped pioneer efforts in quality improvement, primary care design, and implementation of alternative payment systems.

Much of our success is based upon the deep trust and collaboration we have purposely fostered with our provider community throughout many years of working together. We believe there are valuable components of our quality, efficiency, and effectiveness programs that are potentially scaleable and transferrable to other communities beyond our own.

Independent Health's approach toward developing improved systems of care are based upon several guiding principles, but most importantly they are based upon the assumption that primary care plays a pivotal and foundational role in the transformation to an improved system.

Independent Health is very excited about a recent development of a new model of primary care and reimbursement which we call Primary Connections. In this program, primary care practices that are certified patient-centered medical homes are reimbursed not under fee for service, but a hybrid payment system that includes a prospective, population-based payment, a quality bonus, and a shared savings program

that rewards providers for reducing the total cost of care.

The collaborative also develops strong relationships between primary care providers and specialists who compete for primary care referrals based upon transparent data, profiling their quality, and cost efficiency.

I would like to briefly share two stories from our Primary Connection model, one that represents the past and one that represents and illustrates the experience of a patient and physician under the Primary Connection model.

Imagine the year 2010, a 70-year old man with a past history of diabetes, hypertension, and coronary disease contacts his primary doctor early one morning on a Monday complaining of chest pain while climbing stairs at home. He is seen in less than an hour by his primary, where an EKG shows suspicious findings. His doctor sends him to an emergency room where he is first seen by a triage nurse, then a physician assistant, then an ER physician. No provider examining him has access to his medical records. His EKG is repeated; blood work and diagnostic studies are performed. A decision is made to admit him overnight to monitor and observe his condition. He is discharged the following morning and given instructions to follow up with his primary. The primary does not receive a report from the hospital for at least 3 days. Costs would well exceeds $4,000. Care would be fragmented. Handoffs would be poorly coordinated. And the patient and family would be

worried, anxious, and afraid.

The year is now 2013. Under Primary Connections, its patient-centered care, its reimbursement system based on quality outcomes and cost effectiveness, another scenario unfolds. It is again 10:00 a.m. in the morning and the patient presents to the physician's office. Now unlike the previous scenario, the physician immediately contacts his preferred collaborating cardiologist and forwards the EKG to his review. This preferred cardiologist has demonstrated his efficiency, quality, and clinical outcomes and is chosen because of that and because the primary works under a reimbursement model that incents collaboration and new forms of patient management.

After reviewing the studies the cardiologist makes accommodations for the patient to be seen. The same blood work and diagnostic testing that might otherwise have been performed in the ER is completed in the cardiologist's office. The patient and family are advised he is not having a heart attack. The cardiologist and primary speak by phone to coordinate care and follow-up. Later that afternoon, the primary care coordinating nurse calls the patient at home to be certain he is well and asks if there are questions. Total cost of care, $1,200; care coordinated and efficient; communication immediate and complete; patient and family fully informed. Primary care physician is rewarded.

In conclusion, I look forward to sharing with the subcommittee the journey Independent Health and its physician partners are now taking to arrive at this efficiency and effective system of care, as well as our longstanding successful programs to promote quality.

Mr. Pitts. Chair thanks the gentleman.

[The prepared statement of Dr. Foels follows:]

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Mr. Pitts. That concludes the opening statements. We will now go to questions from the members. I will begin the questioning and recognize myself for 5 minutes for that purpose.

Dr. Damberg, the proposed SGR revision has an initial phase with a period of payment stability, while quality-measure development takes place concurrently. What is an appropriate period of payment stability, in your opinion, in order to develop and vet measures and build the necessary quality infrastructure?

Ms. Damberg. As I noted in my testimony, there are an array of measures that already exist in primary care, and those are ready for market. So that transition could begin much faster than on the subspecialty side. As one of the other panelists indicated, some of the clinical subspecialties have taken significant steps to identify clinical process and outcome measures, and I think that those should be leveraged in the near term. And I think in the area where measures currently do not exist, and that space is pretty vast for the subspecialists, that process is probably going to take 3 years to bring measures to market.

Mr. Pitts. Thank you.

Dr. Rich, considering the different levels of provider readiness, how do we balance the need for a stable period enabling providers to build and test the necessary quality infrastructure while still incentivizing early innovators to move to Phase II with

opportunities for quality-based payment updates?

Dr. Rich. So I would agree that a 3-year period for the embryonic novice would be important because it takes that long to develop your measures, get them vetted through an organization that would approve them, and then actually to start collecting data and look at it and using them effectively.

For those who, like us, who have measures already and we are using them already, I would suggest a tiered incentive program whereby the new payment reform would provide incentives to develop databases. If they only start out early with structural and process measures, and then develop outcome measures, that is fine. But those who have outcomes measures can start early with pay-for-performance pilots or pay-for-performance programs as we did in Virginia with WellPoint/Anthem, as well as in the public sector.

Mr. Pitts. Okay.

Mr. Kramer, public feedback has reinforced the concept that it is essential for providers to receive performance feedback in order to make appropriate changes in practice improvements. To the survivor of the pickup basketball game, what does a meaningful, timely feedback process look like for providers, and what are adequate performance feedback intervals?

Mr. Kramer. We strongly support the principle of providing feedback to physicians and other providers on the quality and

affordability of the care that they provide. That should be an integral part of this redesigned payment system. And to the extent it is possible, we should move in the direction of having real-time feedback so that information that is embedded in electronic health records is accumulated and fed back to physicians on a regular basis.

I worked for many years at Kaiser Permanente, one of the pioneers in the development of electronic health records. That kind of ongoing feedback to physicians was essential. I understand that many systems will take a while to get to that point, but that is what we should strive toward. In the interim, we should try to provide feedback as frequently as the information is meaningful in terms of volume of services that provides an adequate database for evaluation over quality.

Mr. Pitts. Dr. Foels, you state in your testimony that one of the guiding principles of IHA are, quote, "Substantive and sustainable improvement in quality and affordability of the American healthcare system will require movement away from traditional FFS reimbursement systems." Can you explain why in your opinion FFS Medicare undercuts quality and affordability in our healthcare system?

Dr. Foels. Yes, thank you.

Yes, we believe that fee-for-service reimbursement does little to reward quality or recognize efficiency. It varies among providers by great degrees. It also inhibits collaboration across provider

communities. Ultimately, the care of a patient is that of a team. It is based on teamwork within a single practice, and it is dependent upon a team across multiple specialties.

And fee for service as currently visioned and currently practiced does not promote any collaboration among providers, and hence we strongly believe that a new system of reimbursement that may involve some degree of hybridizing the best parts of multiple ways to reimburse may be much more effective.

Mr. Pitts. The chair thanks the gentleman.

Now recognize the gentlelady, Dr. Christensen, for 5 minutes for questions.

Dr. Christensen. Thank you, Mr. Chairman.

And thank you for your testimony.

As an African-American physician who practiced for more than 20 years, I know that many racial and ethnic minority providers, providers in rural areas, as I once did, work in communities and treat patients who have long been underserved by the healthcare system and detrimentally affected by the social determinants of health that create, sustain, and even exacerbate the health disparities. As a direct consequence, some patients simply present with more challenges than others, and that needs to be taken into account as we develop these systems. And so as we seek to assess provider quality and efficiency in a reformed Medicare payment system, we will undoubtedly struggle

with how to account for these gaps.

So how should we be thinking about addressing these racial, ethnic, gender, and rural disparities as we move to incorporate quality performance measurement into a new Medicare physician payment system, and how can we assure that the Medicare payment reforms do not leave those providers who serve the Nation's most medically and financially needy in harm's way by ignoring the upstream variables that directly affect patient outcomes?

So anyone can answer, but maybe I would begin with Dr. Damberg by asking her if her pay for improvement along the gradient begins to address that.

Ms. Damberg. I think absolutely. And as I noted, the way in which you structure the translation from actual performance to the payment can be modulated along that performance curve, such that you more heavily incentivize folks who are at the lower end of performance, and generally those folks are struggling with some of the very issues you identify.

So I think that the primary thing that you want to try to avoid happening is you are going to under-resource those providers. So allowing them to earn incentives for each increment of improvement I think will help mitigate that problem.

The other thing that I think is really important is trying to align incentives across providers. And I think if you look at what is going

on in ACOs that are really linking providers across the continuum of care, as well as with social service agencies in the community, because I think there is recognition that it is not just health care that influences whether somebody comes back into the system. And so, again, I think there is really sort of an elephant in the room around larger payment reform, not just working at the margins, which is what incentives overlaid on fee for service really look like.

And so if you look at the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract, where they have aligned incentives, it is a global payment, providers have worked very hard and have closed the disparities gap. So I think there are models out there that really have demonstrated that they can improve care for these disadvantaged patient populations.

Dr. Christensen. Dr. Rich? And I was going to ask the Thoracic Surgeons and maybe Independent Health, have they grappled with this and addressed it?

Dr. Rich. And the STS has long recognized that there are disparities in care. In our database we collect data on Afro-Americans, Hispanics, as well as Asians. We look very carefully at disparities in care for women and for socioeconomic status. And my first answer or response is that we need to measure it and inform providers whether they are addressing these needs or not.

I think to change it you could do what we did at CMS for hospitals

and provide a disproportionate share payment, DSH payment, that allows providers to seek out the communities that need them the most, and to get an added incentive to their fee-for-service payment.

Dr. Foels. And if I might add, and build off the two previous remarks, I, too, am very sensitive to the fact of the gap in disparities, which is not closing nearly as fast as anyone feels comfortable. And I concur with Dr. Damberg's comments that it is important to recognize that inner-city, urban, and rural providers have different starting points for their quality and they should not be punished for that. And there are scoring mechanisms and evaluation mechanisms, reporting mechanisms that would allow their incremental improvement and support.

Dr. Christensen. Thank you.

My time is almost up so I will yield back.

Mr. Pitts. Chair thanks the gentlelady.

Recognize Dr. Burgess 5 minutes for questions.

Dr. Burgess. Thank you, Mr. Chairman.

Dr. Rich, thank you for being here. You are a practicing cardiothoracic surgeon, is that correct?

Dr. Rich. Yes.

Dr. Burgess. So when you drive to work in the morning, do you tell yourself, boy, I hope I am average today?

Dr. Rich. No.

Dr. Burgess. No, you go to work to do your best work every day.

Dr. Rich. That is right.

Dr. Burgess. This is why I have always had a little bit of trouble with the concept of pay for performance. We are goal-directed individuals as physicians. We always go to work to do our best job. We never go into a patient's room expecting to be slightly above average, or hopefully not below average. No, we go in to do our best work. So we all need to recognize we are dealing with a highly motivated population of providers, and somewhat at our peril if we damage that motivation that exists amongst the Nation's physicians. And that is why it is so important to get the SGR reform because it is damaging to the psyche of America's doctors.

Now, I woke up this morning to the paper who said that they were very dismissive of the hearing we have today. The quote in the paper is that the draft that we have in front of us doesn't tackle some of the biggest outstanding issues, such as how to measure quality. So I really liked your comments. In your written testimony you said on behalf of the Society of Thoracic Surgeons, I would like to thank you for a very thoughtful proposal. And I agree with you. I think it is a thoughtful proposal. I think the committee and the committee staff have done a very good job of going to the provider community and soliciting their input as to what these performance metrics would be. Do you agree with that?

Dr. Rich. Oh, absolutely. Having sat at CMS and seeing other

thoughts and legislation coming out of here, I think this is probably the most thoughtful, well-rounded, and sought after for input proposals out there. I was really impressed at the questions and some of the principles that were out there regarding the SGR reform.

Dr. Burgess. Can you say that again for the press? You were very impressed?

Dr. Rich. I think they did a great job.

Dr. Burgess. All right. Well, and let me just ask you, on the issue of CMS, you do reference in your testimony that it is so important that the registries have access to clinical data from CMS. CMS, as we learned over the past several weeks as they releasing some hospital data, I mean, they have got a lot of data, and it would really help you and your specialty in developing these performance metrics, it would really help you to have access to that data, is that not correct?

Dr. Rich. Absolutely. We have access to data that is really financial data. There is a little bit of clinical data in the CMS database, but more financial. Now, when ICD-10 comes out there will be more clinical data. But bringing that financial data into the patient record and matching that with the clinical experience has been an enormously powerful tool for us in Virginia. We have been able to see how quality improvement reduces costs. We have been able to look at maintaining quality and reduce resource consumption and provide the same level or better levels of care.

It is a very powerful tool to have, and access to it has been a little troubling recently. We are trying to do that on a national scale, the STS is, and we are having difficulty because we have to go every time and ask for a special exception.

Dr. Burgess. So is that the bottleneck, the fact that you have to go every time and ask for the specific data?

Dr. Rich. It is one of the bottlenecks.

Dr. Burgess. Are there other bottlenecks that you could identify for the committee. Because we would like to help you, we would like to facilitate that exchange of data, because I believe you are on to something, and I think when you do have the data sometimes you will discover things that you weren't even thinking of as a way to embark on a cost-saving measure. So I want you to have the data and I want you to have access.

Dr. Rich. No, I appreciate that. So another bottleneck has been getting the Social Security Death Index data. That has been shut down because of, I guess, legal issues. And so in the past we were always able to track our outcomes and look at those who have died and figure if we have done a good or a bad job, you know, if they have died 7 months later. So that is a bottleneck.

Dr. Burgess. It is a clinically identifiable endpoint, correct?

Dr. Rich. Usually. Sometimes people argue about it. But --

Dr. Burgess. Just before my time expires, and I may ask you in

writing to get back to us with some of those bottlenecks.

[The information follows:]

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Dr. Burgess. But, Dr. Foels, I need to ask you, you spent some time discussing the fee-for-service aspect of the system and why you don't think that should endure. And yet, in your testimony, no singular payment system is sufficient to simultaneously promote quality, efficiency, and effectiveness. And I said in my opening statement, whatever we do here, it has to allow for the entire panoply of practice options that are out there, allow them to exist and to thrive and, in fact, flourish.

So I would just tell you, I think the committee has done a good job as far as allowing a fee-for-service model to continue. As someone who has practiced OB-GYN, I mean, there is not a lot of Medicare practice in your average OB-GYN practice, but there is some and it is an important part. And if I have got to join an ACO or deal with bundled payments in order to continue to see those patients, I may well say enough is enough, and I am just going to exclude those patients from my practice. But if you allow me to have a fee-for-service model for compensation for those patients, I may be more apt to continue. And there are other examples I could give you, but in the interest of time, do you have a comment on that?

Dr. Foels. Yes, you raise several points, one being that we may need to embrace a variable model for those individuals, those organizations, those physician communities that want to move quicker and faster toward development of virtual high-performing systems.

You also pointed out the fact that the, in my opening comments, that there is no singular payment system that isn't without its benefits or its perversities, so trying to blend the best of all together is effective.

One of the interesting footnotes in our experience is our application of the hybrid payment system to primary care physicians and its subsequent impact on specialty and hospitals that are still practicing under fee for service. And I would be welcome to describe that in further detail. But the takeaway message here is sometimes altering a payment system within one sector of the provider system can have effective and beneficial impacts on other sectors that remain under fee for service.

Dr. Burgess. Thank you, Mr. Chairman. I will yield back.

Mr. Pitts. The chair thanks the gentleman, and now recognizes the distinguished ranking member emeritus of the full committee, Mr. Dingell, for 5 minutes for questions.

Mr. Dingell. Mr. Chairman, I thank you for your courtesy. I commend you for holding this hearing. It is a fine example of good bipartisan, bicameral progress. And it is my hope that it will lead to repealing the fatally Sustainable Growth Rate, SGR, and replacing it with a system that makes good sense for our healthcare system and for our physicians.

We have broad agreement on the goals and now we must come together

in a bipartisan manner to work hard and find out what is the proper solution for this problem.

These questions are for all of our witnesses and will be both friendly and mostly yes, or no.

First question. At the end of 2012, Congress passed legislation to prevent a 26.5 percent reduction in physician payment rates. This short-term fix was signed into law last year and cost about $25.2 billion. Is that correct? Yes or no?

Dr. Rich. Yes.

Mr. Dingell. Thank you. I was afraid I wasn't going to get a volunteer down there.

This year, the Congressional Budget Office found the cost of freezing physician payments for 10 years is $138 billion, more than $100 billion more than their previous projection. I believe this demonstrates the urgent need for the Congress to act.

Now, again, to each witness, do you believe that Congress should repeal and replace the SGR this year?

RPTS KERR

DCMN CRYSTAL

[11:00 a.m.]

Ms. Damberg. Yes.

Mr. Kramer. Yes.

Dr. Rich. Yes.

Mr. Dingell. Sir?

Dr. Foels. Yes.

Mr. Dingell. Sir?

Dr. Foels. Yes, I think initiatives should begin.

Mr. Dingell. Now, in your analysis, did this system improve quality outcomes, yes or no?

Ms. Damberg. Could you clarify which system?

Mr. Dingell. I am sorry?

Ms. Damberg. Could you clarify which system you are referring to?

Mr. Dingell. Well, I am sorry. We will just lay this one on Dr. Foels and make that easier.

Dr. Foels, did the system improve quality outcomes, yes or no?

Dr. Foels. I believe the existing fee-for-service system turns a blind eye to quality and efficiency.

Mr. Dingell. Okay. Now, your Independent Health system

recently implemented a system that shifts away from the traditional fee-for-service reimbursement. That is correct, isn't it?

Dr. Foels. That is correct.

Mr. Dingell. And in your analysis, you found that this new system did improve outcomes, right?

Dr. Foels. Yes, it did, medically.

Mr. Dingell. All right. Now, do you believe that the reforms made by the Independent Health are a good example that the Congress should or could follow when reforming SGR, yes or no?

Dr. Foels. Yes.

Mr. Dingell. Now, there are many other private groups across the Nation that are experimenting with innovative payment models which promote quality care over quantity of care in an effort to make our healthcare system more efficient. I heard a great deal of comment relative to this point today. And it is my feeling we should use these efforts as building blocks. Congress must ensure any new physician payment model does not work counter to other successful innovations that are already in place.

Now, these questions are for all witnesses. Ladies and gentlemen, do you believe the Congress should look at the innovations and changes being made in the private sector when considering reforms to SGR?

Ms. Damberg. Yes.

Mr. Kramer. Yes, absolutely.

Dr. Rich. Sure, yes.

Dr. Foels. Yes.

Mr. Dingell. I am running out of time, so I am not going to ask you to do that at this time, but if you would submit for the record some suggestions of what you feel might be useful, I believe it would be valuable and helpful to the committee.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Dingell. Now, I guess I am going to conclude by pointing out that I think that this committee is on the right track. I am hopeful that it will continue to have an inclusive bipartisan process that will solve this problem which is making a huge mess for all of us, and I think that we can no longer kick the can down the road and that now is the time for the Congress to act.

So, Mr. Chairman, I thank you for your work today and for your leadership, and I am hopeful that this will lead us towards a better conclusion to the situation we confront. And I yield back 27 seconds. Thank you.

Mr. Pitts. The chair thanks the gentleman and now recognizes the chair emeritus of the full committee, Mr. Barton, for 5 minutes for questions.

Mr. Barton. Thank you, Mr. Chairman. I want to commend you and the full committee chairman for starting this process. I think this is something that, given good will on both sides, we might actually could do, and if we are able to accomplish it, it will be a significant achievement of the committee. This is something that is long overdue. Go back to Chairman Dingell's chairmanship, my chairmanship, Mr. Waxman's chairmanship, we have fought with this and wrestled with it, and because of the expense and the way the Budget Act is, when we get down to the lick-log we have always had to back off. So I hope that this time your efforts and Mr. Upton's efforts with Mr. Waxman and

others do bear fruit.

I just have one general question to the panel. It is the issue of balanced billing. It is currently prohibited. I am a proponent of whatever system we move to, that it should be something to be allowed. It makes sense. It allows physicians, providers to bill for those services that are not reimbursable. And I would just like the panel's general position on whether we should include some provision for balanced billing.

Dr. Rich. So I think balanced billing, it is a touchy topic. I think it should be discussed and it should be vetted through the provider community as well as your committees. There is a way to sort of balance bill already in the Medicare system, and that is just to be a nonparticipant, but there are caps on the amount that you can balance bill a patient. So it is not very much. It is 105 percent of Medicare. And it doesn't take many patients not to pay their bill before it doesn't work. So balanced billing has been something that people have talked about and there likely is value in having discussion and perhaps introducing it into the legislation.

Ms. Damberg. While this is not my particular area of expertise, your comments, I think, highlight another deficit around aligning incentives across the healthcare system, and that is price transparency. So I think to the extent that you are considering any kind of balanced billing provision, I think that that has to go hand

in hand with full disclosure of prices for patients, because I know on various occasions I have gone into the fee-for-service market where they no longer take health insurance, and when you ask physicians to tell you what the cost of the visit is going to be, they can't tell you that, and they often refuse to tell you that.

Mr. Barton. Anybody else wish to comment?

Dr. Foels. I would agree with the two previous statements. I think, to Dr. Damberg's point, the ability to capture balanced billing and include that in the efficiency profile of the physician for complete transparency would also have to be discussed.

Mr. Barton. Okay. I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

Now recognize the gentleman from Texas, Mr. Green, for 5 minutes for questions.

Mr. Green. Thank you, Mr. Chairman, for holding the hearing. And like all of us, for 13 -- 16 years now, we have been trying to figure out what we are going to do with the SGR, and this is an important step in that effort. I thank our witnesses for being here.

In the interest of transparency and opportunities for public stakeholder engagement are vital to quality measure development and approval process. Currently, mechanisms such as the National Quality Forum endorsement process that measures application partnership input and pre-rulemaking and rulemaking solicit and incorporate multistake

stakeholder feedback can help. In addition, the Secretary of Health and Human Services is in charge of the National Quality Strategy, which it is a national overarching strategy to guide quality measurement activities and identify gaps in the current framework.

First, Mr. Kramer, I would like to hear your thoughts on the current state of the quality measurement oversight in the Nation's quality agenda. Do you believe we are on track and what more can be done to drive the quality improvement and measurement?

Mr. Kramer. Thank you for the question. I will speak on behalf of Pacific Business Group on Health, but I am also a member of the board of directors of the National Quality Forum as well as National Priorities Partnership that measures application partnership, but I will speak on behalf of PBGH.

I think it is fair to say that the current process is to develop, endorse and prioritize and put into use performance measures, are not getting the results we want. I think this opinion is shared fairly broadly by purchasers, patients, providers, and health plans.

That being said, there are some elements of the current structure and process that I think we can build upon. In particular, the National Quality Strategy, I think, represents a robust, well-vetted process to develop a clear set of priorities for the Nation. But we need to speed up the development of the process of developing and using measures at all steps of the pipeline.

At the front end, measure development, Congress needs to invest in the development of patients-centered measures to complement the measures that are currently in use. These measures represent a public good of enormous value. For a very small investment, the payoff, in terms of improved health and health care, is enormous.

The next step in the pipeline, measure endorsement, we need to streamline the process for reviewing proposed measures and getting input from all stakeholders. National Quality Forum has already begun to make improvements in the endorsement process through the work of all stakeholders. I hope we can build upon that.

Mr. Green. With respect to reforming SGR, in all honesty, if we reform the SGR with the goal of making sure we are paying for, you know, quality and measurements, I think we will see that input. But with respect to reforming it, are there current mechanisms that are both substantive and nimble enough to meet the policy framework in the discussion draft of the legislation? Is this legislation something that makes that possible?

Mr. Kramer. I think this legislation will be a significant stimulus to development of better measures. It needs to be, I would recommend strongly, that it be paired with investment in development of quality measures and a clear direction to CMS to ensure that the measure endorsement process is streamlined, efficient, and involves all stakeholders.

Mr. Green. Okay. I only have a minute.

Mr. Kramer and Dr. Foels, should participation in clinical improvement activities be included as a component of performance-based payment? If so, how could this be structured to support and incentivize meaningful quality improvement in a way that is not otherwise captured?

Dr. Foels. Well, I think that is probably one of the most critical areas to address when addressing this issue of quality measurement, is how will it be reported, how will it be actionable, and trying to look for the process by which systems of care can be reengineered to deliver that quality.

To an earlier comment today, no physician goes in intending each morning to deny care to a particular percentage or to do less than what is absolutely best, but it is often a system of care that they provide in their office or among physicians that functions such that that is the byproduct. And so I think we need to continue to think about the ability to apply these measures on systems with deep collaboration, learning improvement, and share best practice across this.

Mr. Green. I only have a couple of seconds, but I want to make sure that investing in health information technology, medical home certification and use of clinical decision support tools, that could be used as part of the performance-based payment, I would hope, because that seems like where we are going.

Dr. Foels. Exactly to my point. Clinical decision support would be a new system of care delivery that would close those gaps.

Mr. Green. Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

Now recognize gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. Shimkus. Thank you, Mr. Chairman.

Real quickly, Mr. Kramer, I am interested in your opening statement, you talked about surgery and checking. Wouldn't it also have been nice to know, be able to search for fees? For fees or the cost. Or did you ever, after you went through the whole operation, did you know the total cost?

Mr. Kramer. Absolutely. You raise an excellent point. I focused in my opening comments on the quality measures for the surgery I was undergoing, but an essential element for any patient is to also know the price. Building on Dr. Damberg's earlier comments about the importance of price transparency, this is one of the areas where consumers are looking for information and it is simply not available, whether in Medicare or in commercial insurance.

Mr. Shimkus. And I was just going to say, because Dr. Damberg, Ph.D. doctor, not to diminish, but you did mention transparent in the answer to one of the questions as being a pretty key component.

Ms. Damberg. That is right. I do think that consumers very much

want that information, particularly as, you know, insurance products change, and even in the Medicare program consumers face more and more out-of-pocket expenses. And, you know, having them be exposed to more cost-sharing helps align the incentives to the consumer about appropriate use of care, but again, that has to go hand in hand with transparency on prices so that they can make those.

Mr. Shimkus. And I really buy that, especially in the preventive care model. If you can really use transparency and you are encouraging people in wellness, you know, however the transparent system is, and encouraging people for generics versus, you know, the name brand, I mean, there is a lot of things you can do. But if the consumer is not in the game because it is a healthcare debate, then you lose all that additional thought process.

In rural America, there is access issues, and inner-city issues, as was highlighted earlier, where Americans will pay for quality, we know that, or assumed quality. There are, Dr. Burgess is gone, but there are cases of problems in the healthcare system with some providers who are not -- I mean, in any organization there are some problem individuals who disparage and hurt the entire group. And my concern would be then erased because of available funding requirements having to have a lesser choice in quality is a concern. So there is a need to protect that both, I think, in inner-city regions and also the rural care. But I am very interested in this reform proposed, and we have

section 2 and subsection (h), which talks about providers paid under alternative payment models.

And so the question would be, I would like first to Dr. Foels, understanding the premise of the question, can you tell me how using alternative payment models can help fix this system and be beneficial?

Dr. Foels. Yes. There are several ways. You know, our firsthand experience with our Primary Connection model is to retain fee for service where there is the potential for the underutilization of services. So fee-for-service reimbursement is very effective, for example, in encouraging preventative care visits, immunizations, and so forth.

The perversity of fee for service is that it recognizes, by and large, only face-to-face encounters and only those that occur between a physician or midlevel practitioner, and it doesn't recognize all of the very effective and beneficial work that can be delivered by a care team of nurses. It does not recognize telephonic interaction. It does not recognize electronic interaction with patients, which can be very effective. So we developed a component of a prepaid allocation to the practices that was not visit dependent or necessarily provider dependent but was tightly adherent to outcomes.

The third piece here, in savings, really gets back to that earlier issue of price transparency, so allowing a primary care physician to be rewarded for efforts with their collaborative team of specialists

or hospitals to avoid redundancy of testing, to find those components of the system that operate the most efficiently and effectively, and to steer patients in those directions.

Mr. Shimkus. And, Mr. Chairman, just follow up just on that answer.

Shared savings, what do you mean by shared savings?

Dr. Foels. Well, our model of shared savings for primary care is upside only, so it does not include any punitive downside, and it is measured on the total cost of care for the population, total population of patients assigned to that primary care group, and any incremental savings off a previous year's budget are shared proportionately back to them.

So again they are rewarded for the hospitalization that could have otherwise been avoided, which is also a quality issue as well as a cost-effective issue regarding alternatives.

Mr. Shimkus. Okay. Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

And now recognize the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. Castor. Well, thank you, Mr. Chairman. I really appreciate you calling this hearing today on this important topic.

And I appreciate the witness testimony very much. You have made some very constructive recommendations. And I think the general

parameters are clear. That is the easy part. We want to permanently replace the Medicare physician payment formula, this SGR that is very poor public policy, and replace it with a new payment model that improves the quality of care and lowers the cost of Medicare. And that is very easy to state, but it is much harder to get done.

But I know that we can do this. Just look at the report from the Medicare trustees last week. The reforms that we adopted in the Affordable Care Act are helping to reduce the growth in spending in Medicare already. Health spending in Medicare is expected to grow at a slower rate now than the overall economy in the next several years. So that is good news, and it does give us an opportunity to take some of the more difficult steps in payment reform.

But I have to say, I was very surprised in the Republican discussion draft, because I think we are so far beyond the discussion draft. It doesn't provide us with any real direction on payment reform, and I think that is unfortunate. Unless we change it substantially, the way it is crafted now, it will keep us wedded to the SGR and that poor public policy of temporary patches and outdated spending patterns.

I think better model to look to is the bipartisan bill H.R. 574 that I am a cosponsor of. It was drafted by Congresswoman Allyson Schwartz and Congressman Joe Heck. It is called the Medicare Physician Payment Innovation Act of 2013. It provides greater detail.

And when you compare the two, if you look at the current discussion draft now, I don't like that it has upfront cuts to providers. It doesn't really provide any innovation in what we need to do. We should be incentivizing physicians to transform their practices and participate in these innovative payment models. And what this discussion draft does, it says you can opt in if you like. And that is why I think it is too squishy. To use a technical term, it is kind of wimpy. And we can do a lot better. We have the experts here that can help us get there.

If you look at H.R. 574, it repeals the Sustainable Growth Rate permanently, stabilizes the current payment system, it institutes interim measures to ensure access to care coordination, it gives that important boost to primary care that I think everyone agrees on, we can build on the reforms in the Affordable Care Act. And then what it does, it says we are going to aggressively test the models and evaluate these payment models. It provides a very significant transition period, and as Dr. Rich recommended, the focus on best practices and the clinical registry.

So I would recommend to my colleagues to put out a real discussion draft where we can start to get to the more difficult decisions. One of those, what a number of you have mentioned, some of the high cost areas. We know we need to boost primary care and align doctors and have them work together better, but there are some certain high cost

areas. You said there are 10 to 12 we should focus on. And, Dr. Foels, you said it has been difficult in transition, but you have arrived at some interesting payment systems.

Could you all highlight some of the specific areas, high cost, that are going to need greater transition periods or you think we should focus on that are crying out for reform?

Ms. Damberg. I think you are asking a broader question than just around measurement. So when I was talking about the 10 to 12, these are clinical specialties that if you look at sort of the majority of care that seniors need, it falls into areas such as cardiology, gastroenterology, endocrinology, neurology. And recognizing that, you know, we are in this sort of space where there is a vacuum of measures at the moment, and the realistic implementation of these programs, I think the idea should be to focus on where most of the action is in Medicare and focus the measure development work in that space in the near term.

So that can be used in any payment model that exists in the Medicare program. And one of the comments that is in my longer testimony is that whatever happens in the context of the SGR reform should work to align with programs that exist throughout Medicare, including the incentive program for meaningful use of electronic health records. There is a significant amount of alignment and coordination that can happen there, both as physicians and the LNC work with her,

electronic health record vendors to ensure that the EHRs have the functionalities to capture the data that clinicians need to manage care and to report out these measures and to build in those clinical decision support tools to help physicians manage to appropriate care. So those exist in any system and that is something we should be working for across the entire Medicare program.

Mr. Pitts. Gentlelady's time has expired.

The chair recognize the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. Murphy. Thank you, Mr. Chairman. I just want to make sure, and I am particularly focused on the two physicians who are here, this basically puts the onus on the academies and colleges of medicine, various subspecialties, upon you to provide quality standards of best clinical practices. Is that the way you read this? Okay.

And also that the specialties then are to develop on the front end the standards of protocols for best practices and apply those. Is that the way you read this as well? I want to make sure I am understanding this the same as you.

But I also understand that different specialties are farther advanced than others in terms of really establishing protocols. Am I correct on that? Dr. Rich, am I correct on that?

Dr. Rich. Yes.

Mr. Murphy. Now, would you see this, in terms of quality

measures, that basically this is a payment model that is based upon that if you adhere to the standards and protocols established by the medical specialties, that would be considered a quality measure? In other words, if they said for this diagnostic workup or for this diagnosis, once these results are in, this treatment plan, this is the protocol you follow and that would be the standard by which payment would be attached.

Is that your understanding, Mr. Rich?

Dr. Rich. Yes.

Mr. Murphy. Now, what happens if a provider feels the need to vary from that protocol? Does this bill adequately address that yet or do we need some more work in that area?

Dr. Rich.

Dr. Rich. So I think, yes. So we work as a specialty society to develop on an evidence basis guidelines, and we go out to our membership and say get with the guidelines and here are the guidelines for these, you know, procedures that you are doing. So you are absolutely right.

The bill doesn't address discretion that physicians have in using technologies and drugs that are what we would call off-label use. And when I was at CMS, we discussed this at great length, even into the Secretary's office, and the message back to me was that we didn't want to interfere with the discretion of the physicians who are taking care

of these patients to use a technology or drug within a certain patient. It can be abused. And so I don't think it goes far enough here in the legislation.

Mr. Murphy. Well, let me ask you this, too, and Dr. Foels, as well as you can answer this. Then would it be -- I mean, just other issues here -- that, for example, if a person is board certified in a certain specialty, that they -- perhaps one of the ways we could word this -- is that person would be granted a little more latitude. So, for example, if you are recommending something as a thoracic surgeon, and someone else who is a practitioner, it is not within their area but they are following your protocol, that your recommendation, because you are board certified in the area, if you are varying from that protocol, might that be some other wording we could look at, or whatever that is. I am asking the both of you if you have any suggestions, we would appreciate that.

Dr. Foels. Well, to comment on the board certification. That has evolved significantly in the past decade. Most recertification in a medical specialty involves quality assessment improvement efforts within your practice, so I think board certification is much more of a tangible marker of quality and improvement.

To your earlier comment about guideline, I would concur with Dr. Rich that there are very appropriate times where a guideline is not the path that should be taken with a particular patient. The frequency

with which that occurs has potentially predictable ranges, and I think that the guideline adherence can be measured within certain degrees based on that.

Mr. Murphy. Let me ask this, too. In terms of a payment model, I can understand how this could work if you have, for example, a hospital-based employee, where you have a large number of physicians and providers, a wide range of specialties practicing, because then the hospital could receive or the network could receive a global payment for that patient that covered life. If someone, however, is in a private practice, how do you work out the payment systems and still have enough incentive for people to work as integrated, coordinated care team. I am asking anybody on the panel because that is a key question.

Dr. Rich. So you could do global payments. We did in Virginia, we did it in our hospital with independent practices. It is just an agreement, a transparent agreement that you can have, and we worked on that.

Mr. Murphy. Who controls that payment then? I mean --

Dr. Rich. So in Virginia, it was the hospital. The payment flowed down to the hospital and then they distributed it under agreement to the providers, and the providers were selected out depending on their quality and their reputation in the community.

Mr. Murphy. I am a psychologist by training, and I am on some

hospital staff, but if a physician refers to me from another hospital and I am not part of the hospital staff, how do they work out that payment system? And I know I am out of time, but that is something, I think, we really have to work out in terms of this, how we handle. And it does make reference to people who are nonphysician providers, but that is something we would appreciate your input on.

Thank you for the time, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

Now goes to the gentlelady from California, Mrs. Capps, 5 minutes for questions.

Mrs. Capps. Thank you, Mr. Chairman.

Thank you all for being here for this important discussion. I have long been a supporter of fixing the SGR and am happy we are continuing that conversation. Before I get to my questions, I just want to highlight, as we continue on this series of hearings addressing the SGR, I want to make sure we do not forget to address other items as well, like therapy caps that have historically moved alongside the yearly doc fix and share the common purpose of ensuring access to critical care for our Nation's seniors, and the opportunity to finally address the GPCI and other geographic payment inequalities that leave so many providers, especially those in my district, unfairly reimbursed and seniors with really fewer options.

Now, switching gears, as we focus today on quality, I would like

to take a broad look at our health system. There has been a lot of talk in here on this committee about the role of doctors in the healthcare system, very appropriate, but as I have said before, I truly believe if we are going to really move to a more comprehensive prevention-focused system of care, we need to look at the full picture of our healthcare system. This is especially critical when it comes to addressing quality.

Most of the new delivery models like patient-centered medical homes and accountable care organizations emphasize team-based care, and they recognize the critical role and value of nonphysician providers. As such, I think it is important to acknowledge the role of other healthcare providers like nurses, nurse practitioners and physician's assistants in this conversation as well.

So, Dr. Foels, you state in your testimony that management of preventive health and chronic disease is inherently team based, which I agree. Could you expand on how diverse providers could be incorporated into any reformed Medicare payment system and what are your thoughts about their role and how they might improve quality and value?

Dr. Foels. Well, I can perhaps briefly reflect on my earlier comment on an existing fee-for-service reimbursement system, which does not really recognize team-based care to any great degree. A large portion of preventive care can be delivered by nurses or advanced

practice nurses who can identify missed opportunities for preventive services, make those arrangements. This does not require the time of higher licensed individuals. One of our mantra is always practicing to the top of your license.

Mrs. Capps. Right.

Dr. Foels. And I think it is fairly true that nurses are inhibited today, in part by the payment system, from practicing to their full extent.

Mrs. Capps. Thank you. I agree.

And I want to return now to Cheryl Damberg. Under the proposed revision of SGR, which emphasizes best quality practices, nonphysician providers paid under the Medicare payment system are also expected to be rated on quality measures.

In your testimony, Dr. Damberg, you highlighted how we must enlist providers as true partners in defining the measures for which they will be held accountable for as teams and providers. In your opinion, do nonphysician providers need unique measurement sets compared to physician providers, and what role do you believe they should play in defining these measures?

Ms. Damberg. Well, let me start with the latter part of your question. Absolutely, they should be involved. And I think with all of the changes that going on in health care right now, practices are rethinking how they use people. But I want to note that what drives

measurement is it is patient focused, so the patient's health needs determine what measure gets applied. And so if these other nonphysician providers are qualified to deliver that care that the patient needs, then those same measures would apply. So it is not clear to me that you would develop a set of measures that, say, apply to nurse practitioners, but rather the measures are developed around the patient and his or her needs.

Mrs. Capps. I see. That is intriguing, and I guess I would have to say it is pretty novel. Do you see glitches in or challenges in going from the way we do it now to something like this?

Ms. Damberg. I actually don't think it is inconsistent. If you look at the care that, you know, if you go to your physician practice site that you hope that they are delivering, you hope that that care is appropriate for you, given your gender, your age, and your health conditions, right? And the way in which measures are constructed, it really reflects that.

So, you know, if you are a diabetic, they are looking to control your blood sugar and your lipid levels, as well as your blood pressure. So I think it is really an issue of, you know, getting the right measures that focus on the major clinical issues that face patients in our healthcare system.

And then in the context of constructing those measures, you designate who are the appropriate specialties, and some of those may

be nonphysicians, who should be held accountable for delivering that care.

Mrs. Capps. I see some other people nodding. I know my time is up. Is there a general agreement with this? Yes?

Mr. Kramer. I would just say that example of good team-based care, which involves nonphysicians as well as physicians, is the intensive outpatient care program piloted by Boeing and adopted by a number of other large employers for taking care of very sick people with multiple medical conditions. It has been very successful in involving all members of the team, working to the top of their license. It has been done in a more affordable way, getting better clinical outcomes, better patient experience, better provider experience, and lower costs overall. Be glad to share the additional information.

Mrs. Capps. I would appreciate that if you include that in the record.

Mr. Kramer. Yes, it is included in the supplemental materials we have submitted to the committee.

[The information follows:]

******** COMMITTEE INSERT ********

Mrs. Capps. Excellent.

Mr. Pitts. The gentlelady's time has expired.

The chair now recognizes the gentleman, Mr. Guthrie, 5 minutes for questions.

Mr. Guthrie. Thank you, Mr. Chairman. Thanks for convening this. And I agree with our distinguished chairman emeritus, Mr. Dingell, working together bicameral, bipartisan, trying to solve an issue that whenever we get to the countdown of SGRs in the past, that is what I hear about when I go home, is from physicians and people in the medical field. And so it is important that we are doing this and doing it way early and getting ahead of it before we get to that point. So it shows that things are working, and hopefully we can work to a solutions. So I appreciate that very much.

And to follow from my friend from California was talking about, just measurements and qualities, and, you know, a large number of the quality measures in use today were developed following scientific processes to ensure their continued importance, scientific acceptability, which is important, usability, feasibility for reporting. However, there are many more measures in widespread use that fail to meet or require additional resources to meet these criteria for national reporting.

And Dr. Damberg, what process or processes could be enacted that would ensure quality measures or measurement sets are developed with

high scientific rigor, maintain currency to the latest evidence-based clinical practices, and are relevant to new care delivery systems?

Ms. Damberg. So if CMS were taking the lead on measure development, I think what they have to do is institute a process where they work with measure developers who understand the scientific requirements and steps in a measure development process, which includes reviewing the evidence, holding panels with clinical experts that can include physicians and nonphysicians, to ensure that the underlying science is right, and then working to develop a draft measure specification that you go out and test and validate.

So they need to set up a rigorous transparent process to do this. And I think that it should involve clinical subspecialists and primary care physicians in identifying what those performance gaps are. And if you go out and you talk to physicians, they know where the gaps in care are, and so I think by linking the clinical specialists with the performance measure developers, I think you can have a robust development system that will create confidence in the system.

Mr. Guthrie. Well, thanks. And I am also on the Telecom Subcommittee of this great committee, and we are dealing with trying to update things, and telecom is changing so fast, where there is a system that doesn't happen.

So I guess also ask, in health care, my lifetime, they have gone from 6 weeks of recovery from gallbladder surgery to outpatient care.

So just as those things, as we innovate and develop, the system has to be there and develop with that.

Ms. Damberg. Yeah, the system has to be nimble enough and there have to be resources available to allow for annual re-review of measures and updating as necessary and retiring as necessary.

Mr. Guthrie. Well, thank you.

And, Dr. Foels, how would these processes ensure that quality measures evolve with data accumulation and advancement in measure development science and appropriately account for the relative value of measures as they relate to other measures and use? I think I just used measures as every part of speech.

Dr. Foels. Well, you know, I actually want to build off Dr. Damberg's comments in that regard and at the same time address the issues you have raised.

So there are a couple of layers deeper that also have to be fully explored, examined and monitored, and one has to do with the methodology for attribution and accountability. I think the other take-forward lesson we have learned from our community is that, although various metrics are -- certain of them are very attractive because of their ease of operational measurement, aren't terribly important because the community is already achieving reasonably high rates of success. And so prioritizing the measures to which are most important and impactful is also going to be, I think, a critical byproduct of whatever group

is assigned this task.

Mr. Guthrie. Well, it is amazing how innovative we are in medicine, you know, from cancer drugs to where it killed all cells to get the cancer cells to where they are trying to -- in Louisville, University of Louisville, is a doctor there pioneering going to individual, where they actually get just the cancer cells, as you all know better than I. I just want to make sure that whatever system we have, innovation and processes that allow innovation and keep up as we change are in place. So I appreciate that very much, and I yield back 10 seconds.

Mr. Pitts. The chair thanks the gentleman.

Now recognize the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes for questions.

Ms. Schakowsky. Thank you, Mr. Chairman.

I have some questions for you, Dr. Damberg. Optometrists, podiatrists, optometrists, chiropractors have all been recognized by Congress within the definition of physician providers in the Medicare statute. Those medical providers follow the same rules and policies as other physician providers who deliver high quality services to the Medicare population.

For example, these providers face the same threat of reimbursement cuts under the SGR as M.D.s or D.O.s. Using the same rules for all providers included within the physician definition allows

Medicare patients the freedom to choose among licensed healthcare providers for covered services.

I have concerns that the discussion draft actually would undermine a patient's access to the provider of their choice by allowing the Secretary to establish separate quality update incentive programs for optometrists, podiatrists, chiropractors than those established for M.D.s and D.O.s, and it seems to me this could result in providers who perform the same services being assessed by different quality standards and receiving different payment adjustments.

So let me ask you if you think it is important for every physician provider treating the same problem to be measured using the same quality measurement system and eligible for the same quality update incentives?

Ms. Damberg. I actually do. I think, again, per my earlier remarks, the clinical care that is delivered should be focused on the patient's needs, and whatever provider is addressing those needs should be held accountable. And I recognize that there are variations across health systems in how they deploy personnel. So I know firsthand, when I had my bunion surgery at Kaiser, I had a podiatrist who was involved in that. So, again, I think it is very important that the same set of measures apply as relevant.

Ms. Schakowsky. So talking about the patient, by having different quality measures and incentives, do you think that that could affect their access to quality care and their choices?

Ms. Damberg. Do I think it could affect Medicare beneficiaries?

Ms. Schakowsky. Yeah, different, if we had different quality measures, might it not affect them?

Ms. Damberg. It is not clear to me that it would necessarily affect access to care. I mean, I think potentially the risk around access more generally in any incentive-based program comes when incentives get so large that they distort behavior, and particularly in the context of outcome measures you have not accounted for underlying patient factors that attribute to the outcome such that physicians or other types of practitioners may choose to avoid treating patients.

Ms. Schakowsky. Okay. And currently, don't optometrists, podiatrists, chiropractors follow the same criteria right now and successfully report the same quality measures as M.D.s and D.O.s?

Ms. Damberg. In the measurement programs that I have been involved with, I have not seen evidence that they are reporting those measures. So I don't have any knowledge of that firsthand.

Ms. Schakowsky. Okay. Another quality initiative being implemented in Medicare is the electronic health record incentive program, which provides incentive payments, as you know, to physician providers as they adopt, implement, upgrade, demonstrate meaningful use of the her technology. Do you know if optometrists, podiatrists and chiropractors are included in this program?

Ms. Damberg. I do not know that.

Ms. Schakowsky. Okay. And let me see if -- I think these all deal with those. You may not know the answer to this. The answer is yes, actually. Like these quality initiatives, isn't it important for the quality update incentive program being proposed for Medicare to require all physician providers in the Medicare program, including those other providers I listed, to use the same standards and receive the same incentives for the same services? I think it is another way of asking the same question.

Ms. Damberg. The answer should be yes, they should be held accountable to the same standards. I would be loathe to set up two different incentive systems. I just think the complexity of it and sort of the challenge is in sending very different signals. If anything, what we want to be doing is be creating greater alignment across physicians, other practitioners in the ambulatory care setting as well as aligning incentives across the system in which the patient travels. So aligning incentives between physicians and hospitals, that is so very critical. And again, the extent to which this bill can help push that ball down the field a bit more would be very helpful.

Ms. Schakowsky. Mr. Chairman, I just want to say how much I appreciate the tone of this hearing and this discussion, and I hope we could have more like it. Thank you very much.

Mr. Pitts. The chair thanks the gentlelady.

Now recognize the gentleman from Virginia, Mr. Griffith, 5

minutes for questions.

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

I appreciate all of you being here today, and I know there is some good questions that you already answered, and I am going to yield the rest of my time to Dr. Burgess for additional good questions.

Dr. Burgess. And I thank the gentleman for yielding.

Mr. Kramer, let me just ask you a question. In your testimony, you talked about incentives and providing -- building incentives into the structure, but oftentimes, here in the people's House, we end up talking about making something punitive rather than providing an incentive. Can you speak to that and the differential between those two activities, building in an incentive versus building in a punitive activity?

Mr. Kramer. I will offer my opinions on this, although maybe it is best answered by a psychologist. But I think that my experience and experience of our members at PBGH is that positive incentives for doing the right thing are very powerful. There are occasions, however, we want to put in place a mechanism to avoid bad things, and it may be that in some situations that some kind of penalty would be appropriate.

For example, we want to avoid infections, you know, high rates of infection, we want to avoid high rates of mortality, we want to avoid high rates of unnecessary hospital readmissions. There may be some

situations like that in which a penalty would be appropriate, but I think in most cases they can be restructured as a positive incentive. So the negative side of infections is infections are too high, therefore reward progress on reducing infections and frame it as a positive incentive, I think that could be most effective in moving us in a direction so that we get the results we want.

Dr. Burgess. You know, my old epidemiology instructor from Southwestern Medical School used to tell me that in order to adequately measure something you had to eliminate fear, and the providers must not be in fear; otherwise, they are not going to be as forthcoming with you when they have problems. And that is one of the difficulties I see in constructing a system that is more punitive than one based on incentives. So I agree with you, and certainly the prescription drug or the providing for electronic e-prescribing, it wasn't part of the healthcare law, it was part of the stimulus bill, you are actually going to build some resentment toward e-prescribing because of the fact that it is a reimbursement reduction if that doesn't happen, rather than building in an incentive. And I hope we can be sensitive and careful about that as we construct this.

Dr. Foels, I just want to continue our discussion on the fee-for-service aspect for a moment where we kind of got cut off by time, but I do feel so strongly that in our reform of the SGR, you have to allow the -- I mean, a lot of physicians of my age group, fee for

service is what we have always known. We are goal directed. It is an incentive to which we respond. And to just start out with the premise that we are going to eliminate all fee-for-service practice in many ways I fear will only harden those people who would be resistant to the new payment models. And I would just encourage us, as we think about this, there has to be a place for the fee-for-service physician in the new Medicare model, in the new SGR, whatever is the follow-on from the SGR. I always use the example of Muleshoe, Texas, literally a one-stoplight town with one GP, and it is hard for him to be an ACO. I mean, I guess he can call himself ACO, but it is hard for him to be an ACO because he is just a country doc working in a little town and he gets paid for his services.

I think you have to allow him the ability to continue to practice. Do you disagree with that?

Dr. Foels. I agree with your point. I think, again, there are systems of care that are all various levels of maturity and depths of integration across the country. Many of them will be willing to accept a more advanced payment system early on. Others --

Dr. Burgess. And I agree with you, but it should be their choice. It should be their choice when they go into that system. And if the guy in Muleshoe can't do it, we can't exclude him because he is all they have got, correct?

Dr. Foels. And to your earlier point, too, about the

accommodation of physicians to a new system of payment, we have probably over a century of experience in the United States with a fee-for-service system, so it is something that everyone is extremely accustomed to and our systems of payment are all operationally designed around it. And we even found, in our own experience, despite our deep collaboration with our primary care community, that they were not immediately willing to transition to a new care model until we profiled them under how they would actually perform under that and we made the methodology completely transparent. But that took an additional year or two for them to be willfully accepting of the change.

Dr. Burgess. So that is an educational endeavor.

Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

Now recognize the gentlelady from North Carolina, Mrs. Ellmers, for 5 minutes for questions.

Mrs. Ellmers. Thank you, Mr. Chairman. I appreciate so much the opportunity to be participating in this subcommittee hearing on SGR reform. I think that it is something that is vital to healthcare reform into the future.

And I thank our panel for being here and giving your input as well. I certainly associate myself with many of your comments on best practices, Dr. Damberg, especially when we are talking about making improvements with science-based, real information that will actually

improve our healthcare system.

That brings me, Dr. Kramer, one of the other discussions that was just taking place, we were talking about is there room or should there be room for penalties, essentially, I will call it that. And one of my big concerns is that many times physicians are placed in a position because there is a new best practice that is established, may or may not be science based, but, you know, Medicare will require that they adhere to that, and it may end up in a bad patient outcome, an increase in infection rate or something.

In your words, how would you address that? How can we avoid that situation happening where a physician then possibly may be penalized or cannot participate in an incentive program because there is some best practice that is put in place? How could we address that?

Mr. Kramer. I would answer by saying that if we keep the focus on the patient, and the results, the outcome, the clinical outcomes to the patient and the patient's experience in those outcomes, that will address many of the underlying problems that currently exist. So, for example, rather than focussing on whether a clinical best practice was followed or a clinical guideline was followed, rigid adherence to that can sometimes lead to bad results, the inappropriate results.

Mrs. Ellmers. Yeah.

Mr. Kramer. So rather than focussing on rigid adherence to the clinical practice guideline --

Mrs. Ellmers. It should be patient centered. Patient outcome.

Mr. Kramer. Patient centered. What happened to the patient? Was that best for the patient? Did it get the right results? That is what physicians are working toward, that is what drives them as individuals, and that is what we ought to be rewarding.

Mrs. Ellmers. Thank you. I appreciate you saying that. That is my opinion as well.

Dr. Damberg, in the draft of our legislation that is definitely ongoing, you know, we are going to be taking in so much more feedback to make sure that what we put in place is an actual working model that will work in the real world and not just in theory. In your testimony, you talk about the collaboration between CMS and establishing a process where measures can be developed between clinical specialists and, you know, correcting that performance gap area. In your opinion, how important is this relationship between CMS and medical providers in maintaining that value-based performance?

Ms. Damberg. So I think for this program to be successful CMS and the physicians have to work in a very close partnership, and that partnership starts with the measure development process, but it extends way beyond that to CMS trying to figure out how to support physicians regardless of what type of practice they are in, but I would say especially focused on the kinds of practice that Mr. Burgess was talking about, which are, you know, the smallish practices that may be miles

away --

Mrs. Ellmers. Right.

Ms. Damberg. -- from big centers where they can work with other partners to develop capacity. I think that there is a lot of work that needs to go on, on the ground, to develop capacity in practices so that they can achieve the results that we want them to. And there are various entities in communities across this country who are already working with providers.

And I think that CMS should look to leverage those partnerships with community players, and I also think that CMS should look very carefully at private commercial health plans who are also investing substantial resources to work with community providers and build capacity. And I think if they could align the deployment of those improvement resources and work in partnership, that would be a huge help to providers. And I think there are lots of incentives in place for that to happen because many of the commercial health plans participate in Medicare Advantage and are at risk financially for a quality bonus payment themselves.

Mrs. Ellmers. Thank you. I appreciate your comments.

And I see that I have run out of time. Thank you, Mr. Chairman.

RPTS MCCONNELL

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[11:55 a.m.]

Mr. Pitts. The chair thanks the gentlelady.

Now recognize the gentleman from Florida, Mr. Bilirakis, for 5 minutes.

Mr. Bilirakis. Thank you, Mr. Chairman, I appreciate it. And I thank the panel for their testimony. I have a couple of questions.

Start with Dr. Damberg. You talk about a continuum of performance. Should we target a percentage for performance of quality measures? For example, should the average physicians meet 75 percent or 85 percent of performance measures? If the averages are above the targeted percentage, should we recalibrate the metrics every 5 years or so to adjust the metrics and increase the standard of care?

Ms. Damberg. So you are talking about where to set these performance thresholds?

Mr. Bilirakis. Sure.

Ms. Damberg. Yeah. So there are several different ways in which you can establish benchmarks. One is to use national performance benchmarks that are already in place. If you look at the National Committee for Quality Assurance, they have many benchmarks already for ambulatory care measures.

But there are more sophisticated methods. I would call your attention to my testimony where I reference a report by a statistician named William Rogers and Dana Safran at Blue Cross Blue Shield of Massachusetts, and I am not going to go mathy on you, but they used the beta-binomial distribution to set this. And in essence, where they set the top threshold tends to remain very stable over time, and it sets up sort of the optimal performance that can be delivered safely. Because I know one of the previous questions was around, you know, are we going to not give physicians some flexibility around the care they provide? I don't think we personally want to drive everybody to 100 percent, because I think there are some reasons why patients should not get care.

Mr. Bilirakis. All right, thank you very much.

This is for the entire panel. Do you support quality measures tailored to specific diseases such as diabetes and Parkinson's? And if so, how do you develop quality measures for rare diseases? These are hard to diagnose diseases with small populations. If we do develop metrics for specific diseases or conditions, how do we responsibly develop measures for these conditions when research may be somewhat limited? Whoever would like to address it first.

Mr. Kramer. We do need to develop better measures for disease conditions, both common conditions, unfortunately common conditions, such as diabetes, as well as rare conditions. I think a number of those

measures already exist, or are in the process of being developed and through the endorsement process. I think the National Quality Forum has done a reasonably good job of bringing together clinicians, patients, patient-advocate groups, as well as other stakeholders to find the best measures, encourage measure developers to put those forward, and to build on what is already there so that those measures are in place and are available and the outcome results are available to clinicians for their clinical quality improvement efforts, to teams, who are often in a very good situation to manage the care for someone with chronic conditions, but also to patients so that they can identify the best providers and participate in their care.

Mr. Bilirakis. Anyone else?

Dr. Rich. Definitely should have measures for disease conditions. So when I was at CMS in 2008 we did an analysis of the three biggest cost buckets for Medicare populations, and depending on what decile of Medicare patient you were looking at, it was always congestive heart failure, coronary artery disease, and cancer. And you could reverse the order depending on how old the patient was. But that represented somewhere around 45 to 47 percent of the healthcare dollar that we spent at Medicare. And if you are going to create disease-specific measures you should start there, and I think that would be what Mrs. Castor would want to hear as well.

I do think that there is a team approach to taking care of people

with coronary artery disease. Myself, a cardiologist, PCP, all care for these patients, the same for heart failure, and creating a robust set of measures for a disease-specific entity like that across specialties and cross into primary care.

Ms. Damberg. May I add one more point?

Mr. Bilirakis. Yes, please.

Ms. Damberg. I think that the other thing that I would keep in mind is, right now we have some one-off measures, so in the area of diabetes. I would encourage development of measures with an entire episode of care. So if you think of hip replacement surgery, you know, you may start in the ambulatory setting, you transition into the hospital and then you may end up in post-acute care. And so we need to look at this larger bundle of measures that hang together to cut across that continuum.

Mr. Bilirakis. Anyone else, does anyone disagree with the disease-related measures, or specific measures?

Dr. Foels. If I could just reiterate a point that was made earlier, that a particular quality measure does cross disciplines. It follows the patient. And we have had some recent experience with applying diabetic measures to cardiologists who are also caring for those patients, and we know diabetes is a strong risk factor for coronary disease.

And it is important that the cardiologists are also a participant

in improving diabetes care as well. It may not be an area to which they feel they should naturally be measured, but we feel as an integral part of an entire team that cares for that particular chronic condition, it would be appropriate to apply measures in that regard.

Mr. Bilirakis. I have one more question, Mr. Chairman.

Mr. Pitts. Go ahead.

Mr. Bilirakis. Just briefly. What about patients? Should patients groups have a role or input into the process when determining these measures?

Mr. Kramer. Absolutely, yes. Patients is why we are here. We are here to take care of people who are beneficiaries of Medicare. And more broadly, if it is done right for Medicare, can help our entire healthcare system. By keeping a patient focus, finding out what is important to them in terms of their outcomes, making sure we have measures of those outcomes, and then providing rewards to physicians and care teams to achieve those outcomes, that will do what is right for the patient. If it is done right for the patients, it will work for the rest of us.

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

Mr. Pitts. The chair thanks the gentleman.

Now recognize the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questions.

Dr. Cassidy. Thank you, Mr. Chairman.

First, Dr. Rich, I will just say that there is a T-surgeon, Gene Berry, that first acquainted me with your data set on quality. Very impressed with it. I just thought about it ever since. So let me compliment your society and my local doc who acquainted me with that.

Mr. Kramer, I enjoyed your remarks. If you are the guy that broke your face playing basketball, I got to tell you, man, your hair is a little gray to be up there on the court. But that said, you know. Listen, we do have to be patient focused.

Now, I will say that solutions in Washington tend to be big. Affordable care organizations are huge. And as a doc who is thinking that oftentimes you are going to have a four- or five-person practice in which, unless you figure out how to align the patient with the interest of that four- or five-person practice, you are not really going to serve those patients best.

Then, Dr. Foels, I was impressed that your organization seems to have been somewhat entrepreneurial adapting. My thinking is that we need something, we call it in this legislation an alternative payment model, where you take that entrepreneurial group of docs, whoever they might be, and you allow them to come up with a different model that none of us have thought about, but in their circumstances works for their patients and for their practice better than anything else, and that CMS, frankly, would be required to approve unless they could show why they should not, as long as the folks doing the model were willing

to take the risk. Any thoughts on that?

Dr. Foels. Yes, I would concur. Our participation with other like plans, regional, not-for-profit insurers that also have deeply collaborative efforts with the community, are moving toward -- and we do that work through the Alliance of Community Health Plans and share a lot of excellent work across disciplines. But what we have found, although we work toward a common goal, we have taken different approaches, and many of those approaches have all been equally successful.

Dr. Cassidy. Yeah.

Dr. Foels. But there are significant and slight differences among them that we need to recognize are regional.

Dr. Cassidy. I totally get that. If your final outcome is giving access to high-quality medicine at an affordable cost, there may be different goals depending upon the practice and upon the patients. So, one, compliments you all for doing so. And, two, I hope this legislation enshrines that.

Dr. Damberg, one thing -- I could have asked this of many of you -- one thing that has been occurring to me though, I am liver doctor who takes of cirrhotics, I am always struck that primary care doesn't want to touch that cirrhotic once they have cirrhosis because it is such a fragile patient. So what do you think, I have tried to coin a phrase called, not primary care physician, but principal care

physician. If you take someone like a nephrologist caring for the renal failure patient, she is really the principal care physician even though she is not, quote, the "primary care physician." Cancer doctors. Patients with heart failure. And really trying to align a payment model to recognize that once someone has CHF no one touches that patient unless the cardiologist first blesses the touching. Does that make sense? I see Dr. Rich nodding his head.

Do you all have any thoughts on this principal care concept? Dr. Damberg, I started it with you.

Ms. Damberg. So let me ask you a question back.

Dr. Cassidy. Yes.

Ms. Damberg. Are you considering this person -- hopefully this is not too much of a value-laden term -- almost like a gatekeeper for that person's care in terms of coordinating the management?

Dr. Cassidy. The principal care physician would then take on the responsibilities currently ascribed to the primary care. It just recognizes that if somebody has cirrhosis --

Ms. Damberg. Something very complex.

Dr. Cassidy. -- they become the one who becomes the coordinator, they become the hub off which everyone else radiates.

Ms. Damberg. Yeah. No, I actually think there is potentially some value in that. I think we are looking to primary care, and particularly medical homes, to coordinate a lot of care, but there may

be care that is sort of outside the purview of primary care where I think it could be useful to set up someone who would be --

Dr. Cassidy. I think if you look at Medical Advantage's special needs programs, most of those folks are probably not managed by primary care in an urban setting. They are managed by some gal, some guy who happens to be a specialist in their condition.

Mr. Kramer, from the business perspective any thoughts you have?

Mr. Kramer. Yes, I think this makes sense. I think a term that we actually use, informally, is accountable care physician. I think it gets at the same thing. There is a physician that may be a specialist, may be a primary care physician, but for certain kinds of patients it would make sense for the specialist to be the accountable physician for the care that is delivered to that patient working with his or her team.

Dr. Cassidy. So if there was a payment model in which -- an alternative payment model in which a group of gastroenterologists would take on the risk bearing of a group of cirrhotics pre-transplant patients, they would then become the accountable physician, if you will, at risk, and then coordinating the care, being the primary care doc for a group of fragile patients. You all are nodding your head yes.

Mr. Kramer. And rewarded for the quality and the total resources used on behalf of those patients.

Dr. Cassidy. Yeah. Well, thank you for your input.

I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

Dr. Christensen has a unanimous consent request.

Dr. Christensen. Thank you, Mr. Chairman. Yes, I ask unanimous consent to insert into the hearing record a paper from the National Senior Citizens Law Center and a letter from AFSCME, both on balanced billing.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Dr. Christensen. Thank you.

Mr. Pitts. All right, that completes our first round. We will do one follow-up per side.

Dr. Burgess, 5 minutes for follow-up.

Dr. Burgess. Thank you, Mr. Chairman.

Dr. Damberg, let me just ask you, can you discuss at all to the extent that providers are dealing with measure reporting, quality improvements, and financial arrangements to link quality payment, is this something that is ongoing that you have observed?

Ms. Damberg. So, yes, indeed. I would say the majority of physicians, at least in primary care in this country, have ongoing measurement reporting of some sort and payment tied to performance. In the clinical specialty areas, it tends to be tied to, again, the set of measures that have been identified, whether that is care for diabetes or cardiac-type measures. In some cases those physicians' payments are also tied to performance currently.

Dr. Burgess. Just specifically in the primary care world, so those measures have already been developed. Are we going to --

Ms. Damberg. They have been developed. They are in widespread use. Many of the pay-for-performance programs in the private sector have actually been in operation since about 2003. So it is a long period of time.

Dr. Burgess. But do you think it is possibly to integrate them

into whatever happens in the Medicare world?

Ms. Damberg. Absolutely, and I think the CMS should be looking to align the measures. So the ambulatory physicians are already accountable through their health plans for the Medicare Advantage measures. Those measures represent a really strong starting point, and that you are basically not asking those physicians to do something different.

Dr. Burgess. Why do you suspect that there has not been wider involvement of that or wider institutionalization of that?

Ms. Damberg. Of the fee-for-service side of Medicare?

Dr. Burgess. Well, on the Medicare Advantage side where it does seem like you have got happy providers, you have got happy patients, the cost is less. Why is there not wider adoption of that within the Medicare system itself? Because there does seem to be some resistance to the Medicare Advantage model.

Ms. Damberg. Well, I think if you look at the physician value-based payment modifier program, that is essentially trying to move down that path with physicians across the board within Medicare. So even absent the SGR, that work is in process. And again, I think it is going to be the primary care physicians who are first out of the gate on that because of the existence of measures.

Dr. Burgess. Yeah, in many ways, if the SGR could not be reformed, if we didn't have the favorable CBO score winds at our back,

it has always seemed to me that Medicare Advantage may offer a way forward on whatever happens with SGR down the road. Is that a fair observation?

Ms. Damberg. I think possibly. I do think Medicare Advantage has been a leader, and it is not surprising because much of the measure, the performance measurement work that has gone on historically has been on the managed care side even in the commercial sector. But even private payers recognized they were not getting value out of the providers on the fee-for-service side, and so they shifted those programs into play in fee for service.

Dr. Burgess. Very well. Let me just ask a question, generally, and anyone can feel free to answer or not. But should the quality improvements undertaken by a physician or a practice, should the quality improvements themselves be included as a component of whatever performance-based payment is adopted? If you have a doctor who realizes that at the start of the year they are not performing as well as they might, and improves their performance, can that be taken into account, the fact that they have improved their performance?

Dr. Rich. Yes, absolutely, I think. And if you look at the hospital value-based purchasing program, it is written into that. So you can have targets, we can have absolute targets, or you can have a quality improvement incentive. So you can't take a low performer and expect them to get to 90th percentile in 1 year, so you ought to

be able to reward them to go from the 10th to the 30th percentile as an incentive to keep trying.

Dr. Burgess. And just as a practical matter, you think that is something that should be included in whatever follows on from SGR?

Dr. Rich. Yes, absolutely.

Dr. Burgess. Mr. Chairman, I shouldn't do this, but I actually want to recognize Dr. John O'Shea, who is here in the audience. He has had a big hand in helping us get to where we are today, and we were sorry to lose him, but at the same time, we are grateful to have had the association in the past couple of years where he has been so instrumental in getting this tough problem moved along. So I will yield back my time.

Mr. Pitts. The chair completely agrees with that statement. Thank you very much.

The chair recognizes Dr. Christensen for 5 minutes for a follow-up.

Dr. Christensen. Thank you, Mr. Chairman, and I don't think I will take all of 5 minutes. But this is a little bit of a different question. But we have not been able to fix malpractice, do malpractice reform. And I wonder if the panelists think that the reforms that we are talking about, and comparative effectiveness research and some of the other provisions could lower the risk of lawsuits and perhaps even the cost of liability insurance?

Dr. Rich. I do. I think if you get providers to participate in clinical registries and quality improvement programs, I think that would be recognized, not only by insurance companies to lower your cost, but just in general I think it would help the healthcare system to reduce complications and reduce lawsuits.

Dr. Christensen. Okay. Well, a lot of what we are talking about in terms of reform relies a lot on primary care physicians. Do you have any concerns that we are not producing enough family physicians, or primary care physicians, or do you think we are on target for where we need to be with primary care physicians? And if not, what do we do until we get there?

Dr. Foels. If I may comment, I have very deep concerns about the adequacy of the primary care physician workforce. When, again, one steps back and thinks about a viable, vital primary care team, it takes the discussion to a little different level above and beyond recruiting interested residents in a primary care professional track. I think there is considerable work that has yet to be realized in making this an attractive specialty.

I think the reengineering of primary care alone, and the ease of work through efficient systems of care that will evolve, which I hope will evolve over very short periods of time in primary care, will again make this a very attractive discipline. And to my early earlier comment, I think we are still underutilizing the valuable talents of

nursing staff to provide care, and a reform payment system would be a valuable contribution toward moving in that direction of, again, designing a viable, vital primary care team.

Dr. Christensen. Thank you.

Anyone else?

Ms. Damberg. I also share that concern, and I think one of the issues that hasn't been addressed here, but I know is being talked about is reweighting the payments such that, you know, if we are going to talk about incentives, right now I think the incentives in the system in terms of the payment structure really go against going into primary care as a specialty. So I think we need to look at ways to correct some of those imbalances in payments.

Dr. Christensen. Thank you.

Mr. Chairman, I don't have any other questions, so I will yield back my time.

Mr. Pitts. All right. Chair thanks the gentlelady.

That completes our questioning. I am sure some members will have additional questions. We will submit those to you in writing. We ask that you please respond promptly.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. And as I stated in the opening statement, we are seeking substantive feedback on ways to complete this legislative draft. I would encourage all interested parties to submit their comments to the committee by next week.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. I remind the members, they have 10 business days to submit questions for the record, so they should submit their questions by the close of business, Wednesday, June 19th.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:17 p.m., the subcommittee was adjourned.]