



House Committee on Ways & Means Subcommittee on Health

Thursday, May 12, 2011

Hearing: "Reforming Medicare Physician Payments"

Members of Subcommittee

Republicans

Wally Herger, CA, Chairman
Jim Gerlach, PA
Sam Johnson, TX
Devin Nunes, CA
Tom Price, GA
Dave Reichert, WA
Peter Roskam, IL
Paul Ryan, WI

Democrats

Fortney Pete Stark, CA Ranking Member
Earl Blumenauer, OR
Ron Kind, WI
Bill Pascrell, Jr., NJ
Mike Thompson, CA

Witnesses/Panel Members

Stuart Guterman, *Vice President, Payment and System Reform, Executive Director, Commission on a High Performance Health System, The Commonwealth Fund*

Lisa Dulsky Watkins, MD, *Associate Director, Vermont Blueprint for Health, Department of Vermont Health Access*

Dana Gelb Safran, ScD, *Sr. Vice President for Performance Measurement and Improvement, Blue Cross Blue Shield of Massachusetts*

Keith Wilson, MD, *Chair, Governing Board and Executive Committee, California Association of Physician Groups*

Opening Statements

Chairman Herger: Flaws of the physician payment cut are well known to members of the subcommittee. Cuts could be devastating, particularly in rural areas, for physicians and seniors. We've kicked the can down the road enough. No more short-term fixes. Each passing year, the cost of a solution grows larger. Need to find a fiscally responsible solution. Need physicians to be a willing partner to fixing the SGR. This hearing is the first in a series of hearings on this



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issue. Today's hearing is about innovative delivery systems across the country that focus on care coordination. Open to hearing other ideas, as well.

Ranking Member Stark: Neither party has been able to address the challenge. Democrats passed legislation last year that would have created separate targets and reset the baseline. Republicans would not vote for that bill, apart from Rep. Burgess. Physician community supported the bill. Thanks the witnesses for participating.

Witnesses/Panel Member Testimony

Stuart Guterman: Congress is faced with a challenge, access to care and reimbursing physicians. How to pay physicians is a critical issue. We need to pay for what we want. Physicians are currently penalized for providing the care they want to provide. One size will not fit all. There must be an array of options available for different structures that providers are in. Payment systems should allow providers to be accountable. We can't focus on a single model.

Lisa Dulsky Watkins: Fee for service promotes volume and rushed care. Vermont Blueprint is poised to address. It's leading system delivery reform in Vermont. Strong bipartisan support and governor support. Overall goal is to improve services and control costs. Their innovations have been two-fold. They continue with FFS, but they have two new streams for PCPs. One is for the patient centered medical home – capitated payment per patient per month. Another is making payments for coordinated care. CMMI has made this possible through one of its demos, allowing Medicare to partner with private payers. They have seen lower utilization and less use of emergency departments. They have significant amounts of data on quality of care and financials. Patients and physicians are very happy with it. Patients feel they are truly cared for and physicians feel the joy of practicing medicine is back.

Dana Gelb Safran: Shares a model that it is time to think about overall system payment vs physician payment. In 2007, BCBS of Mass developed a model that would slow growth and improve care. She describes the Accountable Quality Contract (AQC) program. There are 5 features: (1) a provider agrees to the cost and quality of care for the full continuum of a patients care – prenatal to end of life care. It's a five year deal. (2) Payment is based on a global budget for a defined patient population. (3) Providers who are in the AQC program must be concerned with total spending regardless of where care is provided. (4) The budget is set



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based on historical spending data, and the rate of inflation on spending is negotiated up front. (5) It includes financial incentives for quality. Results so far show that growth trends have been cut in half. Quality of care was higher in the AQC market vs. their other contracts.

Keith Wilson: Highlights the value of capitated payments. In CA, they have 2 decades of making prepaid medicine work. Capitation creates a system that forces providers to care about the cost and find innovative ways to keep costs down. This is done by prevention and keeping people out of the hospital. Their model protects the public through oversight to ensure providers are not taking too much risk. Providers must report on quality metrics and patient satisfaction. Capitation provides a steady stream that is good for planning improvements, such as purchase of HIT. The CA model can be used across the country. The ACO model is not as predictable as capitation.

Questions and Answers

Chairman Herger: Asks their opinion of the FFS model. Watkins says it has been detrimental to primary care. They are on a hamster wheel and not being paid on the quality of care. **Ms. Safran** said that FFS has delivered to us a system that incentivizes more services and it doesn't address quality or outcomes, and that we have to move away if we look to resolve fragmentation in care. **Dr. Wilson** said he has worked under both systems, capitation and FFS, and he prefers capitation. The motivation between FFS and capitation is different. Patients are harmed under FFS because it doesn't lead to coordination of care or improved outcomes. Capitation is a pure form of payment. **Chairman Herger** asked how much provider spending has come under budget in the AQC program. **Ms. Safran** said that every ACQ came under budget, ranging from 1-2 percent under their budget in just the first year. She was surprised how well everyone did under the quality measures. Clear that the incentives were important, but also the ongoing feedback, helped them become successful. The leadership is also dedicated to this. **Chairman Herger** asked how ACQs reduce costs for hospital stays and other services. **Ms. Safran** said that many improvements came through appropriate referrals. She notes that imaging and tests are now commodities. The docs in the AQC refer to lower cost settings for providing these services.

Rep. Stark: Kaiser is the largest physician organization in CA. Asks if the Kaiser staff model could be used in other areas? Notes that Kaiser has not worked well in the DC area. **Dr. Wilson** believes it is possible to transplant the Kaiser model, but you need a critical mass. Said DC is an



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exception, but it has worked other places. Many graduates are looking to join Kaiser-like groups. Other models in CA might be easier to export as Kaiser is a "bricks and mortar" concept and requires significant capital. **Rep. Stark** asks if the Massachusetts universal health care law adds to the performance. **Ms. Safran** said universal insurance has made an impact on slowing the growth in costs. The uptake of providers into the AQC model is likely a result of that. **Rep. Stark** asks if the Vermont model can be exported. **Dr. Watkins** said that their legislative mandate has made a difference.

Rep. Reichert: Witnesses talk about coordinated care, full continuum of care, integrated care. Everyone is hoping for this, and the witnesses have done that in their areas. He is worried about seniors having access to affordable care, and asks if the AQC plan has an education component about their model of care. **Ms. Safran** said BCBS of Mass. has not done any proactive outreach about the AQC because it would be too confusing for the patients. Could not decide what specifically they would need to know or do. Physicians can advise patients if they want.

Rep. Kind: Over-treatment makes patients worse off. He is encouraged by the testimony by the witnesses. The ACA incents the type of care witnesses are describing. He asks who is establishing the quality measures for use by Mass. **Ms. Safran** said they drew from nationally recognized measures. Almost all of the 64 measures are NQF endorsed. The AQC uses ambulatory and hospital measures that focus on process, outcomes and patient experience. They have been completely accepted by the providers. **Rep. Kind** asks if comparative effectiveness research (CER) is important, as well as advance directives. **Mr. Guterman** said it is very important to get a better return on our investment. **Dr. Watkins** agrees on the need for CER, as well as **Ms. Safran**. She said we need a better evidence base. **Dr. Guterman** agrees there is a need for advance directives.

Rep. Gerlach: He asks if Massachusetts has gone through medical liability reform, because he is concerned that tort reform is an issue because of defensive medicine. **Ms. Safran** is not sure. She said she thinks not. She believes it is too early to see malpractice is an issue. She said that Harvard is doing a study on this currently.

Rep. Price: Status quo is not acceptable, and wants to know about the witnesses opinions on the Independent Payment Advisory Board (IPAB). **Mr. Guterman** supports the IPAB and wants it to have broader powers. **Dr. Watkins** and the rest of the panel do not feel that they are qualified to answer questions on IPAB.



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Rep. Pascrell: Comments that patients are not concerned about their healthcare spending since they don't pay the bill if they have insurance. He believes the ACA put in place incentives for primary care and nurses to ensure adequate workforce. **Dr. Wilson** said CA is worried about PCP shortages and said their model uses midlevel providers to mitigate the problem.

Rep. Price: Is astounded that the witnesses did not answer his question about the IPAB, particularly since they are supposed to be leaders in medicine. He asks if FFS should be outlawed. **Dr. Guterman** said no, and feels that FFS medicine can be modified to work. **Dr. Watkins** said FFS should not be outlawed, and said that even under FFS they can improve perceptions of care by patients and providers. **Ms. Safran** said we need to move away from FFS, even if it is by force of law. Hopes they can move to another model. **Rep. Price** asks her if she believes that patients should be allowed to privately contract with their physicians. **Ms. Safran** agrees it should be legal. **Dr. Wilson** said FFS should not be outlawed, and that the important issue is care coordination. **Rep Price** highlights a recent letter from AMGA regarding the ACO proposed rule, which states that 90 percent of AMGA members do not think ACOs can function under the proposed framework. He cautions the panel and reminds the Congress that the SGR was the Congress' solution years ago for the same problem. He said that solutions imposed from Washington cause greater problems.

Rep. Blumenauer: Notes that half of the subcommittee members come from low cost, high value states, such as WI and OR. He agrees that the mess comes from Congress, and points to IPAB as being a solution that keeps Congress out of it. ACA should have done many of the things the witnesses are talking about. He asks if the ACA helps the witnesses' efforts. **Dr. Watkins** said the community health teams are outlined in Sec. 3502 of ACA, and believes it is essential regardless of the structure of payments, single payer or FFS. **Ms. Safran** said the framework is excellent (referring to the ACO proposed regulation) and she is optimistic that CMS will get it right. **Dr. Wilson** said the ACO model holds promise and opportunity. Does have concerns with the funding, but agrees with the intent.

Rep. McDermott: Ask how patients are assigned to physicians or must the doctor bring them to the models being described, and also how are the doctors paid under these models. **Dr. Watkins** said for PCPs, once they get their NCQA recognition, they get a capitated payment amount regardless of the payer. The amount is a function of the score you have been assigned. They only deal with existing practices in VT. There is still FFS payments. Those with the NCQA designation also get the multidisciplinary team to assist them. **Ms. Safran** said that payments



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are made in the same fashion as in FFS; you are just accountable for the total costs of care for your patients. With the AQC program, one would have a new level of information and support. You still submit claims like you would in FFS. You get additional quality dollars based on performance.

Rep. Boustany: Concerned about the ACO regulations, as they are burdensome and overly prescriptive. **Dr. Guterman** suggests that CMS work with physicians to come up with a workable solution. **Rep. Boustany** asks if gain-sharing is a useful way to incentivize coordinated care. **Mr. Guterman** said it needs to be monitored but it could be promising as a tool to achieve efficiencies. **Rep. Boustany** is concerned that there are not statutory protections for gain-sharing. He is also worried that too much focus is being placed on primary care and emphasizes the need to include specialists. **Dr. Wilson** said in CA most specialists don't sign on as salaried doctors. **Dr. Watkins** said there are only a few specialists because the state is small, but they need to loop in specialists at some points. **Rep. Boustany** wants to ensure the specialists are not left out of the discussions on reform.

Closing Remarks

Chairman Herger: Thanks the witnesses for their comments. The committee will continue to discuss this issue and bring in specialists. We ultimately need to bring competition and market forces to reduce costs, which is in sharp contrast to what the President has proposed. We will continue to focus our efforts to fix the SGR.