



**STATEMENT OF HERB B. KUHN
DEPUTY ADMINISTRATOR**

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

“MEDICARE PHYSICIAN PAYMENT”

BEFORE THE HOUSE SMALL BUSINESS COMMITTEE

May 8, 2008



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Chairwoman Velázquez, Mr. Chabot, distinguished members of the Committee, thank you for inviting me here today to discuss Medicare physician payment. The Centers for Medicare & Medicaid Services (CMS) is actively engaged with the Congress and the provider community on this important topic. As indicated in the President's Fiscal Year (FY) 2008 and 2009 Budgets, the Administration supports payment reforms for providers that do not increase Medicare spending, and that encourage providers to deliver high-quality, efficient care. Given the size and impact of the Medicare program, now and in the future, it is critical that we move from passive payer to active purchaser of high-quality, efficient care.

Medicare currently pays for health care mainly based on resource consumption and service volume. Payments for treatment of healthcare associated infections and other preventable complications contribute to growing Medicare costs. The disconnect between current payment policy and fostering high-quality, efficient care is one reason why the health care share of our nation's gross domestic product (GDP) continues to increase. Our nation's total health care bill (already \$2.1 trillion in 2006) is expected to more than double by 2017 to an estimated \$4.3 trillion. By 2017, our nation would be spending almost one of every five dollars on health care.¹ As Secretary Leavitt recently stated, "There is no place on the world economic leader board for countries that spend 25 to 30 percent of their total output on health, and unless we change, that is where we're headed."

¹ Keehan, et al., "Health Spending Projections Through 2017: The Baby Boom Generation is Coming to Medicare," *Health Affairs*, March/April 2008; 27(2): w145-w155.

For the second year in a row, this year's Medicare Trustees Report predicts that Medicare's Hospital Insurance (HI) Trust Fund will be insolvent as soon as 2019, just eleven years from now. This is the fund that pays for Medicare Part A services – hospital inpatient care, limited care in a skilled nursing facility, home health, and hospice care. Medicare's other Trust Fund, the Supplementary Medical Insurance (SMI) Fund that pays for Medicare Part B services including physicians, similarly is expected to face rapid growth in spending according to the Trustees. Unlike the HI fund, SMI is supported by general revenues as well as beneficiary premiums.

In light of Medicare's financing challenges, our single most important goal is to encourage continued improvement in the efficiency and quality of health care delivered to Medicare beneficiaries, while preserving access to services in a way that is fiscally responsible. Our ability to fulfill the goal of access depends, of course, on continued active participation of physicians in Medicare. Currently, nearly 95 percent of eligible physicians and other practitioners are Medicare participating providers, up from approximately 90 percent in 2004.

We have an interest in appropriately compensating physicians for the care they furnish to Medicare beneficiaries. This does not mean we should continue "business as usual" in the area of physician payment, however. Since its inception, the fee-for-service Medicare program has been largely a passive payer of health care services. Our goal throughout Medicare, including with respect to physicians' services, is to pay based on the value of services provided, not simply based on quantity of services or resources consumed.

With respect to physicians, some of the fundamental pillars of appropriate payment include: encouraging physicians to provide the right care at the right time; ensuring greater transparency so physicians and their patients have the information they need to choose and ensure high quality care; and avoiding

unnecessary services, such as duplicate tests. In other words, quality and transparency are critical to appropriate payment.

This concept is neither new nor unpopular. The Institute of Medicine (IOM), MedPAC, congressional legislation, and many in the provider community now agree that well-designed and comprehensive quality and efficiency measurement should play a key role in reforming Medicare physician payments. The *2008 Dartmouth Atlas of Health Care* released in February underscores the importance of such an approach, finding “glaring variations” in the nationwide distribution of health care services and “remarkably uneven” quality of care. Prominent among potential explanations for these disparities is Medicare’s current physician payment policy, which “rewards providers for staying busy.” Additional health care spending does not necessarily mean greater quality of care or better patient outcomes

CMS is playing a leadership role in a multi-pronged approach to addressing such issues, with the overarching goal of linking provider payment for Medicare services to outcomes and best practices. We recognize the problems in the current statutory formula for calculating annual physician payment updates. Service volume and Medicare costs for physician care have increased steadily, but in every year since 2002 Congress has overridden the statutory cost growth control, the Sustainable Growth Rate (SGR). The problem with this recent approach is that it runs up a tab that makes the next scheduled cut even larger. This July, the law requires Medicare to cut doctors’ fees by 10.6 percent.

CMS is concerned by the tremendous amount of uncertainty the recent approach to physician payment issues causes at the physician level, which can be particularly difficult for small physician practices. We are going to continue working collaboratively with medical professionals, the Congress and MedPAC to develop and implement necessary changes to physician payment policy, with the goal of applying the most effective clinical and financial approaches to achieve

better health outcomes and long-term program sustainability for Medicare beneficiaries and taxpayers.

Medicare's Success Depends on Active Participation by Physicians

Currently, updates to Medicare physician payments are made each year based on a statutory formula set forth in section 1848(d) of the Social Security Act. The annual update calculation compares target spending to actual spending for Medicare physicians' services using a combination of annual and cumulative (since 1996) spending targets. By statute, if actual spending exceeds the targets, updates in subsequent years are reduced. If actual spending falls short of the targets, subsequent year updates are increased.

Actual spending on physicians' services has been growing at a faster rate than target spending. Since 2001, the statutory update formula has called for payment cuts. However, in every year since 2002 Congress has intervened to temporarily override formula requirements in favor of a specific, statutorily defined update. In passing these measures, Congress did not include a long-term modification to the underlying update formula, causing the gap between actual and target spending to grow even larger.

We have worked collaboratively with the physician community since the early 1990s to develop Medicare payment rates for individual services. We receive recommendations on the development of these payment rates through a multispecialty physician process administered by the American Medical Association's Relative Value Update Committee (RUC). The statute requires a comprehensive examination of the payment rates every five years and in 2007 we substantially raised the rates for primary care services based on the third five-year review. We are continuing to look at ways to further improve the fee schedule based on concerns raised by MedPAC, primary care representatives, and some others. For example, MedPAC is concerned that the current

distribution of Medicare physician payments may still undervalue primary care services and introduce other distorted incentives that may encourage overuse of some services and underuse of others. We expect to discuss our plans further during future rulemaking.

A system that aligns payment with quality and efficiency can better encourage physicians to provide the type of care that is best suited for our beneficiaries by focusing on prevention and treating complications and the most effective, proven treatments available. A system that also enables beneficiaries to identify providers of high quality care, better understand the cost of care, and achieve the transparency of information that exists in other sectors of the economy--features that have been sorely lacking in the healthcare arena—could also enhance a beneficiary's ability to make informed decisions about their healthcare.

As part of the President's commitment to making health care more affordable and accessible, CMS launched a broad Transparency Initiative in 2006. We are working to improve transparency on price and quality of services provided to Medicare beneficiaries. The Medicare web site now displays quality data that allows consumers to make informed choices by comparing the performance of hospitals, nursing homes, home health agencies, dialysis facilities, Medicare Advantage plans and prescription drug plans. We will continue to consider ways for increasing transparency and expanding our web-based quality compare resources.

Just over a month ago, we announced the posting of new patient survey information to our Hospital Compare website, which now contains twenty-six quality measures plus ten new measures of patient experience of care. We also are adding information about the number of Medicare patients treated for certain conditions and provided certain hospital procedures, and the average Medicare payment. For the first time, consumers have access to the three critical elements they need to make effective decisions about the quality and value of health care

available to them through local hospitals: quality information, patient satisfaction survey information, and pricing information for specific procedures.

CMS has posted this hospital service volume and payment information so the public can see the cost to Medicare of treating beneficiaries with certain illnesses in their community. A better understanding of the cost of care can lead to more informed decision-making – one more way beneficiaries can help improve their health and support the longer term financial health of Medicare.

We are pleased that public interest in our Transparency Initiative is strong and growing, as evidenced by a substantial volume of web page views and ongoing collaboration from the provider and consumer communities.

Ongoing CMS Initiatives Explore and Support Potential Solutions

We believe that a quality health care system is one that:

1. Measures effectiveness by objective standards;
2. Makes it easy for anyone who is interested to review provider track records and what they charge for services;
3. Keeps records and communicates electronically; and
4. Uses financial incentives to enhance efficiency and value.

CMS is engaged in a number of initiatives to implement these four principles within the Medicare program. For example, the Physician Quality Reporting Initiative (PQRI) makes physicians and other eligible professionals potentially eligible for additional payments if they satisfactorily report on quality measures applicable to their practice.

CMS has implemented a broad array of evidence-based quality measures developed through a consensus-based process for the PQRI that promote improved clinical quality, better outcomes and higher efficiency for Medicare beneficiaries. In 2007, there were 74 measures. For 2008 we now have 119

measures that include structural measures on the use of e-prescribing and electronic health records (EHR).

Physician specialty societies, organizations of other professionals, the American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI), and the National Committee for Quality Assurance (NCQA) have all helped us in developing PQRI measures. The measures are endorsed or adopted by the National Quality Forum (NQF) or the AQA Alliance consensus organizations.

We were encouraged by the physician participation rate in PQRI for 2007, its first year, and we expect participation to increase over time. To facilitate this, effective for the 2008 PQRI, we have established several new reporting alternatives to make reporting easier and more meaningful. These include registry-based reporting for 2008, which offers physicians an alternative to reporting quality measures on claims, taking advantage of data reporting to registries that they may be already doing. We are also exploring and testing the capacity to receive information on quality measures directly from EHRs.

We intend to continue to expand and refine PQRI quality measures and the reporting mechanisms available. We will work closely with the AMA-PCPI, the NQF, the AQA and others to make sure our tools promote high quality and efficient care for Medicare beneficiaries.

In addition to PQRI, through several demonstrations CMS is testing new physician payment methodologies that link payment to quality and efficiency. For example, the Medicare Physician Group Practice (PGP) Demonstration, the Medicare Health Care Quality Demonstration, the Medicare Medical Home Demonstration, the Medicare Care Management Performance (MCMP) demonstration, and the new EHR Demonstration are focused on physicians

succeeding in improving patient outcomes and increasing health care efficiencies. We are considering additional demonstrations in this area.

The PGP demonstration is a value-based purchasing initiative that rewards certain large physician groups for improving the quality and efficiency of health care delivered to Medicare fee-for-service beneficiaries. We are seeing evidence that value-based purchasing works. For example, the Everett Clinic in Washington State, one of ten group practice demonstration sites across the country, is raising quality of care with a change as simple as having a doctor follow-up ten days after hospital discharge to address any unsolved or new health problems.

Section 646 of the Medicare Modernization Act (MMA) authorized the Medicare Health Care Quality Demonstration. This demonstration will enable CMS to identify, develop, test, and disseminate major and multi-faceted improvements to the health care system. Projects approved under this demonstration are expected to achieve significant improvements in safety, effectiveness, efficiency, patient-centeredness, timeliness and equity: the six aims for improvement in quality identified by the IOM in *Crossing the Quality Chasm*. Physician groups, integrated health care delivery systems, and regional health care consortia were eligible to apply for the demonstration. The program will identify best practices in terms of system designs that encourage greater quality, efficiency and effectiveness, and focus on ways to make payment more consistent with these practices.

In late 2006, Congress authorized a 3-year Medicare demonstration project of the Medical Home. The demonstration targets high-need Medicare beneficiaries who have been diagnosed with multiple chronic illnesses and require regular medical monitoring, advising or treatment. It establishes a framework to begin building the IOM's vision of patient-centered care: a partnership among practitioners, patients, [and] their families to ensure that patients have the

education and support they require to make decisions and participate in their own care.

Under the Medical Home demonstration, which will be implemented in up to 8 States, a board-certified physician will provide comprehensive and coordinated care as the “personal physician” to Medicare beneficiaries with multiple chronic illnesses. This care would include using evidence-based medicine and decision support tools, health assessments and the use of health information technology (HIT), such as patient registries or electronic health records. Physicians will receive a care management fee, in addition to payment for whatever Medicare covered services they may provide.

The Medicare Care Management Performance demonstration is a pay for performance demonstration with approximately 2300 physicians representing almost 700 practices. It started in July 2007 and provides financial rewards for practices’ performance on 26 clinical quality measures covering care for diabetes, congestive heart failure, coronary artery disease and the provision of preventive health services to beneficiaries with chronic conditions. It also will reward physicians who are able to report measures to us electronically through Certification Commission for Health Information Technology certified EHRs certified by the Certification Commission for Health Information Technology and are able to report the measures to us electronically.

Finally, earlier this year Secretary Leavitt announced a new CMS demonstration program to provide as many as 1200 small to medium-sized primary care practices across 12 sites nationwide with incentive payments for increasing EHR functionality and improving care through the use of EHRs. Individual physicians could earn up to \$58,000 over the course of the five-year demonstration or up to \$290,000 per practice. By design, the demonstration will be budget neutral, requiring that associated costs be offset by savings resulting from more efficient health care delivery.

We are hopeful and encouraged that these opportunities will yield information helpful to CMS and the Congress as we consider options for revising the Medicare physician payment system. However, it is important to note that all of these approaches are in their infancy and need further refinement and analysis before they could be appropriate for widespread adoption in the physician payment system. They also pose significant technical and operational challenges that need to be considered. We will continue to work with physicians in an open and transparent way to further develop these innovative ideas that support the best approaches to provide high quality health care services without creating additional costs for taxpayers and Medicare beneficiaries.

Conclusion

Thank you again for this opportunity to testify on Medicare physician payments. CMS looks forward to working with Congress and the medical community to develop a system that ensures appropriate payments for providers while also promoting the highest quality of care, without increasing overall Medicare costs. As a growing number of stakeholders now agree, we must increase our emphasis on payment based on improving quality and avoiding unnecessary costs. I would be happy to answer any of your questions.