Testimony of
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Chairman Stark, Mr. Camp, distinguished members of the Committee, thank you for inviting me here today to discuss quality and efficiency in Medicare physician payment. The fee-for-service Medicare program has largely been a passive payer of health care services. Given the size and impact of Medicare, it is a top priority at the Centers for Medicare & Medicaid Services (CMS) to transform Medicare from a passive payer to an active purchaser of high quality, efficient health care.

To maximize the value of the Medicare dollar, we are studying and implementing value based purchasing initiatives for Medicare payment systems, including physicians' services. Value-based purchasing links assessment of performance, through the use of measures, to financial and other incentives, such as public reporting. A comprehensive set of performance measures includes not only measures of clinical effectiveness and patient-centeredness, but also measures of resource use. Thus, value based purchasing recognizes the importance of measuring and encouraging both the provision of high quality care and the avoidance of unnecessary resource use in the provision of care.

Medicare's overarching goal in pursuing a more active purchasing strategy is to encourage continued improvement in the efficiency and quality of health care delivered to Medicare beneficiaries. Achieving that goal depends, of course, on the active participation of physicians in the program. While this hearing is not about the Sustainable Growth Rate (SGR), improving the quality and efficiency of physicians' services and other services is important in and of itself while exploring efforts to address the SGR issue.

Medicare payment systems should encourage reliable, high quality and efficient care, rather than payment based simply on the quantity of services provided and resources consumed. Medicare payment systems should encourage physicians to provide the right care at the right time and in the right setting; encourage prevention and ongoing care for the chronically ill; encourage greater transparency so physicians and their patients have the information they need to choose high quality care; and help avoid unnecessary services.

CMS has taken a leadership role in a multi-pronged approach to addressing physician payment issues. We are committed to working collaboratively with medical professionals, the Congress and MedPAC to develop an overall approach to improving physician payment with the ultimate goal of achieving better health outcomes for beneficiaries in the most efficient manner that does not increase cost to taxpayers or Medicare and its beneficiaries. Strategies to measure and encourage quality services, to understand appropriate resource use, and to examine current value-based purchasing models are all at the heart of CMS efforts to help modernize the physician payment system.

Assessing and Encouraging Quality

Quality measures are the basic foundation and pre-requisite for a payment system that encourages physicians to provide the most clinically appropriate care, rather than the highest volume. The physician community, supported by CMS, has been engaged in efforts to develop meaningful measures of quality care.

CMS implemented the Physician Voluntary Reporting Program (PVRP) in 2006. Under PVRP, for services furnished to Medicare beneficiaries during 2006, physicians were able to voluntarily report to CMS a starter set of 16 evidence-based performance measures that captured quality of care data. In December 2006, CMS provided confidential feedback reports containing reporting and performance rates to the physicians who had submitted performance data for the second calendar quarter of 2006. That experience provided a basis for the 2007 Physician Quality Reporting Initiative

(PQRI) in the Tax Relief and Health Care Act of 2006 (TRHCA). The PQRI establishes financial incentives for eligible professionals to report quality measures. Specifically, eligible professionals who successfully report a specified set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5 percent of total allowed charges for covered services. To ensure smooth and timely implementation of the program, CMS posted the 2007 PQRI measures to our website well in advance of the April 1, 2007 statutory deadline. We currently are on target to post the refined measure specifications in a few weeks, again well in advance of the statutory deadline (July 1, 2007) for this step.

TRHCA also requires CMS to use notice and comment rulemaking to propose a set of measures that could be used for 2008. By statute, the 2008 measures shall be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA), that include measures that have been submitted by a physician specialty; and that the Secretary identifies as having used a consensus-based process for developing such measures. In addition, such measures shall include structural measures such as the use of electronic health records or electronic prescribing technology. TRHCA also requires that, as part of rulemaking for 2008 measures, CMS address a mechanism for providing data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database).

Numerous clinical databases and registries are maintained not only by medical professional societies, but also by medical boards, disease groups, patient safety groups, medical group management organizations and therapist groups. In fulfillment of the TRHCA requirement, CMS is exploring the possibilities of drawing on these databases and registries for reporting of quality measures. Such use could decrease the burden of quality reporting for professionals and CMS while increasing the quality and usefulness of the data. As we implement the statutory requirement to develop measures for 2008, we also are sorting through options for structural measures.

Beyond our efforts to implement PQRI and other quality provisions in TRHCA, CMS continues to collaborate directly with the medical community on the development of quality measures. The Physician Consortium of the American Medical Association (AMA) has played an important role in the development of physician quality measures, and CMS has supported their efforts. We also are supporting consensus processes of the AQA and NQF to adopt and endorse measures. These significant efforts have provided the basis for both the 2006 PVRP and the 2007 PQRI programs and are continuing for quality measures for 2008.

Measuring and Addressing Resource Use

As noted earlier, there is extensive variation in physician use of resources to treat a given condition, particularly geographic variation. Greater volume of services does not appear to correlate with higher quality care or improved outcomes; in fact physician "practice style" often is suggested as at least partly responsible for resource use variation.

We are investigating ways to measure individual physician resource use that links quality in the provision of care to Medicare beneficiaries and encourages physicians to focus on efficiency. A goal of resource use measurement is to provide information that is meaningful, actionable, and fair to physicians in order to reduce inefficient practice patterns. We have tested approaches for reporting resource use with physician focus groups and the results suggest that physicians may understand their practices from a patient-by-patient perspective, not from an aggregate statistics perspective. Reports on aggregate annual Medicare expenditures could be more meaningful and actionable to physicians if accompanied by appropriate detail. We have also learned that detailed data for a specific procedure or service out of context may limit the meaningfulness of the report and the ability of physicians to act on the information. The physician focus groups have also emphasized that adequate risk adjustment is essential to creating a fair measurement tool.

Measuring physician resource use in Medicare will be an ambitious undertaking. Nearly 700,000 physicians receive Medicare payments, and those physicians submit about 800

million claims per year. As with the development of Medicare payment systems which typically are multi-year, multi-step processes, so too will be the measurement of physician resource use. Given the benefits that could result from appropriately measuring physician resource use and sharing that information with physicians, the task has much potential. We are working with MedPAC, the AQA Alliance, the National Committee for Quality Assurance (NCQA), NQF, the Agency for Healthcare Research and Quality (AHRQ) and the Government Accountability Office (GAO) on physician resource issues.

In measuring resource use among physicians, it is important to include not just the services furnished by a physician, but also the services a physician orders -- laboratory and diagnostic tests, as well as hospital and other services. Given large resource use variations, resource use measurement has the potential to support physicians in the best exercise of their clinical judgment, and to ultimately provide incentives for high-quality, efficient care.

A tool used in assessing resource use for an episode of care is an "episode grouper," which organizes the different services furnished to a beneficiary into clinically meaningful episodes using the diagnoses and other information on claims. When services are grouped, the total costs of all services involved with treating a condition or illness can be compiled. The resources used by different physicians in furnishing similar episodes to similar patients can be compared. CMS is evaluating two commercial and proprietary episode grouper software products currently on the market and used by other payors. Episode groupers have great promise as a way to organize Medicare data to make meaningful resource use comparisons among physicians.

There are multiple issues to sort through with respect to accurately measuring resource use, including the development of rules for attributions of services to physicians, adjustments for patient characteristics, specification of the physician unit for episodes of care, identification of appropriate comparison groups, etc. Appropriate adjustments

would need to be made to ensure that physicians are being compared for comparable episodes.

We currently are in the early stages of a long-term effort to properly measure physician resource use. As with any long-term policy development, there are many steps and iterations along the way. Initially Medicare data would need to be assembled to present as comprehensive a picture of physician resource use as possible, covering as many specialties as possible, and as many services of physicians as is practical to measure. As the possibilities and limitations of our data are better understood and measurement issues are sorted through, an assessment can be made about specialties, services or physicians for which resource use is most promising.

After initial resource use evaluations are made, it is important to engage individual physicians in discussions about their data. Sharing the resource use information with physicians confidentially would allow them to see how they compare to peers, and provide us with their input to inform and help refine the next iteration of resource use comparisons.

Ongoing Demonstrations Linking Payment to Quality and Efficiency

Through several demonstrations, CMS is testing new physician payment methodologies that link payment to quality and efficiency. These demonstrations -- the Medicare Physician Group Practice (PGP) Demonstration; the Medicare Care Management Performance Demonstration (MCMP); the Medicare Health Care Quality Demonstration; and the Medical Home Demonstration -- are focused on physicians succeeding in improving patient outcomes and lowering overall health care costs.

The PGP Demonstration, authorized under Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, is a value-based purchasing initiative that rewards large physician groups for improving the quality and efficiency of health care delivered to Medicare fee-for-service beneficiaries. The MCMP demonstration, authorized under Section 649 of the Medicare Prescription Drug

Improvement and Modernization Act of 2003 (MMA), is a value-based purchasing initiative with small to medium sized physician groups. The demonstration promotes the adoption and use of evidence-based care and health information technology to promote continuity of care, stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes.

Physician groups have volunteered to participate in these value-based purchasing demonstrations. As part of the demonstrations, physician groups are making investments in infrastructure and redesigning care processes to improve quality of care and report a comprehensive set of quality measures focusing on high volume and high cost Medicare conditions. In addition, participants are implementing innovative care management programs designed to reduce avoidable inpatient admissions and emergency room visits to generate savings for the Medicare Trust Funds. Physician groups are making these investments to improve quality and patient care management with no guarantee that they will receive an incentive payment since such payments are tied to their ability to generate savings and/or achieve performance thresholds for improving patient care processes and outcomes.

Section 646 of the MMA requires a Medicare Health Care Quality Demonstration. CMS is currently implementing this demonstration 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 Institute of Medicine in its *Crossing the Quality Chasm*.

Physician groups, integrated health care delivery systems, and regional health care consortia are eligible to apply for the demonstration. These projects may involve the use of alternative payment systems for items and services provided to beneficiaries, and they may involve modifications to the traditional Medicare benefit package. In addition, the Agency for Healthcare Research & Quality (AHRQ) may use this program as a

laboratory for the study of quality improvement strategies, and CMS will provide the data necessary to analyze and evaluate the projects conducted under this program. 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.

Most recently, TRHCA directed the Secretary to conduct a 3-year demonstration project of the Medical Home. This demonstration will occur in rural, urban and underserved areas in up to 8 states. The demonstration will target high-need Medicare beneficiaries who have been diagnosed with multiple chronic illnesses and require regular medical monitoring, advising or treatment.

The Medical Home can be large or small medical practices where a board-certified physician provides comprehensive and coordinated patient centered medical care and acts as the "personal physician" to the patient. 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 remote patient monitoring. A care management fee for the coordination of services will be paid to the patient's personal physician, in addition to whatever Medicare covered services they may provide.

We are 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

Mr. Chairman, thank you again for this opportunity to testify on quality and efficiency in Medicare physician payment. It is a top priority at CMS to transform Medicare from a passive payor to an active purchaser of high quality, efficient health care services. We are studying and implementing value based purchasing initiatives for Medicare payment systems, including physicians' services.

As a growing number of stakeholders now agree, well-designed and comprehensive quality and efficiency measurement should play a key role in Medicare physician payments. This approach has been supported not only by MedPAC, but also the Institute of Medicine (IOM), Congressional legislation, and many in the health care community. In addition, the Fiscal Year 2008 President's Budget supports budget-neutral physician payment reform and states that "an important component of improving quality is encouraging more efficient and high-quality physicians' services."

We look forward to working with Congress, the physician community, MedPAC, and other interested parties as we continue to analyze appropriate alternatives to the current system that could ensure appropriate payments while promoting high quality care, without increasing Medicare costs.

Thank you and I would be happy to answer any questions.