

**REPEALING THE SGR AND THE
PATH FORWARD: A VIEW FROM CMS**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED THIRTEENTH CONGRESS
FIRST SESSION

—————
JULY 10, 2013
—————



Printed for the use of the Committee on Finance

—————
U.S. GOVERNMENT PRINTING OFFICE

87-971—PDF

WASHINGTON : 2013

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON FINANCE

MAX BAUCUS, Montana, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia	ORRIN G. HATCH, Utah
RON WYDEN, Oregon	CHUCK GRASSLEY, Iowa
CHARLES E. SCHUMER, New York	MIKE CRAPO, Idaho
DEBBIE STABENOW, Michigan	PAT ROBERTS, Kansas
MARIA CANTWELL, Washington	MICHAEL B. ENZI, Wyoming
BILL NELSON, Florida	JOHN CORNYN, Texas
ROBERT MENENDEZ, New Jersey	JOHN THUNE, South Dakota
THOMAS R. CARPER, Delaware	RICHARD BURR, North Carolina
BENJAMIN L. CARDIN, Maryland	JOHNNY ISAKSON, Georgia
SHERROD BROWN, Ohio	ROB PORTMAN, Ohio
MICHAEL F. BENNET, Colorado	PATRICK J. TOOMEY, Pennsylvania
ROBERT P. CASEY, Jr., Pennsylvania	

AMBER COTTLE, *Staff Director*

CHRIS CAMPBELL, *Republican Staff Director*

CONTENTS

OPENING STATEMENTS

	Page
Baucus, Hon. Max, a U.S. Senator from Montana, chairman, Committee on Finance	1
Hatch, Hon. Orrin G., a U.S. Senator from Utah	3

WITNESS

Blum, Jonathan, Acting Principal Deputy Administrator and Director, Center for Medicare, Centers for Medicare and Medicaid Services, Baltimore, MD ..	4
---	---

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Baucus, Hon. Max:	
Opening statement	1
Prepared statement	27
Blum, Jonathan:	
Testimony	4
Prepared statement	29
Hatch, Hon. Orrin G.:	
Opening statement	3
Prepared statement	44

COMMUNICATION

American Medical Rehabilitation Providers Association	47
---	----

REPEALING THE SGR AND THE PATH FORWARD: A VIEW FROM CMS

WEDNESDAY, JULY 10, 2013

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Wyden, Stabenow, Nelson, Cardin, Brown, Bennet, Casey, Hatch, Grassley, Crapo, Roberts, Enzi, Thune, Isakson, and Toomey.

Also present: Democratic Staff: Mac Campbell, General Counsel; David Schwartz, Chief Health Counsel; and Karen Fisher, Professional Staff Member. Republican Staff: Dan Todd, Health Policy Advisor.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

Benjamin Franklin once said, “You may delay, but time will not, and lost time is never found again.” Those words ring true today as we work to repeal the Sustainable Growth Rate, otherwise known as SGR. This is a formula used to pay doctors who treat Medicare patients. It is antiquated, inefficient, and flawed. Over the past decade, the SGR has called for Medicare payment cuts to physicians that are unsound.

Next year, physicians face a 25-percent cut under the formula. This deep cut would mean many seniors could lose access to their doctors. I refuse to let that happen. In each of the last 10 years, Congress has prevented these cuts to physicians by passing a patch, but we have never addressed the root cause of the problem, the SGR itself. It is time to repeal this broken formula. We need to do it this year.

The most recent 10-year estimate for repealing the SGR is about \$139 billion. This is a lot of money, but last year’s estimate for repeal was nearly twice that amount. So we must act. But we cannot just repeal the SGR; we need to change the entire fee-for-service system that Medicare uses to pay physicians.

Fee-for-service promotes volume over value. That is certainly not a model of efficiency. We need to encourage physicians to coordinate patient care to save money and improve health outcomes. At the same time, we must remember that the payment system sets payments for other providers as well as physicians. This system

pays nearly 850,000 clinicians, and 300,000 of these clinicians are advanced practice nurses and physician assistants.

The new SGR system must work for all of these health care providers. The Center for Medicare and Medicaid Innovation is testing new ways to compensate physicians and other providers who deliver high-quality, efficient care. The Affordable Care Act took a key step in controlling Medicare costs by creating Accountable Care Organizations.

These groups of doctors and hospitals work together to provide quality care for Medicare patients. These multi-specialty groups are helping us understand how to incentivize providers to provide value. These organizations share in the savings they achieve when they provide more efficient quality care.

I am proud that the Billings Clinic in Montana became an Accountable Care Organization this past January. Teams of providers are working together to coordinate care for chronically ill patients. That is just one of their missions. They are also focused on improving access to primary care, with the goal of getting sick patients a doctor's appointment the same day.

While new systems are being tested, we need to improve the current system. Doctors and nurses who see patients every day can give valuable ideas about what works and what does not. That is why, in May, Senator Hatch and I sent a letter to the health care provider community asking for their advice: what can we do to improve the system? What would make your practice better? We asked for specific, concrete ideas.

The response was encouraging. We received 133 letters. Physicians told us that they are working to improve their quality of care, to improve communications with patients, and to work in teams. They are trying. They are developing new types of practices with a focus on outcomes and continuous care. They are using evidence-based guidelines to reduce unnecessary services. Physicians want to improve their performance and efficiency, and Medicare's payment policy needs to incentivize that improvement.

I want to highlight the letter from the American College of Physicians. They gave us concrete examples, down to how Medicare could incentivize physicians to use guidelines to help them decide when to order tests and perform procedures. This would encourage doctors to provide the care seniors need and avoid unnecessary care that might cause harm. I am not saying we will accept all of their suggestions, but their comments help us see different angles of potential policies.

We also have brought experts to the Finance Committee to hear their ideas about fixing the SGR. We held three roundtables and a hearing in May. It is now time to hear from CMS.

In his 2014 budget proposal, the President agrees that we need to move to alternative payment models, and he recognizes this will take time. His budget proposal also advocates reforms to the current system. Today we will learn what CMS is doing to improve physician payments. We want to hear CMS's views on a new plan for Medicare physician policies.

For, as Benjamin Franklin warned, "You may delay, but time will not. . . ." So let us get to work repealing this flawed system and developing a new one that works for providers and patients.

Senator Hatch is not here this morning. Oh, he is? Yes, he is here. Boy, what timing. I am impressed. I am impressed.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch, it is all yours.

**OPENING STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH**

Senator HATCH. Well, thank you, Mr. Chairman. Thank you for calling today's hearing. This is an important subject. As many of you know, over the past several years both Chairman Baucus and I have called for permanent repeal of SGR. Indeed, over the past year Medicare physician payment issues have received significant attention from this committee.

Just last summer we convened several roundtable discussions with former CMS administrators, leading private sector health organizations, and leading physicians, to gain better insight into physician payment reform efforts and ideas to improve our payment system for physicians serving Medicare patients.

This is our second hearing on physician payment issues this year. Moreover, the last 2 months the chairman and I have received more than 130 responses to the letter we sent to the health care community seeking input on improving the physician fee schedule and helping physicians transition to alternative payment methods as they develop.

I want to thank the stakeholder community for their thoughtful responses. Rest assured, we will give them strong consideration as we work to find a long-term solution for paying our physicians. There is no doubt that we have all grown weary of the end-of-the-year scramble to stop the draconian payment cuts to physicians serving Medicare beneficiaries, but this year is different. We have a new, important consideration to encourage our action.

According to CBO, the current cost to repeal the SGR has been substantially reduced. If the Congress does not act now, when will we ever find a path forward? We must seize this opportunity, and it is up to this committee to find the solution. We must act soon so we can finally put our physicians on a stable financial footing.

I look forward to hearing from Mr. Blum this morning about how CMS has sought to improve the Medicare physician payment system and how the administration can work with us to find a bipartisan path forward. I want to thank you for being here. We appreciate your being here to testify.

Thank you, once again, Mr. Chairman, for continuing this important discussion. I look forward to continuing to work with you as we look to provide a stable foundation for paying our physicians now and in the future. I believe we are making real progress, and I am hopeful we will produce a permanent solution this year. I think we have to.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator, very much. I appreciate that.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. I am pleased to welcome today's witness, who is Jonathan Blum, Acting Principal Deputy Administrator at the Centers for Medicare and Medicaid Services and Director of the Center for Medicare.

Jon, it is great to have you back. You have provided invaluable service to this committee when you have worked with the committee in years past; I know you will today too for CMS. Thank you very much for your service and all that you do.

As you know, our standard procedure is, your statement will be included in the record, and we ask you to speak for about 5, 6 minutes. But take your time, and say what you want to say.

STATEMENT OF JONATHAN BLUM, ACTING PRINCIPAL DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR MEDICARE, CENTERS FOR MEDICARE AND MEDICAID SERVICES, BALTIMORE, MD

Mr. BLUM. Thank you. Chairman Baucus, Ranking Member Hatch, members of the Finance Committee, thank you for holding this hearing and giving CMS the chance to discuss its recommendations for how to reform Medicare's physician payment system.

There are two issues for us to consider: (1) how to set a realistic baseline for physician payments, the so-called SGR issue; and (2) how to reform the payment system to continue its shift from paying for volume to paying for value.

If Congress fails to act before January 1st, CMS will have no choice but to reduce physician payments by 25 percent. Over the past decade, Congress has stepped in to avoid these reductions, but often at the very last minute, creating tremendous confusion for physicians and their patients, not to mention wasted funds and time as we scramble to implement the cut and then to reverse it.

CBO's latest estimates for a fully funded fix are at the lowest level in recent memory. This year can be the year that we put the annual SGR issue to rest. Indeed, the President's budget once again proposes a fully funded SGR fix. We agree with the growing consensus among the Congress and stakeholder groups that a fix to the baseline should be paired with reforms for how we pay physicians.

Specifically, our budget recommends four core principles for any reform: (1) providing a period of payment stability where the update factor would be predictable for a multi-year period; (2) continuing the development of new payment models like ACOs and primary care medical homes where physician practices and groups are accountable for the total quality and total cost of the care; (3) over time, studying differential payment updates based on physicians' successful participation in these new models; and (4) continuing our pathway forward to make the underlying physician payment system more accurate, more focused on primary care and patient care coordination, and more focused on the total quality and value of the care.

CMS's current work to implement the Affordable Care Act and other changes have laid the groundwork for these four principles articulated in the President's budget, and, while not always discussed, there has been tremendous work undertaken over the past

5 to 6 years that has made significant changes to our current physician payment system.

Working together, we have changed the underlying physician payment system in five ways. First, we have shifted the payment system to increase payments for primary care services.

Second, we have reduced our payments dramatically for high-cost imaging services. These high payments not only waste valuable resources, but have also led to inappropriate utilization, which is costly and harmful to beneficiaries.

Third, CMS has established new payment codes to reward care-coordination activities. Last year, CMS built separate payment codes for transition management services to help beneficiaries navigate from the hospital setting to a post-acute care setting or back to their home. In this year's physician payment rule, we proposed to add new payment codes to pay for complex care management for those beneficiaries who have multiple chronic conditions.

Fourth, over the last few years we have reviewed over 1,000 payment codes that represent 40 percent of payments under the Physician Fee Schedule. Revaluing these codes will reduce Medicare costs as well as shift the value of our fee schedule to primary care services. Continuing in this direction, in this year's payment rule, CMS has proposed to pay for physician service no more than what is paid for the same service at a hospital setting. This represents a strong step towards reducing site-of-service payment differentials.

Fifth, we have begun the process to phase in the value modifier. In 2015, the value modifier will apply to about 25 percent of all physicians. Under our just proposed rule, the percentage will grow to 60 percent by 2016.

The President's budget framework is also built upon the continued development of new payment models that move away from the open-ended fee-for-service system, and here we see much potential for the basis for future legislation with promising results beginning to emerge from CMS's work.

For example, we are very pleased with the status of the ACO program. To date, the program is serving 10 percent of the total fee-for-service Medicare population. We expect to approve many more ACOs into the program for the January 1, 2014, start date. Despite press stories that some Pioneer ACOs may choose to shift their participation to the base Shared Savings Program, we expect that the pioneer track will demonstrate overall savings in its first year.

We are also encouraged by our primary care medical home programs. Although it is still early to measure cost savings, it appears as though the programs have moved key quality metrics in parts of the country.

In short, we are at a crossroads for long-term physician payment reform. The opportunity to permanently fix the SGR has never been better. Congress should not waste this opportunity. We have also demonstrated that we can make substantial changes to our current physician payment system and build new payment models to phase out the open-ended fee-for-service program. CMS stands ready to assist this committee with your work.

The CHAIRMAN. Thank you, Mr. Blum.

[The prepared statement of Mr. Blum appears in the appendix.]

The CHAIRMAN. You mentioned in your statement payment stability. I assume that is sort of a short-term or a solid, stable transition into a more permanent system. Could you tell us more or give us more definition of what you mean by that?

Mr. BLUM. Well, we think there are two reasons we need payment stability. Number one is that the annual update factor of the threat of 24-, 25-percent reductions, I think, has created confusion within the physician community. But I think our first principle is to make sure that we set payments that are predictable, that physicians can plan for. So that is principle number one.

But we also feel that we need more time to help physicians participate in new payment models. Our budget does not say precisely what that period should be, but what I would recommend is a period of 4 to 5 years where we can give stability, give time, but also create more opportunities for physicians to participate with a new payment model.

The CHAIRMAN. So, if I heard you correctly, you are saying in about 4 to 5 years you think you will have worked through the payment models and come up with the ones you think make the most sense?

Mr. BLUM. We believe that a period of stability is important. That seems to us about 4 to 5 years. That will give CMS more time, physicians more time, to develop the capabilities. It is hard work to participate within an ACO-like model, but we feel that we need to set that period for stability, but also to continue the shift. So 4 to 5 years seems to us the correct balance.

The CHAIRMAN. In addition to ACOs, you mentioned medical homes. What are the basic ways you are working to move from fee-for-service to quality, and how will they work?

Mr. BLUM. Well, we have different models that have been established, both by the law but also through our new demonstration authority through the Center for Innovation. Clearly we have placed tremendous emphasis on Accountable Care Organizations, and, to date, the results are promising.

We expect to see overall savings in the pioneer track that was the first wave of the program, so we feel that the ACO program has promise for continued success. The ACO is not going to be able to serve all physicians, so that is why we have also created other models, like primary care medical homes, that are more tailored to a physician practice.

We also have a program being put in place right now, the value modifier, that is going to apply to all physicians, where a portion of their payment will be tied to the overall quality, to the overall value, of their care.

So I think it is important that we create multiple models that are tailored to different geographic circumstances. There is not going to be a one-size-fits-all model. That has been one of the key lessons for CMS in the past couple of years. But we do see promise, we do see much more opportunity for more physicians to participate.

The CHAIRMAN. So, in the short term, what changes would you like to implement, or maybe you need new authority? This is this

year. We are not going to implement this for a few more years. What do we do in the short term?

Mr. BLUM. Sure. One of the reasons why the CBO score has come down is because the agency is managing payments much more aggressively. I talked about the misvalued code initiative, where CMS now is actively reviewing payment codes that are misvalued, that seemed to be driving utilization.

The CHAIRMAN. Misvalued why?

Mr. BLUM. Because they are just paid at too high of a level, which creates over-utilization, like high-cost imaging in the past. So it seems to us that any reform package needs to also continue to direct the agency to stay vigilant, to make sure that our underlying payment system that is the building block to ACOs and primary care, stays as accurate as possible. I think more direction from the Congress to encourage CMS to be vigilant, to be aggressive in taking on misvalued codes, would pair very well with the overall payment strategy.

The CHAIRMAN. Is there a question of doctors having immediate access or timely access to their own quality data that helps them improve their own performance?

Mr. BLUM. We think it is vitally important that we provide that information back to physicians. Right now, through the value modifier concept and the physician feedback reporting, we are working to phase in that feedback, which currently covers about an 8-month time period from the time when a physician submits data, to the time the agency collects data and then submits it back to physicians. Clearly we have more work to do to make it more real-time, but, based on our analysis, we are working as well as any other private sector system that we are aware of. We are going to work harder to kind of speed that timetable up.

The CHAIRMAN. My time is about out here. Could you give me just a rough sense and say, in 5 years, what percent of physicians' and physician assistants' reimbursements will be quality-based as opposed to fee-for-service, and, in 10 years, what will those numbers be?

Mr. BLUM. That is a hard question, but I think Congress should establish that goal going forward. Right now in our physician payment system, a small portion is tied to quality, somewhere around 2 to 4 percent. I think having a schedule set going forward would be another important step for Congress to establish.

The CHAIRMAN. What additional authority would you like?

Mr. BLUM. The budget neutrality requirement that we have in the statute constrains our ability sometimes to be truly forceful in reducing over-valued services. I think one opportunity we have is to think carefully, but also to think about waiving that budget neutrality requirement so we can drive total costs down to a lower level.

The CHAIRMAN. Thank you very much.

Senator Hatch?

Senator HATCH. Mr. Blum, many of the ongoing payment reform efforts that are being conducted by CMS require increased quality reporting from physicians. Over the past several years, CMS has implemented and expanded the Physician Quality Reporting Sys-

tem, or the PQRS. However, physician participation remains below 50 percent, as I understand it.

Some have suggested that the measures included in PQRS are not meaningful to clinical practice, that the system is too heavily weighted to process measures. Many have said the system needs to be re-tooled to focus on outcomes and outcomes measurement.

Do you agree with these critiques of the PQRS, and, if so, how can CMS move to a more outcomes-based reporting system?

Mr. BLUM. I think there are a couple of considerations built into your question that are all very important. First is, that we agree that we need to increase participation in physician reporting of quality metrics. With the value modifier policy going into effect, physicians will face more and more financial penalties for failure to report.

So we think, over time in the next couple of years, that that 50 percent will grow as physicians become aware that, if they do not report, do not participate, their payment levels will be decreased by the program according to current law. So, while we are still below 50 percent, that percentage has grown in the last couple of years, and we expect it to grow.

In regards to the number of quality measures, this is really a balance that we are trying to strike. We want to make sure that quality metrics are simple and they are meaningful and they can be comparable, but at the same time we want to make them relevant to a physician practice.

One dynamic is that, when you reduce the number of measures and focus on a core quality set, you make those measures less relevant to certain specialties. So we are trying to find the right balance between simplicity and reporting that still makes those measures relevant to individual physician practices.

Senator HATCH. Now, many experts have highlighted the importance of improved communications between payers and providers of care. A major hurdle to physician payment reform is physician engagement. How often does CMS share quality and resource data with practicing physicians, and, two, what has CMS done to improve its engagement with physician providers?

Mr. BLUM. Well, one of the requirements that we are working to implement that was led by the Finance Committee in a bipartisan way, is to direct the agency to provide feedback reports back to physicians. We have started that process. We have piloted in four States. That is now being phased in for all physicians.

But over time, in the next several years, all physicians will be given feedback reports based upon the relative quality, relative resource use compared to their peers, by law, by policy, by the agency. We are making that feedback confidential to physicians, but we are providing, and will provide to all physicians over the next several years, the feedback on their relative quality, relative performance, to encourage better engagement.

Senator HATCH. Many of your efforts have been focused on primary care physicians. While there is little disagreement that we need a greater focus on primary care in our health system, most of our spending on Medicare occurs in specialty medicine. Currently, many of the payment reform efforts have been aimed at ex-

panding primary care, but little attention has been paid to developing new models of payment for specialty physicians.

What are some of the challenges you face as you evaluate opportunities within the various specialties, and how does CMS plan to advance payment reform for specialty physician practices?

Mr. BLUM. It is true, and we are concerned with this dynamic, that models like ACOs and primary care, by definition are designed to capture more primary care physicians than physician specialists. So we believe that it is vitally important for us to move, in the next phase, to build payment models that are more tailored and more responsive to physician specialties.

One of the things that we have done through the Innovation Center this year is to solicit from physician specialties ideas for new payment models through a grant process that must lead to a potential for new payment models.

We want these models to be led by physician specialties, but we have created a brand-new opportunity through our Innovation Center to build, working with societies, those new payment models that are much more tailored towards oncologists, for example, or other physician specialties.

Senator HATCH. Mr. Chairman, my time is up.

The CHAIRMAN. Thank you, Senator, very much.

Senator Wyden?

Senator WYDEN. Thank you very much, Mr. Chairman.

Mr. Blum, a big part of the Affordable Care Act was based on the concept of shared savings. I think you all felt strongly about it, as we did. There is bipartisan interest in this. In order to tap the full potential for the concept of shared savings, providers have to know how they are doing.

They have to know, in effect, from their patients and the data, how things are going. The providers are telling us they cannot get their claims in real time. They cannot get that information. Now, Senator Grassley and I have introduced, and I think you are aware, legislation to open up the Medicare database.

I think that in order to tap the potential of shared savings, this is another reason to support this bipartisan legislative approach. What is your reaction to that? Because I think that, if we do not open up the Medicare database right now, it is going to be hard to empower consumers at a time when they clearly want to make choices about cost-effective health care, and my sense is it is going to be hard to tap the full potential of shared savings. What do you all want to do about that? If you decide today you want to announce support for the bipartisan bill, that would be fine too. [Laughter.]

Mr. BLUM. I am not sure I can say that today, but what I can say is, that we agree that when providers can see their full claims information, that is powerful. Our feedback from the participants in the ACO model, the bundled payment model, is that, for the first time, these opportunities have allowed them to see the complete picture of how their patients receive care, and to design interventions. So we are fully supportive and fully share the goal that more information, more data, is necessary for these payment models to succeed. They have to be balanced with—

Senator WYDEN. The providers, Mr. Blum, are saying they cannot get it now in a timely way.

Mr. BLUM. Sure.

Senator WYDEN. That is the reason I am asking. So what are you going to do about that?

Mr. BLUM. Well, I think a couple of things. For organizations that come into our ACO program that sign confidential data use agreements, they can see complete claims information. So working with our models, that creates——

Senator WYDEN. Within what time period? After they sign those agreements, when can they see the data?

Mr. BLUM. I believe they receive the data in two different ways. They can receive raw claims versus summary information. One of the other learnings that we have taken from the ACO models is that it is very difficult for providers themselves to handle the claims. It takes computer power, it takes infrastructure. So any effort, I believe, to provide that data back must be meaningful, must be easy to understand.

The ACOs that we work with had a lot of challenges taking on that kind of degree of zeroes and ones in our data.

So I think any effort to expand access needs to take into account that that data is raw, but it has to be turned to data that——

Senator WYDEN. Will you get back to us in writing on the time period when providers can expect to get access to data——

Mr. BLUM. Yes.

Senator WYDEN [continuing]. Because I asked it a couple of times, and you did not answer that question. So get back to us this week on the time period when providers can get that data, because they have to have it for shared savings.

Mr. BLUM. Sure. So one thing to consider for your legislation is that we are dependent upon providers to submit the data to CMS, so, under current law, I believe they have up to 12 months to submit a claim from the time that it is provided. So that is one challenge to timely data, so we need to work through that provision before we can provide that real-time information back.

Senator WYDEN. We will be glad to work with you on it. But again, if we are going to make an integral part of the Affordable Care Act—something I support, I know you support—work, and that is a shared savings concept, we have to have a timeline when providers can get their data, because, without that data, they cannot really compare it and tap the potential of the concept I know you are for.

One last question with respect to the Innovation Center. In effect, CBO has essentially said that savings, any ideas that we now come up with, are already accounted for. Essentially, that is built into the Act for the Innovation Center.

I just want to make sure that CMS is clear that it is not going to get credit for every idea under the sun with respect to holding down costs and innovation, that congressional legislation and other proposals can also be scored and they will not be held up just because there is an interpretation from CMS that every single idea under the sun is going to be due to the Innovation Center. Can you tell me that this morning?

Mr. BLUM. We are eager for ideas, and we will be happy to work with you and your office to identify new ideas. I cannot speak to CBO's scoring conventions, but what I can say is, we want to find every opportunity to reduce the costs of care while improving the quality of care.

Senator WYDEN. My time is up. I just do not want all of the members of the Finance Committee, Democrats and Republicans, to in effect get boxed in, and, when they have good ideas, everybody says, oh, we cannot pass that legislation because savings all come from the Innovation Center. So we would like to follow that up with you as well.

Mr. BLUM. Great. Very good. Thank you, Senator.

Senator WYDEN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator, very much.

Senator Grassley is not here. Senator Stabenow?

Senator STABENOW. Thank you very much, Mr. Chairman.

Welcome, Mr. Blum. It is nice to see you. I want to talk more about the proposed rule that you have as it relates to care coordination, which is so important, your primary care and complex chronic care management proposal for separate payment for complex chronic care management services in 2015, and specifically around the issue of Alzheimer's disease.

This is something that affects, now, one out of nine seniors in some way, at a huge cost for all of us, as well as for families, and so on. When we look at the fact that there are 5 million people living with Alzheimer's disease, and about half of them have never gotten a formal diagnosis, and only 19 percent of people over 65 who have dementia have gotten any kind of a diagnosis recorded in their medical records, somehow we have to focus on this.

Earlier this year the advisory council created under the national plan to address Alzheimer's disease, as you know, recommended that Congress and CMS re-design Medicare coverage and reimbursement to encourage appropriate diagnosis of Alzheimer's disease and to provide the coordinated care planning that is necessary.

I have introduced a bill based on that with Senator Collins and Senators Brown, Menendez, Nelson, and others, called The Hope for Alzheimer's Act, that would do just that, namely, improve early detection of Alzheimer's disease, help families from the moment of diagnosis, help families, patients, and caregivers be better equipped with knowledge of treatment options, support options, and so on.

So the bill would streamline the services by combining the existing Medicare benefits for diagnosis and care planning into a single package of services and include a comprehensive clinical diagnosis evaluation for Alzheimer's disease and care planning services.

So, given all that you are doing to streamline payments and emphasize care coordination, I guess my question is, how does Alzheimer's fit into that? Are you looking at Alzheimer's disease and care planning to enhance the effort, and are you considering Alzheimer's as one of the conditions under your complex chronic care coordination services?

Mr. BLUM. Sure. We agree that early detection, early diagnosis for Alzheimer's, and all chronic conditions, is key to reducing overall spending but, more importantly, to improving the quality of life for the patients whom we serve. We agree with the growing consensus that a lot of the care that happens, provided by a physician, by their practice, happens in non-face-to-face settings, so we need to create more discrete payment opportunities for that care that happens in the non-face-to-face setting, which led us to propose this new complex care management fee, really built on the medical home concept, where we really incent active patient engagement with their physicians and pay for the care that happens in the non-face-to-face setting.

We have also added to our new wellness visit that dementia screening needs to be an important part of that. I have had a chance to read your legislation, and I want to understand it better, but I think we agree in concept, and hopefully the changes that we have made through our own authorities are consistent and supportive to your overall policy goals.

Senator STABENOW. Well, I look forward to working with you. It seems to me the direction you are going in is exactly what we are talking about, and there is a huge need, as you know, in the area of Alzheimer's disease, for supporting patients and caregivers. It seems to me, from reading the proposed rule, that this would be part of that, so I want to work with you on that.

Let me talk a little bit more about ACOs. I guess my time is just about up, but let me just ask, when we talk about the fact that there are \$500 billion in reductions projected for Medicare spending over the next 3 years, we know that is not all ACOs, it is a lot of things.

But I would just indicate as my time runs out, rather than asking a question, that I think we have a lot of opportunities, certainly in Michigan, with what we have seen with ACOs and the Pioneer ACOs. I think there is a lot of opportunity to reduce costs in a way that increases quality, and I look forward to working with you on this.

Mr. BLUM. Great.

Senator STABENOW. Thank you, Mr. Chairman.

Senator HATCH [presiding]. Thank you, Senator.

Senator Cardin?

Senator CARDIN. Thank you very much, Mr. Chairman.

Mr. Blum, welcome back to our committee. It is always nice to have you here.

I agree that we have two issues we have to deal with. One is the elimination of the SGR, but then, also, what do we replace it with? I would just urge more urgency in finding what we can replace it with. As Chairman Baucus pointed out, we have a more friendly estimate that we can work with this year that may not be available in the future.

Second, we need savings in Medicare, and the physician reimbursement structure offers great promise of savings in the system. So I would just urge us all to have a greater sense that we need to try to get this resolved sooner rather than later so that we can, once and for all, get rid of the fear that physicians have that we will hit a deadline and these cuts will become real and the bene-

ficiaries could be denied access to care, and replace it with a plan consistent with delivery system reforms and quality issues that we have talked about, that we have enacted in the Affordable Care Act.

I want to talk about one issue that is particularly important to Maryland dealing with the durable medical equipment and the competitive bid second round that took effect on July 1st. The information I have is that there were 68 contracts awarded in Maryland involving 47 different companies that are not licensed to provide services in Maryland. That is a direct violation of the law that requires companies, to win bids, before they can submit a bid, to be licensed by the State. That was not true in Maryland.

We have written to you. Senator Mikulski and I have written to you of our concern here. We know there was a similar problem in Tennessee. You took some action, but not complete action, on Tennessee. Can you just give me an update on where we are? This is, again, an urgent issue.

We have companies that did not win bids that are in danger of going out of service, providing not only concern about access to care for the Medicare population but also the Medicaid population. Are you planning to re-bid? What are you planning to do? It has been a couple of weeks since we have written to you on the subject.

Mr. BLUM. Well, thank you for your letter and thank you for the attention. We believe that competitive bidding is vitally important to the Medicare program. We have expanded the program from nine areas of the country to 100 areas of the country. We have maintained the principle that we will track down and work through any issue that is brought to our attention.

We have heard about various State licensure issues, and I have directed our team to chase them all down. We have isolated two parts of the country where we had some issues—Tennessee you mentioned, but also the State of Maryland. We heard that 68 sites potentially did not have State licensures. That has now been brought down to 47 agencies. I am confident that the majority of those 47 will meet State licensure requirements. We are still working through the complete list, but I think right now my analysis is that the majority have complied with State requirements.

Senator CARDIN. Was there not a requirement that they be licensed before they could make a bid?

Mr. BLUM. We are still working through that issue, but my understanding is that the majority have fulfilled their obligations. We are going to stand by the principle that every operating supplier must have followed State licensure requirements at the time they bid, but also today. CMS took action in Tennessee. We want to make sure that any action that we take is considered and carefully addressed. I pledge to work through this issue as fast as we possibly can.

One of the issues that we discovered in the State of Maryland was that they were not following, not necessarily enforcing, their own State licensure requirements. CMS will make sure they are enforced, but, of the 47 that have been identified, I am confident that the majority will meet State licensure requirements.

Senator CARDIN. Let me just make a comment in my few remaining seconds. Our concern is access and that there be access to both

the Medicare and Medicaid population. There has been an arrangement between CMS and the States on State licensures. I do not quite understand your reply challenging the independence of the State to determine licensure issues.

It sounds, by your reply, that it looks like CMS may be taking over licensure responsibilities, which I do not think you really want to do. I think the law was pretty clear that they had to be licensed before the bids were submitted. And now disadvantaged companies that no longer are contract companies may go out of business. That does not seem fair to me.

Senator Mikulski and I will be following up with you, and we would expect that you will keep us informed on this issue.

Mr. BLUM. Absolutely. Our principle is the same as yours.

Senator HATCH. Senator Roberts?

Senator ROBERTS. Thank you, Mr. Chairman.

Mr. Blum, I want to start out by thanking you and your staff for your help in providing technical assistance on legislation I have proposed related to the long-term acute care hospitals. It is called LTAC. I know you are familiar with that. We believe we are making headway on a score with CBO, and I think that is in part attributed to your efforts, and I want to thank you.

We are hopeful that after this round of comments, we will receive the feedback that we have addressed outstanding concerns from CMS. I think there are a few outstanding issues. I wanted to make sure that you and the committee knew that this continues to be a top priority for me and others on the committee, so thank you for that effort.

Last night I was involved in one of these tele-town hall meetings that members of the Senate conduct, where you are talking to quite a few folks. You are lucky if you get, what, 30, 32 questions in the hour that you have. But I got several questions like this.

There was a very nice lady from Wichita—and I get the same question when I am home a lot—who asked me why she cannot find a doctor and why the doctor of her choice will no longer accept her Medicare. That is true in Dodge City, Abilene, Salina, Topeka, Kansas City, Wichita, all over our State, and I think is pretty much true throughout rural and small-town America.

I have heard that a growing number of doctors in Kansas are no longer accepting Medicare patients due to the uncertainty and the instability in the system, as you yourself have pointed out. I know this is a real challenge for us.

The situation right now, I think, is getting pretty dire, more especially in the rural health care delivery system. I do not know what percent of our doctors in Kansas—I am not sure we will know, but there is an estimate now that 30 percent are not accepting Medicare patients.

Then we have a lot of doctors who are joining up to be salaried employees with various hospital groups as opposed to operating in the fee-for-service environment. The reason for it, as we try to delve into that or dig down into the reason as to why they are doing that, is because they are just, quite frankly, damned tired of putting up with all the regulations around quality control.

Lord knows, nobody wants to be opposed to quality control, but they just cannot keep up with the regulations with regards to the

small practice that they had. Now they have become salaried. Well, now we are back to HMOs, and now we are back to managed care. We went through that, and that was not a very pleasant experience.

Then figure out how many doctors are over 50 years old and how many doctors are planning on retiring in the next couple of years with the uncertainty with the Affordable Care Act and actions of CMS trying to achieve the answers that the Act says that you must do, unless you delay it—

At any rate then, you have about, what, 15, 20 percent of fee-for-service people out there? Like Senator Cardin pointed out, we have a big access challenge on our hands, and I am most interested to know if you can address whether CMS is giving the rural health care delivery system the attention it needs. I know you are trying to achieve balance. I know you are trying to achieve quality control. I know you are trying to achieve savings.

As a matter of fact, I think the administration does not recommend a specific way to pay for the SGR repeal, but instead adjusts the baseline to reflect a permanent fix. So we are adjusting the baseline and we are achieving savings, but we do not have a fix. It worries me that we are going to get down to a situation where people have to drive 50, 75, 100, 150 miles to get to a doctor.

That has been our problem, that has been our challenge for a long time. It is true in Montana, it is true in Utah, Wyoming, Kansas, and I can just go around the room here in regards to the committee. Now I will quit talking and ask you to say that you are certainly looking out for the rural health care delivery system.

Mr. BLUM. Absolutely. I think the core principle that I would say needs to be part of any legislation is not so much the CBO score, but whether patient care is better and whether patients get better access to health care services than they do today. And whether it is the ACA, whether it is our payment rules, whether it is the quality framework that has been put in place in a bipartisan way, we want to make sure that health care costs are lower through better coordination, better engagement. That is as true in rural areas as it is in urban areas.

We work very hard to make sure that our new payment models are responsive to the challenges of rural America. We work very hard to make sure that we are allowing all professionals to practice at the full scope of their State license. We have more work to do working with States, working with others, but I think the absolute core principle needs to be that, in any payment reform or SGR reform, we have to be able to say that patients have better access to their physicians than they do today in all parts of the country.

Senator ROBERTS. Well, I thank you for your response. I would simply reflect the desire of, I think, virtually every Senator who has made comments here, for you to provide the specific policy options, how this is going to work, to us as soon as you can. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Brown, I think you are next.

Senator BROWN. Yes. Thank you, Mr. Chairman.

Thank you for joining us, Mr. Blum. I appreciate it. I have been following House efforts to, for want of a better term, repeal and re-

place SGR. The House Energy and Commerce Committee majority staff released legislation maybe a couple of months ago that would replace the Sustainable Growth Rate with three phases: (1) a period of stable payments; (2) payments based on quality; and (3) payments based on efficiency.

It seems to me that, in a couple of big ways, we are already on the path toward paying for quality and efficiency. One is the Physician Quality Reporting System predating the Affordable Care Act. Second is, CMS is implementing the value-based modifier from the ACA, which will be phased in starting in 2015, to provide differential payments to physicians based on quality and cost of care.

Would you sort of comment generally on their efforts, contrast them to what we are doing. In answering a couple of questions in the midst of that, are they kind of reinventing the wheel? Is it more costly and time-consuming to sort of deconstruct and rebuild? Just if you would kind of outline that for us, your observations.

Mr. BLUM. I will make a couple of points. Number one, I think it is a tremendous achievement that all three authorizing committees are working towards a solution to the SGR. There is a growing consensus that the change needs to be paired with different payment models to phase out of the open-ended fee-for-service program. I think one question and one concern that should be brought forward is, there has been tremendous work over the last 10 years, led in a bipartisan way from this committee and others, to build the quality structure that we have: PQRS, pay for reporting, the value modifier.

I think any effort that goes forward should build upon the current work that we have rather than restart/refresh. We have built tremendous infrastructure, the physician community has built tremendous infrastructure to participate.

While there is a reason for celebration that all three authorizing committees seem poised to want to fix the SGR on a permanent basis, we have to be mindful that we send consistent signals to the physician community, not to restart/refresh, but to build upon the important work that really has led, in a bipartisan way, toward quality reporting, pay for value, and we should not step back where we should step forward.

Senator BROWN. Can you say with some certainty that PQRS and the beginnings of the Affordable Care Act are some of the reasons, either or both of those, that SGR costs into the future are less than they were projected to be some time ago?

Mr. BLUM. Well, I do not believe that the lower CBO score is a statistical fluke. It really is the result of a lot of hard work and a combination of driving more value in our payment system, focusing on care coordination, care quality. Over the last 3 years, Medicare costs have grown at almost zero percent due to a combination of many things: focusing on value, focusing on quality, focusing on payment accuracy. The reason why the CBO score is so low is because of all this hard work.

We have to continue that, we have to build upon that, to ensure that we send consistent signals that we do not intend to replace work that has been done over the past 5 to 10 years. But I believe that the reason why Medicare costs have come down is due to a multitude of factors, including the focus on value, the focus on care

coordination, the focus on quality, and the focus on payment accuracy.

Senator BROWN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Enzi?

Senator ENZI. Thank you, Mr. Chairman.

Thank you, Mr. Blum, for being here. Your testimony was some of the more difficult testimony that I have ever waded through. I am not sure that I understand, even after your explanation. It sounds to me like you are kind of shifting the blame to the committees that are supposed to work on it without you providing a solution for the three committees to be working on.

Your testimony says that you support a long-term plan to reform the physician payment system in a fiscally responsible way. However, the administration elected not to fix the SGR when we were doing the Affordable Care Act. The President promised a docs fix in the State of the Union speech while we were considering his reform package. Of course, he promised tort reform too. Neither showed up in the bill, yet the AMA stood behind him when he signed the bill.

There is not any mention in your testimony of how we can pay for the cost of replacing the SGR, which I think costs about \$140 billion over the next 10 years. So what specific proposals would the administration support to pay for an SGR replacement, and have those proposals been scored by the CBO?

Mr. BLUM. The President has put forward in his last five budget submissions for the Congress, a range of savings proposals to reduce costs in the Medicare program. That has been a consistent theme in the President's budgets. This year, the President put forward Medicare savings proposals that were scored by our actuaries, about \$370 billion, that more than paid for the cost of an SGR fix. We have proposed ways to reduce costs for our Medicare Part D program, for post-acute care services, for other services that we believe to be over-valued.

The President also said that he is open to working with Congress to consider any idea to reduce Medicare spending that does not compromise access to quality care. So we believe that we have led on this. The reason, in part, that the SGR score is so low is due to a very, very strong focus on cost reduction, which is why it is so important that we think about things like competitive bidding for durable medical supplies, that we consider payment reforms to laboratory services, which CMS chose to take on this year.

We believe that we have done a lot to reduce overall spending, but the President consistently has put forward, in his last five budget submissions, controversial, but very appropriate, ways to reduce Medicare spending that this year more than offset the costs to an SGR fix.

Senator ENZI. I have to join Senator Cardin in his comments about the bidding process and allowing people to bid who have not gotten licensed yet. And they are doing bids for the whole United States without subcontracting, in rural areas particularly, and it is affecting Wyoming pretty dramatically. They come to the licensed provider on the bid process and tell them what price they can have

for the service that they are providing, not even knowing anything about the territory that they have to serve.

But it appears to me that we are just kind of kicking the can down the road. There have been a number of bipartisan commissions and proposals, including Simpson-Bowles, Domenici-Rivlin, Coburn-Lieberman, that proposed making changes to Medicare Part A and Part B as part of a permanent solution, and those changes simplify the basic structure of Parts A and B, they reduce the costs for many seniors, they protect low-income seniors from catastrophic medical costs, and they better align Medicare premiums with the senior's ability to pay. Such changes could be included as a permanent solution. Would the administration support those bipartisan reforms to the Medicare benefit as a part of the SGR solution?

Mr. BLUM. As part of the President's budget proposal this year, we have put forward ways to reform Medicare cost-sharing, for example, by adding cost-sharing for home health services for certain beneficiaries who qualify for home health services. We have proposed reforms to secondary cost-sharing, changes to Medigap.

Senator ENZI. You are not answering my question about those bipartisan suggestions. You are going into some other things that you already covered in the first question.

Mr. BLUM. We agree with the growing consensus that Congress and we should work together to reform Medicare's cost-sharing structure. We have some proposals that were put forward to achieve that goal in our budget, and we are happy to continue that work together.

Senator ENZI. Once again, the administration is saying, if you have any ideas, give them to us. I have had thousands of them thrown away, and it is a little bit discouraging. I think these were some good suggestions. I think they have been thrown away. I think you said you have been through 1,000 of the payment codes, and that is 40 percent. I thought there were 90,000 payment codes.

My time has expired.

The CHAIRMAN. Thank you, Senator.

Senator Grassley?

Senator GRASSLEY. Thank you.

I obviously missed your testimony, because I was in a Judiciary nomination hearing, so I have a statement, but it ends with a question for you. So obviously, with this important issue before us, I thank you for being here to help us get an answer to it.

The last time you were here, I asked if there was any defense for Medicare fee-for-service, where the provider is paid based on quantity of service provided without any regard to the outcome of quality of care provided or any responsibility to coordinate that care with other providers, and I think the answer that you gave was "no." I believe that I even told you rather abruptly that your answer was "no."

I believe that any number of problems we face in Medicare begin with our payment system. Medicare pays based on the quantity of care provided. The payer and the provider are not at risk for quality of services provided. Why are we struggling with reimbursement for imaging? Because we focus on the amount and the cost

of services provided rather than the quality and the appropriateness of what is needed.

Why are we struggling with reimbursement for durable medical equipment? Because we are trying to transition DME payments to a more competitive system that is perceived to have a greater interest in reducing the number of providers rather than improving the quality and appropriateness of the service provided.

Why don't we champion a payment system that penalizes hospitals for readmissions? Because the current payer has not figured out how to isolate and correct the problems that lead to readmissions with providers outside the hospital. Why are Medicare beneficiaries often caught in the cycle of acute episodes at the end of post-acute treatment, which really is just the pre-acute period before their next acute episode? Because the payer has never had the proper incentive to stop that cycle.

We all know that the integration of services is critical for people with chronic conditions. Medicare is a system that desperately needs more transparency. Senator Wyden and I have drafted a bill to make Medicare data more available, though it is remarkable that we would even need that bill. There is no legitimate opposition. I believe that fee-for-service is fundamentally flawed.

Now let me be clear: there are certain episodes of limited care where a specific payment for a specific service will always make sense, but I continue to believe that our system needs to be in transition towards a payment system that entails greater risk for both the providers and the payers. The payer and the provider must care about the outcome because of financial risk, not just some asyet-to-be-designed low-bar quality metric.

When we talk about SGR reform, I realize that we cannot snap our fingers and make it happen next year or the next year, but if we are to pass anything this year, it has to point in the direction of where we need to be a few years down the road.

I want to support SGR reform. We have wasted too much time and energy and money on this issue over the last dozen years, but I also need to see progress toward a better system. So my question, Mr. Blum, is this: what is CMS doing to increase the use of risk for providers and payers in helping design a sustainable Medicare for the future?

Mr. BLUM. I think that is a great question, and I think we agree that we need to create multiple pathways to encourage more provider systems to enter into the transition from open-ended fee-for-service to alternative payments. We purposely designed the ACO program, which now has more than 250 organizations, some in your home State, to put us on the pathway to that transition.

One of our learnings is, there are different degrees of preparedness across the country to transition to financial risk. So, one important principle is to create multiple opportunities, but to create predictable transition points to that transition.

Depending on the geographic area, depending on the degree of competition in a given geographic market, that answer might be different for different parts of the country. But, like our ACO program that was purposely set up to have multiple pathways and predictable transition periods, that is one step the agency has taken to assist the transition that we are all trying to achieve.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator, very much.

Senator Isakson, you are next.

Senator ISAKSON. Thank you, Mr. Chairman.

I think you answered the chairman earlier about this period of stable payment. You said it would be about a 4- to 5-year period of time?

Mr. BLUM. Correct.

Senator ISAKSON. Has the administration or have you recommended what the payment mechanism during that period of stability would be?

Mr. BLUM. I think what our principle would be is that we would set an update factor that would be predictable, that would be set in statute. During that time table, that time period, two things would happen. Number one, the CMS, working with the Congress, would continue to develop new payment models, continue our pathway on ACOs, but also continue our work to make the fee schedule more accurate, more focused on care coordination, more focused on primary care.

But then, once that transition period had been completed, or that period of stability had been completed, we believe that it would be appropriate for Congress to consider differential payment rates or updates depending on physicians' successful participation in those new payment models to increasingly reward physicians who have made the transition to that value-based concept rather than the open-ended fee-for-service, as Senator Grassley talked about.

So we think it is important to create that period of stability so we can continue our work to do those two things together: build the alternative payment systems, but fix the underlying building blocks that are the basis for those new payment models.

Senator ISAKSON. So the 4- to 5-year period of transition or stability would be basically an extension of SGR with an inflation factor added to it for each year, so you know predictably over that 5 years what reimbursement would be. Is that—

Mr. BLUM. Well, I think the goal would be to have something that is sustainable, that is consistent with the overall CBO score. But the vitally important point is that physicians have predictability for a period of time to help them transition to this new system. We do not think it is helpful to have a continuing threat of 24- to 25-percent payment reduction to encourage more physicians to adapt to this new transition.

Senator ISAKSON. When you cited high-cost imaging as one of the codes that you had reviewed and actually lowered the cost of to Medicare, I assume it was by reducing reimbursement. Is that correct?

Mr. BLUM. Correct.

Senator ISAKSON. And you did that evaluation based on the cost of actually delivering the imaging, I presume?

Mr. BLUM. It is based upon a time-based notion that is built into the statutory framework, but in principle, yes.

Senator ISAKSON. And so would it be fair to say that all codes are evaluated or reevaluated based on the actual cost of delivering the service which the code designates?

Mr. BLUM. By statute, we have to use a relative time-based approach, and so it is based upon the relative time and effort and work requirements to deliver a particular service. But what we know, for example, with high-cost imaging is, in the past, it was paid very well, and the use of it was high.

Through acts of Congress and also through our own authorities, we have brought those payments down. We have not seen any degradations of access to care to our beneficiaries, but we do think it is appropriate for us to work together to continue that process.

Senator ISAKSON. It begs the question, though, when you make that statement—and I respect the statement completely—that why physicians are dropping out of Medicare is because their reimbursement rates are so low they cannot stay in business, and it portends that maybe some of the coding and the evaluations that are done actually do not reflect the cost of a physician delivering the service for which the fee is reimbursed.

Mr. BLUM. We understand that, in some pockets of the country, we are seeing physicians leave the fee-for-service Medicare program, but overall, across the country, participation has remained steady. It is something for us to watch very carefully.

Obviously, if the 25-percent cut were to go into effect, we would have a much different situation, but to date, for the key access measures that we look at, we have not seen significant changes across the country. But there are some pockets that we are concerned about.

Senator ISAKSON. Well, I very much want to fix the SGR, and I think the 4- to 5-year period of time probably is a realistic evaluation time. I commend you on referring to coordinated care. Senator Wyden and I worked extensively on some legislation we are preparing for CMS and for Medicare that focuses on reimbursement for coordination of care for seniors on Medicare.

About 72 percent, I am told, of seniors on Medicare have two or more chronic conditions for which they are receiving services that are reimbursed, most times from different providers, without a coordination of the care, which oftentimes leads to complications and higher costs.

So I think if you can focus on a way to encourage the coordination of care for seniors who have multiple chronic conditions, you will probably have a lower cost and a higher quality in terms of the delivery of those services to those patients.

Mr. BLUM. We agree.

Senator ISAKSON. Good. Thank you, sir. Thank you for your appearance.

The CHAIRMAN. Thank you, Senator.

Senator Casey?

Senator CASEY. Thanks, Mr. Chairman.

Mr. Blum, thanks for being here again. We appreciate your public service. At your last appearance here you provided testimony, and I am not quoting you directly, but when you spoke to the issue of reducing both readmissions and hospital-acquired infections, you said that we could save as many as 65,000 lives, a fairly substantial assertion. I know you have worked very hard in furtherance of that goal.

I wanted to ask you in particular, and I am noting that, in your testimony at the end of page 4, on to page 5, after talking about this issue you say, "CMS has created a new procedure code to recognize the additional resources involved with community physicians coordinating a patient's care in the 30 days following discharge."

Then you go on, on page 5, to say, "The new procedure code establishes a separate payment for care management services that account for patient communication and medical decision-making, as well as face-to-face visits post-discharge for qualifying beneficiaries."

I know that is not the only effort you are undertaking, but can you address the other efforts you are doing or are undertaking to empower physicians and others to reduce hospital readmissions and also hospital-acquired conditions?

Mr. BLUM. Sure. Senator, we continue to see declines in all-cause hospital readmissions, and, in the data that I cited back in February, that trend continues to point in the right direction. So it is giving us promise that the strategies are working. And whether it is in our hospital payment systems and our physician payment systems or other payment systems, we are trying to accomplish what Congress really set out to do, to accomplish a couple of things.

Number one is to make sure that all parts of the health care system have the incentive to talk to each other, to make sure that professionals focus on the care, not just what happens in those four walls but after the patient leaves those four walls, like hospital readmission penalties and the value-based purchasing system.

The other principle is that we want to make sure that physicians receive greater payment to provide that complex care management that happens to patients between physician office visits. While this is an area that the agency in the past has been hesitant to move on due to budgetary concerns, we are comfortable moving forward now if the system is designed correctly, if we have assurances that those physician practices have the capability to provide that complex care management, and that patients who have complex conditions receive those services.

So we think it is a vitally important step to create greater incentive, greater payments, for that complex management. We know that there are parts of the country that do this very well, and we want to make sure that we build the payment policies that reinforce them and continue to drive that readmission all-cause rate downward, as it is going right now.

Senator CASEY. Are there any impediments that you see to making greater progress on reducing readmissions in the hospital-acquired infections? Impediments meaning, within the law or otherwise in terms of kind of the real-world implementation of these reforms.

Mr. BLUM. I think we need to create more infrastructure. As Senator Wyden and Senator Grassley discussed, we need more opportunities to share information in a way that is meaningful but also protects patient confidentiality.

One of the things that we really learned working with providers is that, when they can see the complete picture, when they can see how many different skilled nursing facilities, for example, that

their patients go to and the relative outcomes from those different skilled nursing facilities, it changes behavior. So I think one area that we can continue to work together on is how we share that information, share that data, in a way that is meaningful but also protects patient confidentiality.

Senator CASEY. I wanted to raise one quick question at the end of my time here. We know the SGR has a tremendous impact on physicians and likely an impact on physician recruitment. Maybe, because I am running out of time, if you could—we will send you a question—the main question I had was about the impact of the SGR on physicians, and also physical therapists. I am out of time, but maybe you could answer that one in writing. Thank you very much.

The CHAIRMAN. Thank you, Senator.

Senator Toomey?

Senator TOOMEY. Thank you, Mr. Chairman. Thank you, Mr. Blum, for being with us today. I want to kind of step back for a minute, if we could. We have talked a little bit around the edges about some of the manifestations of the problems that arise from the payment schedules that we developed.

Senator Isakson mentioned doctors who were refusing to participate in Medicare in some cases. We know there is over-utilization of certain services. You mentioned in your testimony at some length and talked about the aggressive efforts that you have taken, and continue to take, to evaluate misvalued payment codes.

I understand all that. I guess my question is, to what extent do you believe that we are guaranteed to get these payment codes wrong probably all the time because we have a committee that decides what a price should be for something?

I mean, I am reminded of just how complicated this process is, coming up with 7,000 different Relative Value Units which assign a number for a work component, then a number for a practice expense, then a different number for liability insurance, all of which are then adjusted by the Geographic Practice Cost Index, right? You have this incredibly complicated formula by which we try to establish a price.

Doesn't everything we ever learned in economics tell us that committees cannot figure out prices? Markets tell us what prices ought to be. So I guess my question is, do you agree that there might be a better way to go about this in a very fundamental way, which would be to find a way to use price discovery in a competitive setting to determine what we ought to pay, rather than having, admittedly, very smart people spending an awful lot of time doing calculations?

I mean, I just do not think that the smartest people in the world can figure out what my car is worth by a formula, but it is really easy to figure it out when you go to try to sell it. Is this not one of the fundamental problems we have in trying to establish fee schedules?

Mr. BLUM. I agree with you that the challenge with fee schedules is that, when they are set in one given year but then kind of updated over time, they do not always reflect the changes in market dynamics, changes in efficiencies, how that service is delivered.

So we always have to be vigilant to review those fee schedules and readjust them to make sure they reflect market realities. I know it is controversial, but that is why we felt it was so important to move forward with durable medical equipment competitive bidding, because the fee schedules were set back in the 1980s and really have not been updated for that market reality.

The same is true for laboratory services, so we have some thoughts, in our proposed rule that came out this week, to change that fee schedule based upon a dynamic. So there are areas where we can use those competitive principles, those market reality principles. We have to operate within the law, obviously, but we agree with you that there are more opportunities for you to use those principles.

Senator TOOMEY. On the hospital side, of course, we have four different models of bundled payments. Do you think that using a bundled payment approach—of course, you could choose to have a committee decide what the bundled payment should be—might lend itself somewhat more readily to introduce market pricing for services?

Mr. BLUM. I think the bundled payment model is still a demonstration and is still in its early phases, so we will hopefully learn tremendous information. One of the principles that we have followed with the four models is, the hospitals can come forward to choose their services and to offer a discount on the current total payments. So we are hopeful that these pilots will lead to better coordinated payment policy, but they are still an experiment.

Senator TOOMEY. And then, just very quickly, the last question, you mentioned that you do believe, if I understood you correctly, that CMS could do more to use market-based price signals to establish payments? Are there any specific reforms that we ought to look at on the physician side in particular?

Mr. BLUM. That is a question I will have to think through and get back to you on, but I do believe that we can learn from the experiences of the Part D system, the durable medical supplies, to achieve more competitive principles for our payment system.

Senator TOOMEY. Thank you.

Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Mr. Blum, what about rural providers? Some communities are lucky to have a doctor. Maybe they have a physician's assistant. They are quite a ways from a clinic, a hospital, and so forth. So how do we implement quality in a rural setting?

Mr. BLUM. I think we all agree with the principle that beneficiaries should have the same access of care, the same quality of care, no matter where they live, in a large urban area or in a frontier area. It is probably true that many of the payment models that we have developed and that are being recommended by stakeholders work better in urban communities than rural communities, because you need a population that you can manage and that you can measure.

So it might be that the framework that the Congress has created, the value modifier, which pays individual physicians based upon their relative quality, relative cost, could be the foundation to ensure that we have continued access to physician services in a rural

area, but still have the incentive for better quality of care and better total cost management.

So I think there is some infrastructure that has been created that can both achieve the goal of preserving access, but also create payment structures that are responsive in a rural area.

The CHAIRMAN. What are some examples of that?

Mr. BLUM. Well, right now, the value modifier for all physicians that is being phased in over time will provide every physician who participates in the Medicare program their relative quality and their relative resources so they can see how their patients compare to patients in similar areas of the country and to care being provided by their peers. The physicians can start to get feedback on the relative quality and relative total cost of care.

This is at its very early stages. We are still phasing it in to large physician practices, but it could be the infrastructure that this committee continues to build upon for its long-term strategy.

The CHAIRMAN. So, when you mentioned 4 to 5 years' transition earlier, that would include rural providers, that is, more importantly, rural beneficiaries?

Mr. BLUM. Sure. Absolutely. I think we always have the visual on it to make sure that access is preserved but that we are setting equal standards for quality of care throughout the country.

The CHAIRMAN. Well, thank you very much, Mr. Blum, for your hard work. I think you can tell there is a subtext to this committee. Everyone, I think, on this committee believes we should move in this direction, and I think you will find the enthusiasm here to move even more quickly and aggressively.

You have our support. I want to work with you. Let us know what else you need and how we can help, because, clearly, at least in my judgment, beneficiaries, our seniors, will be served with successful efforts in this direction. It will also help bring some of the costs down in Medicare. I would just urge you to go ahead. Thank you very much for your work. Do not forget rural America.

Mr. BLUM. I will not. I will not. Thank you.

The CHAIRMAN. Thank you very much.

The hearing is adjourned.

[Whereupon, at 11:28 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

**Hearing Statement of Senator Max Baucus (D-Mont.)
On Improving the Flawed Medicare Payment System**
As prepared for delivery

Benjamin Franklin once said, "You may delay, but time will not, and lost time is never found again."

Those words ring true today as we work to repeal the sustainable growth rate, or SGR. This is the formula used to pay doctors who treat Medicare patients. It is antiquated, inefficient and flawed.

Over the past decade, the SGR has called for Medicare payment cuts to physicians that are unsound. Next year, physicians face a 25 percent cut under the formula. This deep cut would mean many seniors could lose access to their doctors. I refuse to let that happen.

In each of the last 10 years, Congress has prevented these cuts to physicians by passing a patch, but we never addressed the root cause of the problem — the SGR itself.

It is time to repeal this broken formula, and we need to do it this year.

The most recent 10-year estimate for repealing the SGR is \$139 billion. This is a lot of money, but last year's estimate for repeal was nearly twice as much. So we must act.

But we cannot just repeal the SGR. We need to change the entire fee-for-service system that Medicare uses to pay physicians.

Fee-for-service promotes volume over value. That is certainly not a model of efficiency. We need to encourage physicians to coordinate patient care to save money and improve health outcomes.

At the same time, we must remember that the payment system sets payments for other providers as well as physicians. This system pays nearly 850,000 clinicians, and 300,000 of these clinicians are advanced practice nurses and physician assistants. A new SGR system must work for all of these health care providers.

The Center for Medicare and Medicaid Innovation is testing new ways to compensate physicians and other providers who deliver high quality, efficient care. And the Affordable Care Act took a key step in controlling Medicare costs by creating Accountable Care Organizations. These groups of doctors and hospitals work together to provide quality care for Medicare patients.

These multi-specialty groups are helping us understand how to incentivize providers to provide value. These organizations share in the savings they achieve when they provide more efficient quality care.

I'm proud that the Billings Clinic in Montana became an Accountable Care Organization this past January.

Teams of providers are working together to coordinate care for chronically ill patients. That's just one of their missions. They're also focused on improving access to primary care, with the goal of getting sick patients a doctor's appointment the same day.

While new systems are being tested, we need to improve the current system. Doctors and nurses who see patients every day can give valuable ideas about what works and what doesn't.

That's why in May, Senator Hatch and I sent a letter to the health care provider community asking for their advice. What can we do to improve the system? What would make your practice better? We asked for specific, concrete ideas.

The response was encouraging. We received 133 letters. Physicians told us they are working to improve their quality of care, to improve communications with patients and to work in teams. They're trying.

They are developing new types of practices with a focus on outcomes and continuous care. They are using evidence-based guidelines to reduce unnecessary services.

Physicians want to improve their performance and efficiency, and Medicare's payment policy needs to incentivize that improvement.

I want to highlight the letter from the American College of Physicians. They gave us concrete examples, down to how Medicare could incentivize physicians to use guidelines that help them decide when to order tests and perform procedures. This would encourage doctors to provide the care seniors need, and avoid unnecessary care that might cause harm.

I'm not saying we will accept all of their suggestions, but their comments help us see different angles of potential policies.

We also have brought experts to the Finance Committee to hear their ideas about fixing the SGR. We held three roundtables and a hearing in May. It is now time to hear from CMS.

In his 2014 budget proposal, the President agrees that we need to move to alternative payment models, and he recognizes this will take time. His budget proposal also advocates reforms to the current system.

Today we will learn what CMS is doing to improve physician payments, and we want to hear CMS's views on a new plan for Medicare physician policies.

For as Benjamin Franklin warned, you may delay, but time will not. So let us get to work repealing this flawed system and developing a new one that works for providers and patients.

###

STATEMENT OF

JONATHAN BLUM

ACTING PRINCIPAL DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR MEDICARE,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

REPEALING THE SGR AND THE PATH FORWARD: A VIEW FROM CMS

BEFORE THE

U. S. SENATE COMMITTEE ON FINANCE

JULY 10, 2013

Statement of Jonathan Blum on
Repealing the SGR and the Path Forward: A View from CMS
Senate Committee on Finance
July 10, 2013

Chairman Baucus, Ranking Member Hatch, and members of the Committee, thank you for this opportunity to discuss physician payment in the Medicare program, including the Sustainable Growth Rate (SGR). The Administration is committed to working with the Congress to reform the Medicare physician payment system to provide predictable payments that incentivize quality and efficiency in a fiscally responsible way. As we work with the Congress, our efforts are focused on two main goals: (1) ensuring physician payments emphasize high-quality, high-value care and (2) using proven payment models to improve accountability for the care furnished to Medicare beneficiaries. We want to thank this Committee for its past and consistent leadership to build a sustainable physician payment system.

There are two distinct issues that are at the heart of today's hearing. The first is how Medicare can best pay physicians for the care they furnish to beneficiaries. The current physician payment system does not create incentives for physicians to furnish the highest-quality care in an efficient manner. The Administration believes that finding better approaches to reward quality care that results in improved health outcomes instead of quantity of services, while not increasing overall costs, remains an urgent priority. CMS is working to improve physician payment policy through CMS' rulemaking process including the Medicare Physician Fee Schedule, while testing new payments models and delivery system reforms that can help make physicians more accountable for the care they furnish.

The second issue, which often gets conflated with the first, is addressing the baseline for Medicare physician payments, more commonly discussed in context of the SGR. The SGR was established in the Balanced Budget Act of 1997, which created a formula for establishing yearly SGR targets for physicians' services under Medicare. The use of SGR targets is intended to control the growth in aggregate Medicare expenditures for physicians' services. The SGR targets are not direct limits on expenditures. Payments for services are not withheld if the SGR target is exceeded by actual expenditures. Rather, the physician fee schedule update is adjusted to reflect the comparison of actual expenditures to target expenditures. If expenditures exceed the target,

the update is reduced. If expenditures are less than the target, the update is increased. The current, statutorily mandated system for updating Medicare payments to physicians has required significant cuts to physicians in recent years as a result of the SGR. The Congress has repeatedly intervened to prevent these negative payment updates from occurring with temporary adjustments to the payments, but has not yet changed the underlying SGR formula. Absent Congressional intervention or reform of the SGR methodology before the end of this year, scheduled cuts of an estimated 24.4 percent¹ will go into effect in January 2014, although this figure may change once we have more information on 2013 spending.

The continuous threat of these severe cuts can cause disruptions and concerns for providers and beneficiaries. Additionally, sustained reductions in payment rates raise concerns about the current system's ability to ensure access to care for Medicare beneficiaries. Short-term adjustments, while successfully eliminating drastic payment cuts for a given year, create uncertainty and unease for the hundreds of thousands of physicians and other practitioners who furnish care to Medicare beneficiaries. These short-term adjustments fail to transform the payment system towards paying for value and also create additional administrative costs for CMS since we must prepare for existing law payment rate reductions, but need to shift quickly to implement payment rates without the reductions that the Congress frequently passes just before or after the cuts are scheduled to start.

The Administration is determined to work with the Congress to put in place a long-term plan to reform the physician payment system in a fiscally responsible way and to craft a payment system that gives physicians incentives to improve quality and efficiency, while providing predictable payments for care furnished to Medicare beneficiaries. The Administration also supports a period of payment stability lasting several years to allow time for the continued development of scalable, accountable payment models. CMS is working towards lowering Medicare spending growth by emphasizing care value and promoting provider accountability. These fee schedule reforms and accountable payment models help increase the fiscal longevity of the Medicare program, while also improving beneficiary care.

¹ <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/SGR2013-Final-Signed.pdf>

Increasing Value for Beneficiaries and Taxpayers

While CMS alone cannot address the long-term challenges posed by the SGR formula, CMS has taken and will continue to take steps to improve the health care delivery system, promote primary care, and establish initiatives that encourage health care providers to deliver high-quality, coordinated care at lower costs.

CMS continues to make changes to the Medicare Physician Fee Schedule and other Medicare payment policies to improve efficiency and accuracy in Medicare payment and the quality of care for our beneficiaries. We have improved payment for primary care services, while enhancing our efforts to address payment for misvalued services under the physician payment system. We have begun to implement important delivery system reforms included in the Affordable Care Act, including the value-based payment modifier that provides incentives for physicians and physician groups to furnish high-quality, efficient care. In short, Medicare is leading the way in developing new payment systems for physician services. The reforms CMS is pursuing will not only improve Medicare, but also help promote similar reforms among private payers. CMS is taking the lead to actively transform Medicare from a passive payer of services into an active purchaser of high-quality, affordable care that enhances the value of services that Medicare beneficiaries receive through these newly established initiatives.

As I noted in my testimony before this Committee earlier this year, Medicare beneficiaries are already starting to enjoy better quality of care through innovative care delivery systems designed to improve their health outcomes and reduce costs. Affordable Care Act reforms are contributing substantially to recent reductions in the growth rate of Medicare spending per beneficiary² without reducing benefits.

Moving from Volume-Based Payments to Value-Based Payments

CMS has aggressively managed the Physician Fee Schedule to promote better care and efficiency for those in Medicare. The recently released Calendar Year (CY) 2014 Physician Fee

² ASPE Issue Brief: "Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows" for full report please visit: <http://aspe.hhs.gov/health/reports/2013/medicarependinggrowth/ib.cfm>

Schedule Proposed Rule CMS-1600-P proposes a number of significant changes that will better align physician payment with costs of the resources required to furnish high-quality, efficient care.

Additionally, we have proposed additional changes that will help facilitate the alignment of programs, reporting systems, and quality measures. The alignment of CMS quality improvement programs will decrease the burden of participation on physicians and allow them to spend more time and resources caring for beneficiaries.

Care Coordination and Primary Care

CMS recognizes primary care and care coordination as critical components in improving the value and quality of care for individuals. Accordingly, CMS has taken steps to prioritize the development and implementation of a series of initiatives designed to ensure accurate payment for, and encourage long-term investment in, primary care and care management services. To further advance those goals, CMS has made several proposals in the CY 2014 proposed Physician Fee Schedule rule that we believe will result in more coordinated and higher quality care for Medicare beneficiaries.

We view potential refinements to the Physician Fee Schedule such as these as part of a broader strategy that relies on input and information gathered from our initiatives, research and demonstrations from other public and private stakeholders, the work of all parties involved in the potentially misvalued code initiative, and from the public at large. For example, as described in greater detail in the next section, in the CY 2013 Physician Fee Schedule final rule with comment period, we adopted a policy to pay separately for care management involving the transition of a beneficiary from a hospital stay to care furnished by the beneficiary's primary physician in the community.

The care a patient receives after discharge from an inpatient hospital stay is critical to reducing the risk of being readmitted and requiring additional expensive care. With this in mind, CMS created a new procedure code to recognize the additional resources involved with a community physician coordinating a patient's care in the 30 days following discharge to the community from

an inpatient hospital stay, skilled nursing facility stay, and other specified outpatient services. Although Medicare has traditionally paid for care management services in conjunction with a face-to-face visit, the new procedure code established a separate payment for care management services that account for patient communication and medical decision-making, as well as a face-to-face visit post-discharge, for qualifying beneficiaries. The CY 2013 Physician Fee Schedule final rule also discussed the possibility of other efforts to bolster care coordination for Medicare beneficiaries, and solicited public comment regarding how the program might recognize and pay for advanced primary care medical home services in the fee-for-service setting.

For CY 2015, we are proposing to pay separately for complex chronic care coordination services furnished to patients with multiple complex chronic conditions. This proposal is in response to the physician community which has told us that the care coordination included in many of the evaluation and management services, such as office visits, does not adequately describe the typical non-face-to-face care management work involved with these types of beneficiaries. Our analysis of Medicare claims indicates that patients with multiple chronic conditions are at increased risk for hospitalizations, use of post-acute care services, and emergency department visits.³ Complex chronic care management can help to avoid these adverse events, improve beneficiary outcomes, and avoid a financial burden on the health care system. Successful efforts to improve chronic care management could improve the quality of care while simultaneously decreasing costs.

Potentially Misvalued Codes

CMS has made important strides to improve the accuracy of our physician payment system and to emphasize the value of primary care. Through the misvalued code initiative, CMS has taken a much more aggressive stance in evaluating potentially-misvalued payment codes and, when codes are found to be misvalued, acting to update and revise the payment accordingly. From the start of the misvalued codes initiative in 2008 through the end of 2012, CMS has reviewed 911 codes. CMS has prioritized review of services by examining codes included in particular categories. The agency has established a particular focus on those Physician Fee Schedule

³ See <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>.

services that have not been reviewed recently and those where there is a potential for misuse. CMS has adopted appropriate work Relative Value Units (RVUs) and direct Physician Expense (PE) inputs for these services as a result of these reviews and continues aggressively to identify potentially misvalued services. The agency continues to seek input from the AMA/Specialty Society Relative Value Update Committee (RUC) and other stakeholders regarding the most accurate valuation of services. In the CY 2012 final rule with comment period, we established a process for the public to nominate codes for consideration as potentially misvalued. CMS has made our expectations clear and the RUC has taken initiatives to more aggressively focus on potentially misvalued services. We will continue to rely on the RUC for input, but we believe these decisions ultimately rest with the Secretary.

In addition to identifying and reviewing potentially misvalued codes, the Affordable Care Act⁴ specifies that the Secretary shall establish a formal process to validate RVUs under the Physician Fee Schedule. CMS has entered into two contracts with outside entities to develop validation models for RVUs. During a two-year project, the RAND Corporation will use available data to build a validation model to predict work RVUs and the individual components of work RVUs: time and intensity. Under the second contract, the Urban Institute will actually measure the time it takes to furnish specific services. After gathering data, a clinical panel will review the time data. Given the central role of time in establishing work RVUs and the concerns that have been raised about the current time values, we are eagerly anticipating the results of these projects.

In the CY 2014 proposed rule, CMS is proposing to address more than 200 misvalued codes by comparing fee schedule rates to hospital outpatient and ambulatory surgical centers (ASC) payment rates. This policy will assure that Medicare does not pay more for a service furnished in a physician office than it would pay if the service were furnished in a hospital or ASC. In addition, we are proposing an additional 20 codes as potentially misvalued services. These services were identified in consultation with the Medical Directors of the various Medicare Administrative Contractors.

⁴ Note: Section 3134(a) of the Affordable Care Act added section 1848(c)(2)(L) of the Act

Multiple Procedure Payment Reduction

Medicare has a longstanding policy of reducing payment for second and subsequent surgical procedures furnished on the same patient by the same physician or physician group practice on the same day. This policy is largely based on presumed efficiencies in the practice expense and pre and post-surgical physician work. For the past several years, CMS has proposed and expanded the multiple procedure payment reduction (MPPR) to other services. Since CY 2006, CMS has implemented MPPRs that apply to the following kinds of procedures when furnished together: the professional and technical components of certain diagnostic imaging services, therapy services, and certain cardiovascular and ophthalmologic diagnostic tests. Although CMS is not proposing any new MPPR policies for CY 2014, the Agency will continue to look for payment efficiencies when multiple procedures are furnished together.

Using Data to Improve Quality and Value

CMS is undertaking a variety of other initiatives to help promote quality reporting and to improve the value of physicians' services furnished to Medicare beneficiaries.

An important element in promoting value for Medicare is the Physician Quality Reporting System (PQRS). PQRS is a pay-for-reporting program that uses a combination of incentive payments and downward payment adjustments to promote reporting of quality information by eligible professionals. CMS believes that satisfactory reporting of measures by physicians provides information on activities that could lead to improvements in the quality of care furnished and transformation in how practices approach quality. CMS also provides technical support to physician practices to ensure more complete reporting of quality measures through the Quality Improvement Organizations (QIOs). QIOs also currently support physicians in quality improvement activities based on the analysis of the data.

The PQRS program provides an incentive payment through 2014 to eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare Part B fee-for-service beneficiaries during the applicable reporting period. Beginning in 2015, a downward payment adjustment will apply to services of eligible professionals who do not satisfactorily report data on quality measures for covered professional services.

The CY 2014 Physician Fee Schedule proposes increasing the number of measures an eligible professional is required to report under the individual reporting options from three measures to nine. Physicians have had several years to become familiar with PQRS, and we believe that it is important to collect enough quality measure data to be able to capture a more complete picture of the care being furnished to a beneficiary, especially when this data may eventually be used to evaluate an eligible professional's quality performance under the Value-based Payment Modifier. The first step to improving quality is beginning to measure and report on the quality of care that is currently being provided.

In 2012, CMS also provided Quality and Resource Use Reports (QRURs) based on data from 2011, to 54 large group practices and to over 31,000 individual physicians in nine states that practice in groups with 25 or more eligible professionals. These reports contained performance information on the quality of care furnished, and the cost of that care, to Medicare beneficiaries by these physicians and groups of physicians. Many of the groups who received these reports noted that they found the reports informative and also suggested ways to improve the reports to facilitate care coordination and quality improvement. We have adopted many of these suggestions in the QRUR reports that we plan to make available in September 2013 to all groups of physicians with 25 or more eligible professionals.

As we collect data from physicians, we are also working to allow consumers to use this information as they make health care decisions for themselves and their families. Providing consumers with information on care quality to make informed decisions about their health care is an important element in making information transparent and incentivizing the delivery of high quality care. In December 2010, CMS launched the first phase of the Physician Compare website⁵. In this initial phase we posted the names of eligible professionals who satisfactorily submitted quality data for 2009 PQRS, as required by the Affordable Care Act.

Last month, we launched a redesign of Physician Compare offering significant improvements including a complete overhaul of the underlying database and a new Intelligent Search feature,

⁵ <http://www.medicare.gov/physiciancompare>

addressing two of our stakeholders' primary critiques of the site and considerably improving functionality and usability. The redesign includes new information on physicians, such as:

- Information about specialties offered by doctors and group practices;
- Whether a physician is using electronic health records;
- Board certification; and
- Affiliation with hospitals and other health care professionals.

Physician Compare is also now connected to the most consistently updated database so that consumers will find the most accurate and up-to-date information available. In 2014 quality data will be added, and this will help users choose a medical professional based on performance ratings.

We are now instituting our plan for a phased approach to public reporting of performance information on Physician Compare. The first phase of our plan was finalized with the 2012 Physician Fee Schedule final rule with comment period⁶, where we established that PQRS Group Practice Reporting Option (GPRO) measures collected through the GPRO web interface would be publicly reported on Physician Compare. These measures will be publicly reported on Physician Compare in CY 2014. We are also phasing in these reporting requirements on Physician Compare for Accountable Care Organizations (ACOs) since they are considered a GPRO under PQRS.

In addition, in the CY 2013 Physician Fee Schedule final rule with comment period⁷, we also finalized our decision to publicly report Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) data for group practices of 100 or more eligible professionals, and for ACOs participating in the 2013 GPRO. We anticipate posting these data on Physician Compare as early as 2014. Moreover, the 2014 Physician Fee Schedule encourages all groups of physicians with 25 or more eligible professionals to participate in the CG-CAHPS survey, and proposes to publicly report results on the Physician Compare. We believe that assessments of patient experience and satisfaction are an important component of evaluating the

⁶ <http://www.gpo.gov/fdsys/pkg/FR-2011-11-28/pdf/2011-28597.pdf>

⁷ <http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf>

quality of care furnished to Medicare beneficiaries and can be very useful for consumers as they seek to obtain the best care from Medicare-enrolled providers.

We will continue to phase in an expansion of Physician Compare over the next several years by incorporating quality measures from a variety of sources, as technically feasible.

Physician Value-Based Payment Modifier

To ensure that Medicare payments to physicians reward high-quality, efficient health care, the Affordable Care Act required CMS to develop a physician value-based payment modifier and to apply it to all physicians and groups of physicians by 2017. This modifier may also be applied to other eligible professionals starting in 2017. The value-based payment modifier is an adjustment to payments under the Physician Fee Schedule based upon the quality of care furnished compared to costs.

We have aimed to align the PQRS program with the value-based payment modifier as much as possible. We believe that alignment of our programs is especially critical for programs involving physicians. The policies that we have adopted in recent years and the proposals that we have made for 2014 facilitate the alignment of programs, reporting systems, and quality measures to make this vision a reality. Furthermore, as the leaders of care teams and the healthcare systems, physicians and other clinicians serve beneficiaries both as frontline and system-wide change agents to improve quality. However, we believe that to improve quality, quality measurement and reporting is an important component.

CMS adopted a policy in the 2013 Physician Fee Schedule final rule with comment period to apply the value modifier to physician groups of 100 or more eligible professionals in 2015 based upon performance during calendar year 2013. The CY 2014 Physician Fee Schedule proposed rule would also continue to phase-in the physician value-based payment modifier and proposes that the value-based payment modifier would apply to physicians practicing in groups of 10 or more eligible professionals in CY 2016 (based on performance in 2014). We estimate that this proposal would expand the value-based payment modifier to cover 17,000 physician group practices and nearly 60 percent of Medicare enrolled physicians in CY 2016. We believe this

proposal continues our policy to phase in the value-based payment modifier by ensuring that the majority of physicians are covered in CY 2016 before it applies to all physicians in CY 2017. We are currently seeking comment on this proposal.

Improving Accountability through New Payment Models and Other Initiatives

In recent years, CMS has begun testing several different payment models to help inform us as we begin to look for ways to improve physician payments in the long-term. Such models can take different forms, but all have several common attributes such as encouraging care coordination and rewarding practitioners who furnish high-quality, efficient care. As experience with these models develops, CMS will also seek to hold practitioners increasingly accountable through the application of financial risk for consistently furnishing low quality care at excessive costs. HHS will continue to seek input from physicians and other professionals in designing these models. We will encourage practitioners to partner with Medicare by participating in a value based payment model. The Administration supports payment reform that would, over time, link the payment update for physicians' services to such participation. Those that successfully participate could receive higher payments under Medicare, while those who furnish lower quality, inefficient care would receive lower payments.

Accountable Care Organizations

Long-term reform to Medicare physician payments must establish appropriate incentives and reward physicians who find ways to furnish beneficiaries with higher-quality, efficient care. CMS has implemented new models of care to improve the health care delivery system and is testing additional models. A key part of CMS' work in this area is a multi-part initiative built around ACOs, which are one of the Affordable Care Act's key reforms to improve the delivery of care.

As I discussed in my February 28 testimony to this Committee, in just over a year, over 250 ACOs were formed and are working to improve the care experience for more than four million Medicare fee-for-service beneficiaries nationwide. The new ACOs include a diverse cross-section of physician practices across the country.

ACOs that lower their growth in health care costs, while also meeting clearly defined performance standards on health care quality, are eligible to keep a portion of the savings they generate for the program. As a result of these efforts we are seeing providers working together to develop and implement strategies to redesign care processes, promote preventive and evidence based care, and better coordinate Medicare Part A and B services for patients with chronic disease and high-risk individuals.

In addition to the ACOs participating in the Shared Savings Program, the CMS Center for Medicare and Medicaid Innovation (Innovation Center) is testing two different payment models for ACOs: the Pioneer ACO model and the Advance Payment ACO model. The Pioneer ACO model is designed for health care organizations that have experience coordinating care for patients across care settings. The Advance Payment ACO model is aimed at assisting smaller organizations, including physician practices and rural health care organizations, to successfully participate in the Shared Savings Program. Through this model, participants receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure. These models test the impact of different payment arrangements in helping these organizations achieve the goals of providing better care to patients and reducing Medicare costs.

Innovation Payment Models that Increase Provider Accountability

In recent years, CMS has also begun testing other models of delivery system reform to improve physician accountability and the quality of care for Medicare beneficiaries. Many of these initiatives are focused on primary care and include the following:

The Comprehensive Primary Care initiative⁸ is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. Medicare is working with commercial insurers and state Medicaid agencies and offering enhanced care management payments to primary care doctors who better coordinate care for their patients. Primary care practices that have chosen to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients. The Comprehensive Primary Care initiative

⁸ Further information about the CPC initiative is available at: <http://innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.htm>

is being tested in the following markets: Arkansas, Colorado, New Jersey, New York in the Capital-District-Hudson Valley Region, Ohio and Kentucky in the Cincinnati-Dayton Region, Oklahoma in the Greater Tulsa Region, and Oregon. CMS pays a monthly care management fee to selected primary care practices on behalf of their fee-for-service Medicare beneficiaries and in years two, three and four of the initiative, each practice has the potential to share in savings to the Medicare program.

The Multi-payer Advanced Primary Care Practice Demonstration⁹ is testing the patient-centered medical home model to improve the safety, effectiveness, timeliness and efficiency of health care. The Multi-payer Advanced Primary Care Practice Demonstration takes a multi-payer approach to creating more advanced primary care services or “medical homes” that utilize a team approach to care, while emphasizing prevention, health information technology, care coordination, and shared decision making. CMS pays a monthly care management fee for Medicare fee-for-service beneficiaries receiving primary care from advanced primary care practices participating in the demonstration. The following states are participating in the demonstration: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota.

The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration¹⁰ is also testing the patient-centered medical home model to improve quality of care, promote better health, and lower costs. Participating FQHCs in the demonstration are expected to achieve National Committee for Quality Assurance (NCQA) Level 3 Patient-Centered Medical Home recognition by the end of the demonstration as well as help patients manage chronic conditions and actively coordinate care for patients. To help participating FQHCs make the needed investments in patient care and infrastructure, CMS is paying a monthly care management fee for each eligible Medicare fee-for-service beneficiary receiving primary care services. In addition, both CMS and the Health Resources Services

⁹ Further information about the MAPCP Demonstration is available at: http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/mapcpdemo_Factsheet.pdf.

¹⁰ Further information about the FQHC Advanced Primary Care Practice Demonstration is available at: http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/FQHC_Fact_Sheet.pdf and the Innovation Center’s website at: <http://innovations.cms.gov/initiatives/FQHCs/index.html>.

Administration (HRSA) are providing technical assistance to FQHCs participating in the demonstration. There are currently 483 FQHCs participating in the demonstration.

Created by the Affordable Care Act, the Independence at Home Demonstration¹¹ is testing a service delivery and payment incentive model that uses home-based primary care teams designed to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions. The home-based primary care teams are directed by physicians and nurse practitioners to furnish primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations. CMS will award incentive payments to healthcare providers who succeed in reducing Medicare expenditures while maintaining or improving quality of care by reducing the need for hospitalization, improving patient and caregiver satisfaction, and leading to better health and lower costs to Medicare. The Independence at Home Demonstration is testing whether home-based care can reduce the need for hospitalization, improve patient and caregiver satisfaction, and lead to better health and lower costs to Medicare. CMS announced in April and August 2012 the selection of 15 independent practices and three consortia to participate in the Independence at Home Demonstration.

Conclusion

The delivery system reforms that CMS is actively pursuing and testing do not obviate the need for a legislative solution to address the Sustainable Growth Rate formula on a more permanent basis. The Administration remains committed to working with the Congress to identify a fiscally responsible long-term solution to provide physicians with stable payments and beneficiaries with ongoing access to physician services. We recognize that this problem is complex, and will require continued partnership and work by the Congress, stakeholders, and the Administration. In the meantime, CMS continues to aggressively work to effectively manage the physician fee schedule, strengthen primary care, and pursue efforts to test innovative delivery system models that may help inform the development of new Medicare payment systems that reward high quality, high value care.

I appreciate the Committee's interest in this issue, and look forward to continuing to work with you to improve the Medicare program.

¹¹ Further information about the Independence at Home Demonstration is available at: <http://innovation.cms.gov/initiatives/Independence-at-Home/>

**STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF JULY 10, 2013
REPEALING THE SGR AND THE PATH FORWARD: A VIEW FROM CMS**

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, delivered the following opening statement at a committee hearing examining effective ways to permanently repeal the sustainable growth rate (SGR) formula within the Medicare physician fee schedule and make improvements to the current system as physicians transition to alternative payment models:

As many of you know, over the past several years, both Chairman Baucus and I have called for a permanent repeal of the SGR. Indeed, over the past year, Medicare physician payment issues have received significant attention from this committee.

Just last summer, we convened several roundtable discussions with former CMS Administrators, leading private sector health organizations, and leading physicians to gain better insight into physician payment reform efforts and ideas to improve our payment system for physicians serving Medicare patients.

This is our second hearing on physician payment issues this year.

Moreover, over the last two months, the Chairman and I have received more than 130 responses to the letter we sent to the health care community seeking input on improving the physician fee schedule and helping physicians transition to alternative payment methods as they develop.

I want to thank the stakeholder community for their thoughtful responses.

Rest assured, we will give them strong consideration as we work to find a long-term solution for paying our physicians.

There is no doubt that we have all grown weary of the end-of-year scramble to stop the draconian payment cuts to physicians serving Medicare beneficiaries.

But this year is different.

We have a new important consideration to encourage our action. According to CBO, the current cost to repeal the SGR has been substantially reduced.

If the Congress doesn't act now, when will we ever find a path forward?

We must seize this opportunity and it is up to this committee to find the solution. We must act soon so we can finally put our physicians on a stable financial footing.

I look forward to hearing from Mr. Blum this morning about how CMS has sought to improve the Medicare physician payment system and how the Administration can work with us to find a bipartisan path forward.

Thank you for being here, Mr. Blum.

And I thank you, once again, Mr. Chairman, for continuing this important discussion.

I look forward to continuing to work with you as we look to provide a stable foundation for paying our physicians now and in the future. I believe we are making real progress and I am hopeful we will produce a permanent solution this year.

###

COMMUNICATION



Marsha Lommel, MA, MBA, FACHE
President and Chief Executive Officer
Madonna Rehabilitation Hospital
AMRPA Chair

July 22, 2013

The Honorable Max Baucus
Chairman
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Orrin Hatch
Ranking Member
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

RE: Repealing the SGR and the Path Forward: A View from CMS

Dear Senator Baucus and Senator Hatch:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), I appreciate the opportunity to submit a statement for the record in response to a hearing held by the Committee on Finance on July 10 entitled *Repealing the SGR and the Path Forward: A View from CMS*. We are pleased to see the Committee's commitment to addressing the flawed SGR formula and look forward to working with the Committee on this important endeavor.

AMRPA is the national trade association representing inpatient rehabilitation hospitals and units (IRH/Us), outpatient rehabilitation centers, and other medical rehabilitation providers. AMRPA members provide medical rehabilitation services in a vast array of health care settings, including rehabilitation hospitals and units, hospital outpatient departments, and settings that are independent of the hospital, such as comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and outpatient practices in skilled nursing facilities (SNFs). AMRPA members work with patients to maximize their health, functional skills, independence, and participation in society so they are able to return to home, work, or an active retirement. Our physicians and therapists are paid under the Medicare Part B physician fee schedule and its associated SGR methodology for their services. Therefore, repeal of the SGR and creation of a new payment approach is of critical interest to our members. As we have noted in previous comments on this issue, AMRPA recommends several guiding principles on which SGR repeal should be based. We have included these principles in Appendix A.

1710 N Street N.W., Washington, D.C. 20036 · Phone: 202-223-1920 · Toll-Free: 888-346-4624 · Fax: 202-223-1925
Administrative Offices: 206 South Sixth Street, Springfield, Illinois · Phone: 217-753-1190 · Fax: 217-525-1271

Three key issues arose from the July 10 hearing we think are important to highlight for the Committee: 1) the need for a transitional period between SGR repeal and the implementation of a new payment system for outpatient services; 2) the need to focus on true reform rather than cost and utilization control; and 3) the use of Medicare savings in the President's FY 2014 proposed budget as a mechanism for paying for SGR repeal.

A Transitional Period of Payment Stability Once the SGR is Repealed

During the course of the hearing several Members of the Committee, and in particular Senator Baucus, raised the issue of a transitional period between SGR repeal and implementation of a new payment system. We appreciate the Committee's recognition of this issue as a critical element to ensure a successful transition to a new payment system once the SGR is repealed. Mr. Blum noted in his testimony before the Committee that CMS estimates that four to five years of payment stability during a transitional period may be required. In fact, a transitional period is a central component of the SGR repeal framework under development by the Energy and Commerce Committee of the House of Representatives.

As you may be aware, several therapy professional societies are developing alternative payment models that may align with the Committee's vision; however, stakeholders require additional time to develop these alternatives. For example, the American Physical Therapy Association (APTA) is developing a payment system that would provide payment for each treatment session based on the severity of the patient's condition and the intensity of services delivered by the physical therapist. The American Occupational Therapy Association (AOTA) is also working on alternative payment. The American Medical Association Specialty Society Relative Value Scale Update Committee (AMA RUC) has convened a panel that is reviewing the APTA and AOTA proposals, in conjunction with other proposals offered by other specialty societies, but we do not anticipate its work will be completed until at least 2016. While we have not officially endorsed any alternative payment models to date, we support efforts to reform the existing payment system for therapy services. As a result, we believe that a minimum of five years will be required to allow for the development of alternative payment models, including a quality infrastructure, and the testing and approval of such models by the Secretary.

The Committee Should Focus on True Reform Rather than Cost and Utilization Control

In his questions to Mr. Blum, Senator Grassley stated that he was concerned the "focus is on the amount and cost of services provided rather than the quality and appropriateness of what's needed." We echo Senator Grassley's concerns. Time and again, we have seen proposals to cut cost and control utilization at the detriment of innovative strategies to achieve true reform of the payment system. For example, outpatient therapy services are subject to an annual financial limitation, known as the therapy caps. In 2013 there is one \$1,900 therapy cap for physical therapy and speech-language pathology services combined and a second \$1,900 cap for occupational therapy services. This amount is not based on considerations of Medicare beneficiary need or sound payment policy but rather was arbitrarily established due to concerns that outpatient therapy utilization was growing rapidly. For example, a patient with a hip replacement will require far less therapy than a patient who has sustained a stroke. Hip replacement is not normally considered a condition with results in permanent disability, while a stroke may require extensive physical therapy, occupational therapy and speech/language therapy. In addition, inpatient rehabilitation services are restricted by the use of the 60% rule which

requires at least 60% of admissions to IRH/Us come from one of 13 conditions. In testimony before the House Ways and Means Committee in June 2013, both Mr. Blum and Mark Miller, Executive Director of the Medicare Payment Advisory Commission (MedPAC), noted that the 60% rule was a “blunt instrument” not designed to ensure the appropriate placement of patients into the various post-acute care settings but rather a mechanism to control admissions to IRH/Us.

We believe the discussions at this hearing yield hope that the SGR might be repealed and true payment and delivery system innovation might be given an opportunity to flourish. We strongly encourage the Committee to view any proposals to repeal the SGR in light of their ability to achieve reform rather than simply demonstrate cost savings.

The President’s Budget as a Mechanism to Pay for Repeal of the SGR

In his testimony to the Committee, Mr. Blum noted that the Medicare savings proposals contained within the President’s FY 2014 proposed budget, totaling \$371 billion over 10 years, would be sufficient to pay for repeal of the SGR. However, AMRPA is extremely concerned that many of the savings proposals contained within the President’s proposed budget unfairly and disproportionately target IRH/Us. While spending on IRH/Us represents only 1.2 percent of total Medicare spending, post-acute care cuts account for more than 17 percent the President’s budget. Of the \$371 billion in savings identified, \$63 billion would come from the post-acute care sector alone. Therefore, we urge the Committee to consider these proposals cautiously to ensure the cost of repeal of the SGR is not borne on the back of IRH/Us and the vulnerable patients they serve.

For example, the President’s budget calls for reinstatement of the 75% rule, site neutral payments between IRH/Us and SNFs for select conditions, market basket reductions, and post-acute care bundling. But these proposals fail to recognize the lack of growth or spending concerns in the IRH/U sector, and the differing regulatory environment between IRH/Us and other post-acute care providers. Since 2003, IRH/Us have had the lowest Medicare spending growth of any post-acute care provider and growth has been negative in three of the last five years.¹ Additionally, MedPAC’s March 2013 Report to Congress paints a picture of a sector in a modest state. It stated that the supply of IRH/Us has been declining since 2005 and decreased to 35,250 beds in 2011. Overall, the supply of IRH/Us is relatively stable. MedPAC noted that the volume of Medicare FFS beneficiaries treated in IRH/Us remained relatively stable in 2010, but MedPAC’s March 2013 Report finds that the aggregate supply of IRH/Us continued to decline in 2011. Any cuts will reverse recent, limited stability.

IRH/Us have already experienced significant payment reductions including market basket reductions and productivity adjustments called for by the Affordable Care Act and a 2 percent reduction as a result of sequestration. These hospital and outpatient payment cuts will be incurred in addition to a \$4 billion cut to IRH/Us over 10 years enacted by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). MMSEA froze the IRH/U market basket update at 0 percent from April 1, 2008 through the end of Fiscal Year 2009 — six full quarters without an update.

Medical rehabilitation is a critical component of the health care delivery system and is aimed at maximizing patient health, preventing subsequent medical complications, improving functional

¹ MedPAC June 2012 Data Book (Chart 8-2).

skills, restoring independence, and promoting participation in society. Medical rehabilitation prevents unnecessary medical costs in the long-term and allows patients to return to their homes, work, and community. Additional cuts to IRH/Us could further jeopardize access to care for Medicare beneficiaries (and all other patients) and individuals with disabilities. These vulnerable populations should not be expected to shoulder the burden of offsetting the cost of the Medicare physician fee fix.

In closing, we are pleased with the opportunities the Committee has given the stakeholder community to share our strong support for repeal of the SGR and its replacement with a payment system that allows us to continue to serve Medicare beneficiaries. If you have any questions, please do not hesitate to contact Sarah Warren (swarren@amrpa.org) or Carolyn Zollar (czollar@amrpa.org) at 202-223-1920.

Sincerely,



Marsha Lommel, MA, MBA, FACHE
Chair, AMRPA Board of Directors
President and CEO, Madonna Rehabilitation Hospital

Appendix A**Principles for SGR Reform**

In order to advance SGR reform, AMRPA developed a number of principles for reform of the formula that will help ensure that a new payment is beneficial for patients and feasible for providers. Specifically, AMRPA requests that the Committee consider the following principles as it seeks to reform the Medicare physician payment system:

1. Any deliberation of modifications to or repeal of the SGR should include consideration of repeal of the therapy caps or, at the very least, extension of the therapy caps exceptions process. The therapy caps are an arbitrary financial limitation imposed annually on Medicare beneficiaries in an effort to control spending for therapy services. Unfortunately, the sickest Medicare beneficiaries, those with disabilities or multiple chronic conditions, are often the types of patients who need therapy services but are the most negatively impacted by this limitation. As with the SGR, the extension of the therapy caps exceptions process tends to be part the annual end-of-year process to avoid the implementation of a policy detrimental to beneficiaries.
2. Congress and the Department of Health and Human Services (HHS) should be aware that changes to the Medicare payment system are often adopted by private insurers and State Medicaid programs. As a result, the Committee should consider the implications of any changes to the Medicare payment system on the non-elderly population, especially young people. At the very least, HHS should clearly articulate that Medicare payment systems are meant to apply primarily to elderly patients (65 years and older) covered by Medicare.
3. All stakeholders, including health care professionals and patients, should be consulted in the development of a new Medicare physician payment system.
4. The special needs of vulnerable populations must be addressed in the payment system. We are specifically concerned about the unique needs of persons with disabilities, persons with multiple chronic conditions, which many rehabilitation patients have, and patients who have the potential to resume prior activities if they receive adequate rehabilitation care.
5. Health care professionals have been paid under the Medicare physician fee schedule payment system since 1992. Therefore, any changes to this system will require extensive provider, professional, and patient outreach and education. As a result, implementation of a new payment system should include a sufficient transition period and resources for such education.
6. A reformed payment system should include metrics related to quality of care and related outcomes, patient access, and patient choice, as critical components of the system.
7. Quality measures selected for the payment system should promote positive outcomes and avoidance of adverse events and promote the effective and efficient care.

8. The skills and services of health care professionals should be appropriately recognized and valued. Providers and professionals should be empowered to deliver services that are clinically appropriate for the patient based on clinical evidence and professional judgment.
9. Payments must reflect the true cost of care and resources utilized based on the patient's conditions. Systems that allow for a fixed number of visits or an average cost limit disproportionately penalize patients with complex disabilities such as spinal cord injuries, brain injuries, and some neurological conditions that require extended rehabilitation.
10. Provider administrative burden should be minimized whenever possible.

