TESTIMONY BEFORE THE

SENATE FINANCE COMMITTEE

ON

MEDICARE PAYMENT OF PHYSICIAN SERVICES

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Chairman Baucus, Ranking Member Grassley, and members of the committee, my name is Byron Thames. I am a member of AARP's Board of Directors and a physician. Thank you for inviting AARP to testify on reforms to Medicare's payment for physician services.

AARP believes that physicians are central to the delivery of health care, and that Medicare's payment system should encourage quality and affordable care. Today's hearing focuses on the sustainable growth rate (SGR) system, which has been widely recognized as flawed. The SGR does not distinguish between those doctors who provide Medicare beneficiaries with high quality care and those who provide unnecessary or inappropriate services. Moreover, the SGR has not been effective at controlling the volume or intensity of services, which has led to higher Medicare spending and greater out-of-pocket costs for beneficiaries.

AARP believes that ultimately the SGR should be replaced with a system that encourages physicians to provide beneficiaries and the Medicare program with greater value for the health care dollar. Medicare beneficiaries need and expect their doctors to provide effective treatment. Payment incentives should encourage high quality, not unnecessary quantity. A truly sustainable payment system will be built on a foundation that emphasizes four key elements: information technology; greater use of comparative effectiveness research;

performance measurement including physician resource use; and enhanced care coordination.

The Doctor-Patient Relationship: What AARP Members Say

AARP recently conducted a survey asking older Americans – current and future Medicare beneficiaries – about their experience with physicians. The vast majority of those surveyed report good access to and high levels of satisfaction with their physicians, but the cost of care remains a concern for people.

Medicare beneficiaries are beginning to feel the impact of the large Part B premium increases caused, in part, by the many legislative changes that have overridden the SGR. Of those surveyed, fourteen percent of beneficiaries said that they had to give up something to pay for an increase in their Medicare premium. Twenty one percent said they had to cut back on groceries.

The AARP members surveyed are among the over 43 million Americans who rely on Medicare for their health care. Physicians are central to the delivery of that health care. AARP believes physicians who treat Medicare patients should be paid fairly. But as we have learned from our members, the program must be affordable for beneficiaries as well. Determining how to balance these two needs is a complex, yet critical, policy problem that must be solved for the Medicare program to remain strong for future generations.

AARP supports long-term reform of the physician payment system. Annual short-term fixes simply exacerbate spending growth and only delay needed discussions about how to control rising expenditures. AARP believes the time has come to move toward a payment system that rewards physicians for providing greater value for health care spending. A recent Institute of Medicine report, *Rewarding Provider Performance: Aligning Incentives in Medicare*, concluded that "because the current basic payment systems reward overuse of services, use of high-cost complex procedures, and do not acknowledge the wide variations in quality across providers, . . . payment reforms are needed now to recognize care that is of high clinical quality, patient-centered, and efficient."

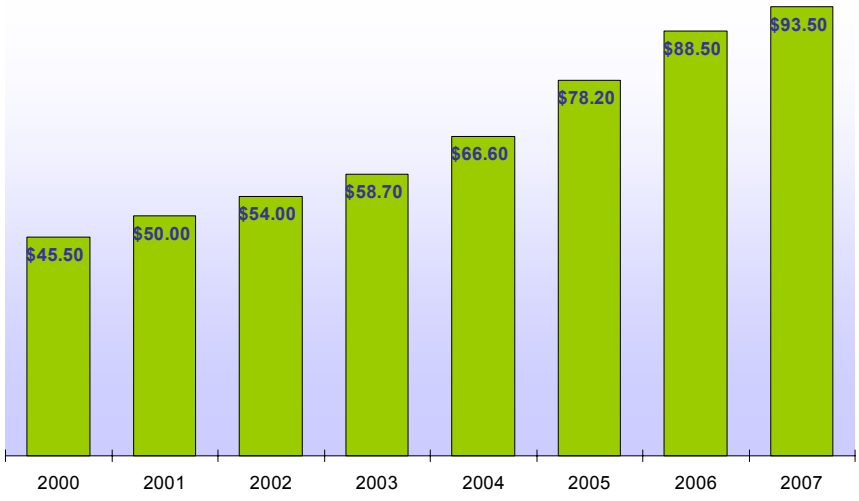
We couldn't agree more. All Medicare beneficiaries must have access to physicians who provide high quality care. At the same time, beneficiaries need to be protected from extraordinary out-of-pocket costs.

Overriding the SGR: Direct Financial Consequences for Beneficiaries

The SGR system, designed to keep spending in line with an overall target, was viewed as necessary to address unchecked increases in the volume of physician services. Since 2002, actual spending on physician services has exceeded the SGR target, thereby triggering reductions in physician updates. With the exception of 2002, however, Congress has consistently voted to override this mandated reduction in response to physician concerns.

Unfortunately, each time Congress overrides the SGR there is a direct cost for Medicare beneficiaries. That's because by law, the monthly Medicare Part B premium is set at 25 percent of Part B spending. The Part B premium has doubled since 2000 – due in part to the payment increases for physicians (see chart).

Part B Premiums More than Double Since 2000



Source: 2006 Medicare Trustees Report

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Beneficiaries again face large increases in their 2008 premiums due to a convergence of three factors. First, the congressional action taken late last year to avert a physician pay cut in 2007 will not affect the beneficiary Part B premium until next year because the 2007 premium had already been calculated. Second, other factors will put additional upward pressure on Part B premium cost growth for 2008 (e.g., growth in Medicare outpatient spending, expenditures for physician-administered drugs, and Medicare Advantage payments, which exceed

costs in traditional Medicare by approximately 12 percent, on average). Third, if Congress acts again this year to prevent a reduction in physician payments – estimated by the Congressional Budget Office at 10 percent – these additional costs could also be rolled into the 2008 beneficiary premium.

Increased costs to beneficiaries are not limited to premiums. Cost-sharing obligations – which usually reflect 20 percent of Medicare's payment – also jump each time provider reimbursement rates increase. For each increase of $10 billion in physician payments, beneficiary coinsurance amounts increase roughly $2 billion. In addition, the increased Part B spending also leads directly to a higher Part B deductible. Since 2005, the annual deductible has increased along with per capita Part B expenditures.

The Medicare program must be kept affordable to remain true to its intent. When it was created in 1965, more than half of older Americans were uninsured and they were the population most likely to be living in poverty. Today, about 50 percent of Medicare beneficiaries have incomes below $15,000, and the median income for an individual between the ages of 65 and 69 is less than $30,000. The average older person already spends about one quarter of his/her income on health care. This does not include the additional, and often substantial, costs of services that Medicare does not cover – including long-term home and nursing home care. If Part B premiums and cost-sharing continue to escalate, many more beneficiaries will find it increasingly difficult to pay for the care they need.

Each time the SGR is overridden, the price tag beneficiaries pay in the long run increases. Due to the cumulative nature of the targets, physician payment updates in future years must be lowered to offset the accumulated excess spending and to slow expected spending for the coming year. As a result, under the SGR methodology, physician fees are expected to be reduced each year at least until 2012. Under this scenario, we can expect to continue the now annual cycle of physician groups lobbying Congress to avoid these payment cuts, doctors threatening to stop taking Medicare patients, and Congress overriding the SGR at the last minute. We must find a better approach.

Alternatives to the SGR: MedPAC's Report to Congress

Today, MedPAC releases a new report that examines alternatives to the current SGR. The Senate Finance Committee asked AARP to respond to this report. As requested by Congress, MedPAC studied the implications of moving from a single, national SGR to five potential sub-national target systems that would be based on: geography, type of service, group practice, hospital medical staff, and outliers. We commend MedPAC for providing a thorough examination of each alternative's advantages and disadvantages.

From the beneficiary perspective, we believe the outlier option holds the most promise for higher quality at a lower cost to the Medicare program. One of the major advantages of the outlier approach is that it would allow the Medicare

program and others to learn from those physicians who use fewer resources while maintaining a high level of quality. It is important to better understand the differences between inappropriate volume growth and appropriate growth (e.g., from technology changes that improve care for patients). This information could be used to identify best practices for the treatment of specified patients and conditions. An outlier policy could also promote individual physician accountability. It does not require a large scale restructuring of the existing physician marketplace and could be used to measure most physicians in the United States.

Similarly, as MedPAC notes, encouraging specific actions, such as care coordination or investment in information technology, may be more successful than varying reimbursement levels based on a physician's specialty, or region, or practice type.

MedPAC presents two alternative paths for Congress to consider for paying physicians in the Medicare program. The first path would be to repeal the SGR and pursue policy approaches for improving the value of the Medicare physician payment system. The second path would be to retain some type of expenditure target – applied to all Medicare providers, calculated at a geographic level.

Medicare's experience with the SGR has not proven to be successful and beneficiaries have borne the financial penalty in higher out-of-pocket-costs. As

MedPAC noted, it is a flawed system that inappropriately influences clinical decisions about where and how many services are provided.

Clearly, the SGR has not been effective at controlling the volume of physician services. According to the Government Accountability Office, from 2000-2005, while Medicare physician fees rose by 4.5 percent, program spending on physician services grew by nearly 60 percent. On a per beneficiary basis, spending for physician services grew by approximately 45 percent.

Many experts have concluded that one of the SGR system's fundamental flaws is its assumption that physicians would act collectively – on a national level – to control the volume of service. MedPAC concluded in 2002 that, "if anything, an individual physician has an incentive to increase volume under such a system."

The SGR does not distinguish between those doctors who provide high quality care to beneficiaries and those who provide unnecessary services. In fact, physicians providing the most efficient care are penalized under Medicare's current payment system while a physician who orders more tests or performs more procedures than are indicated is paid more.

The volume performance standard, which was used to set Medicare fee updates from 1992-1997, was eliminated because of concerns about how it distorted payments for one service relative to another. It is not clear that a new form of

expenditure target will be any better for beneficiaries or Medicare, and another administratively-complex formula could lead us down yet another time-consuming and failed path of unintended consequences. As MedPAC warns in its executive summary, "the risk that a formulaic expenditure target will fail and have unintended consequences is substantial."

For these reasons, the first path outlined by MedPAC may have more promise. AARP believes Congress and CMS should focus their efforts on redesigning the payment incentives to promote quality and encourage efficiency. Congress should not abandon its emphasis on controlling expenditures, but it should put its energy into finding strategies that encourage better, more efficient, and patient-centered care.

There are a number of factors to consider. First, ultimately repealing the SGR would be quite costly. A transition to a value purchasing framework must not be financed at beneficiary expense. Therefore, some kind of transition may be necessary. Second, we need to make sure beneficiaries are protected from extraordinary out-of-pocket expenses as the Part B payment system is reformed. One such protection would be a cap on Part B premium increases. Congress could stipulate that the Part B premium could only increase by a certain percentage, dollar amount, or a five-year average. While beneficiary premiums would still increase, the increases would be limited, and beneficiaries would be in a better position to plan their monthly expenses.

Another potential option is to limit total Part B out-of-pocket costs. Unlike many health insurance policies available to younger Americans, Medicare has no catastrophic limit for cost-sharing. Protecting sicker beneficiaries who are more vulnerable financially is critically important.

Third, elimination of the SGR cannot be viewed as carte blanche for physicians to maximize revenues through uncontrolled increases in the volume of services. The volume of unnecessary services in Medicare remains a problem – in terms of the quality of care provided, the added cost to beneficiaries, and the rate of growth in Medicare spending. A new physician payment system should be designed to encourage appropriate care and prevent unrestrained volume.

Congress cannot continue to avoid the current problem in the Part B payment system. The annual physician payment fixes Congress has enacted since 2003 have created an increasingly bigger hole which will become harder to climb out of as each year passes. We believe the time to act is now. AARP stands ready to work with Congress and the physician community to develop a workable solution.

Changing the Incentives to Promote High Quality

AARP also believes Congress needs to change the incentives in Medicare's physician payment system to promote quality and encourage efficiency. We recommend Congress focus its efforts on four key areas: encouraging

widespread adoption of health information technology; expanding the use of comparative effectiveness research; utilizing performance measurement including physician resource use; and enhancing care coordination.

Information Technology – AARP believes health information technology (HIT) has enormous potential to both improve quality and eventually lead to lower costs throughout our health care system. Yet the United States lags far behind most industrialized nations in maximizing its potential benefits. According to the Commonwealth Fund, only about one-fourth of U.S. primary care physicians report use of electronic medical records, compared with nine of ten primary care physicians in the Netherlands, New Zealand and the U.K.

Among the many advantages of HIT, it could: help providers coordinate care across settings, reduce errors and duplicative services, support clinical and patient decision making, improve communications between doctors and patients, and help to foster patient management of their health conditions through ready access to their personal information. Finally, HIT could create "virtual" integrated delivery systems without requiring formal mergers or affiliations.

Expand Comparative Effectiveness Studies and the Clinical Evidence Base – Consumers, providers, and purchasers need objective, credible, evidence-based information to help them make good health care decisions. Congress recognized this need in section 1013 of the Medicare Modernization Act of 2003 by

authorizing $50 million for head-to-head comparisons of treatment options. To date, the Agency for Healthcare Research and Quality (AHRQ) has received only $15 million for 2005 and $15 million for 2006 – far below the authorized amount. Congress should provide AHRQ, at a minimum, with $50 million in FY 2007 for comparative effectiveness research and begin to look at expanding the opportunities for both financing and using this research.

Comparative effectiveness research is a way to compare drugs within a therapeutic class, similar procedures, or drugs versus procedures to determine which treatments are most effective. In addition, as the MedPAC report notes, comparative effectiveness research could also be used to help "prioritize pay-for-performance measures, target screening programs, or prioritize disease management initiatives." This type of research could improve the overall quality of health care delivery and patient outcomes while reducing inappropriate, inefficient, and ineffective care. There is a clear need for a significant government role in paying for this important evidence, since Medicare and other federal programs stand to benefit (over 40 percent of health care is paid by the federal government) from having a stronger base of evidence on which to make payment and other decisions.

Performance Measurement – We applaud Senators Baucus, Grassley and other members of the Committee for their hard work in ensuring that bonus incentive payments to physicians who report on quality measures were included for 2007.

These quality reporting efforts begin to move Medicare in the important direction of providing better quality and more value for beneficiaries.

Pay-for-reporting represents a first step and the initial Centers for Medicare and Medicaid Services (CMS) list of quality measures for the Physician Voluntary Reporting Program – now referred to as the Physician Quality Reporting Initiative – is a starting point for a discussion. However, there is still substantial work to be done on the quality measures themselves so that when we actually pay-for-performance there will be rigor in the process to justify spending Medicare resources on this initiative.

For pay-for-performance to be successful in improving care for beneficiaries, AARP believes Medicare should focus first on high cost, highly prevalent conditions for which valid, reliable measures exist (such as for diabetes and congestive heart failure) as well as on efficiency and resource use and care coordination. While it is important that all physicians participate in the program eventually, this should not be CMS's first priority. The top priority should be improving health care for Medicare beneficiaries and giving them value. Let's start with good measures that can effectively assess performance across the high priority areas that have been identified.

AARP believes that the federal government must financially support the development of performance measures. Improving health care should be

considered a public good and we will not be able to improve quality unless we have valid and reliable measures to assess what we are doing. Measures should be vetted through an open forum with meaningful consumer input (such as the National Quality Forum).

There are many gaps in our ability to assess health care quality. These gaps must be filled as quickly as possible. We need to improve risk adjustment methods to remove any incentives doctors may have to avoid patients with multiple chronic conditions, or inadvertently penalize providers in underserved communities.

Performance assessment must include resource use and efficiency. Researchers at the Dartmouth Medical School have found that regions of the United States with the highest health care spending do not appear to have sicker patients or better outcomes than regions with lower spending. They estimate that Medicare could reduce spending by at least 30 percent, while improving the outcomes of care, if the physicians whose practice styles are the most resource intensive (i.e., they order more diagnostic services and procedures) reduced the intensity of their practice. In its discussion of an outlier policy and measuring resources and providing feedback, MedPAC provides convincing arguments for why CMS should measure physicians' resource use over time and provide the results to physicians. AARP strongly recommends that CMS adopt this recommendation, especially if the SGR is eventually repealed. It is critically

important that the Medicare program continue to focus efforts on ways to help physicians practice most appropriately. We would hope that the information could eventually be used to help beneficiaries identify those physicians who deliver high quality care. It could also eventually be used to help design payment policies.

Enhancing Care Coordination – Finally, we should focus again on the doctor-patient relationship, a relationship of great importance to most AARP members. Under Medicare's current physician payment system, physicians who conduct procedures receive higher compensation than those who diagnose and manage complex problems. Doctors who spend time with their patients and their family members to discuss treatment options are reimbursed at much lower rates. For example, the national average Medicare reimbursement for placement of two coronary artery stents via cardiac catherization was $1,012 in 2002; a two-hour family meeting was reimbursed on average between $75 and $95. It should be noted that national comparisons conducted by Dartmouth researchers indicate that communities with more robust primary care provide lower cost, higher quality care. It is clear that the mix of physicians in a community has a direct impact on quality and cost. Moreover, patients report more care coordination problems the more specialists they see.

As the MedPAC report emphasizes, the Medicare program could improve the efficiency of health care delivery by increasing the use of primary care services

and encouraging coordination of care. Coordination of care is important for individuals with multiple chronic conditions and especially as individuals move across care settings. AARP believes that Medicare's payment methods should be changed to create incentives in the fee-for-service system to better coordinate care so that beneficiaries receive the best care possible. In addition, other practitioners, such as nurse practitioners, physician assistants, and advanced practice nurses, might help fill this growing gap of primary care and needed care coordination.

Treatment of chronic illnesses accounts for the majority of health care expenditures, including those of the Medicare program, yet the traditional Medicare system is not designed to prevent complications. For example, a 2003 study by Elizabeth McGlynn of the quality of care delivered to adults in the U.S. found that only 24 percent of people with diabetes had their blood sugar appropriately monitored, and 45 percent of people presenting with myocardial infarction received the proper medications known to reduce deaths among patients suffering from this condition. Medicare beneficiaries – whether they choose managed care or traditional Medicare – should have access to better chronic care management.

Recently enacted Medicare legislation has expanded the number and type of Medicare demonstration projects to examine the impact of various strategies for improving the coordination of care for beneficiaries with chronic conditions in

traditional Medicare, such as the Medicare Health Support demonstration, the Physician Group Practice demonstration, and the new Medical Home demonstration.

AARP supports developing comprehensive, coordinated approaches to financing and delivering a wide range of needed care to chronically ill people. We hope to see effective strategies of this kind applied to the broader Medicare beneficiary population soon.

Conclusion

In conclusion, millions of AARP members depend upon Medicare every day. They need access to the best quality care and the physicians who deliver it. And they need that care to be affordable. The SGR system has not successfully controlled physician spending. To help keep Medicare affordable for beneficiaries today and financially strong into the future, AARP believes the incentives in the current physician payment system need to be changed to promote quality and encourage efficiency. We look forward to working with you and your colleagues to address this challenge.