Physician Payment Post SGR

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Thank you, Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee on Health for inviting me to testify on innovative physician payment systems that might be useful alternatives to the sustainable growth rate system, that ironically has proven not to be sustainable. Before I commence with my substantive remarks I would like to emphasize that my comments reflect solely my beliefs and do not reflect the opinions of any organization I am affiliated with, including MedPAC.

I believe that we all share the same goal of developing payment systems that provide sufficient support for health care providers, promote access to care for Medicare beneficiaries, encourage delivery of high value, appropriate care and discourage use of wasteful inappropriate care. Moreover given the country's fiscal situation, such a system must be financially viable in increasingly difficult budgetary times. I hope we can agree that the current physician payment system that relies on the SGR does not accomplish those goals. If implemented as designed it would call for approximately a 30 percent reduction in physician fees that would undoubtedly threaten access to care and possibly the viability of many medical practices. Medicare's fee for service foundation does little to encourage cost containment or high quality care and the details of the SGR formula lead to fee reductions that are not tied to any sensible clinical objectives. Moreover, the difficulties associated with patching the SGR have led to disruptions and uncertainties regarding payment that impede progress towards our goals.

Yet while critiquing the SGR is easy, identifying a viable alternative is difficult. There is unlikely to be a perfect solution and, given that the health care system has grown and adapted to the basic fee-for-service structure that the SGR is based on, any path to a solution will take time. That said, I think that increasingly the private sector, which faces many of the same issues as Medicare, has developed promising alternatives. I will discuss one option I consider particularly promising today, the Alternative Quality Contract implemented by Blue Cross Blue Shield of Massachusetts, known commonly as the AQC.

My intent is not to advocate for the AQC or any of the specific details of the AQC, only to note its basic design features, their promise, and possible challenges to models like the AQC. I think several aspects of the AQC are instructive and while evaluation of the AQC's impact is ongoing, many proposed payment reforms share similar traits.

But before launching into a description of the AQC, I would like to speak broadly about payment reform. First, it is important to distinguish between the form of payment (fee-for-service vs bundled payment) and the level of payment. The form of payment creates incentives. Creating the appropriate form of payment can facilitate the creation of appropriate incentives for managing costs, improving quality and achieving other goals. But even if we adopt the best form of payment, it will be a challenge to set the right level of payment. Provider costs vary across and within markets, in some cases due to factors beyond the providers control and in other cases due to factors providers can control. Thus it is difficult to know exactly what prices should be set or even the process by which the prices may be set. Even the best payment system can function poorly if the level of payments are set too low (or too high). In my opinion a discussion of post-SGR payment should primarily focus on the form of payment, not the level of payment. Payment levels (and updates) can be discussed as a second step.

Second, while I recognize that I have been asked to discuss physician payment, I think the question presupposes a fragmentation of payment I think is detrimental. Specifically, the existing Medicare system (including the SGR) structures payment by provider type. We have separate fee schedules for physicians, hospitals, nursing homes, and a whole array of other providers often delivering similar services and treating the same patients. This creates numerous inequities and paradoxes that make managing the system and improving coordination of care across different settings difficult. Just to give one example, a colonoscopy preformed in a physician's office costs Medicare on average about half of the cost if it is performed in a hospital outpatient setting. This largely reflects different treatment of the technical fee for providing the service, which may be justified, but it is difficult to assess the appropriate fee differential, if any (because case mix and other factors are hard to observe).

Many scholars and policy analysts have concluded that moving away from a fee-for-service system is justified. A more bundled system, that pays for an episode of care or provides a global budget can allow more flexibility for providers and obviate the need for purchasers (such as Medicare or private insurers) to micro manage payment systems. Moreover, such a bundled system can facilitate cost containment strategies that avoid slashing per unit price when volume rises, as the SGR does. In a bundled payment model the relevant question is not: how do we pay physicians, but is instead: how do we pay for care.

Implementing such a bundled payment system is not easy, but as I mentioned earlier, innovative systems exist and, at a minimum our experience demonstrates their feasibility (and I believe promise). The AQC is one such system.

Briefly, the AQC is integrated into the Blue Cross Blue Shield's HMO model and rests on three fundamental pillars: First a global payment rate in which a provider system receives a budget to cover the costs of providing all of an enrollee's care. The exact payment rate is set through negotiation between the plan and provider groups, with updates specified for the 5 year duration of the contract. The provider group is at risk if spending on the patient exceeds the payment rate and captures savings if the spending falls below the payment.

In the AQC the payment is tied to the organization (e.g., physician group) that employs the patient's primary care doctor, which in the HMO is chosen by the enrollees because all HMO members are required to designate a primary care doctor. Yet although patients choose a primary care doctor, the AQC does not limit their choice of provider when they seek care (beyond the limits that exist in the HMO product for any enrollee). Specifically, if a patient designates Dr. Smith to be their primary care provider, Dr. Smith's physician group receives the global budget. The patient can then seek care from any network provider (with referral) and the costs will be counted against the budget given to Dr. Smith's practice. If the patient decides to switch primary care

doctors by notifying BCBSMA, then the global budget would be transferred to the new doctor's practice, assuming the new doctor is in a different AQC group. Because the network is very broad, AQC enrollees have access, with referral, to the vast majority of providers. A similar model could be easily adapted to PPO products that require patients to designate physicians.

Second, the AQC incorporates a comprehensive pay-for-performance system that rewards providers groups for performance on 64 quality measures ranging from process measures to outcome measures and from clinical measures to patient experience measures. The quality measures include both physician and hospital oriented measures. The provider group that employs the patient's primary care physician can earn up to 10% of TOTAL fees as a quality bonus above their budget target. Because the bonus is based off of total fees, not primary care fees, the bonus can be quite significant.

Third, the AQC includes significant provider support and data analysis (from Blue Cross Blue Shield of Massachusetts) which helps participating groups identify areas of improvement and manage care in a real time basis. One advantage of having all of the data is that BCBS can see care patterns across the entire network and support provider efforts to react.

The AQC differs from capitation plans of the 1990s because the contract extends for 5 years and incorporates significant performance incentives for quality and health outcomes.

The model has several strengths. Most importantly it creates a business case for improving quality and efficiency. Innovative programs that reduce use of unnecessary care or inefficient care, including reducing readmissions or unnecessary diagnostic or therapeutic procedures would not be viewed as losing revenue from forgone services, but instead be viewed as creating profit. Primary care groups are further incented to direct referral to the most efficient, low cost providers. The global budget also provides

stability and predictability of spending growth. The five year contract duration and the requirement that patients designate a physician greatly facilitate management and accountability by protecting providers against immediate reductions in rates if they achieve efficiency and by obviating physician responsibility for patients they were not aware were in their practice.

Global payment systems in the past have raised several concerns. For example, many have worried that they would lead to reductions and delivery of effective and needed care. The AQC is designed to prevent this by setting the global payment at least equal to the prior year's payment (so no provider group will be forced to reduce access to care). Moreover, health risk adjustment further reduces the risk that providers face and further dampens any incentives to skimp on care. But the most important protection is the quality bonus system. Early evidence suggests that these features have led to an increase, not decrease, in the quality of care delivered.

Further, many observers have noted that not all physician groups are capable of functioning in a global budget environment. Certainly this is true and my most important response to this concern would be that just because all groups are not ready for AQC type payment, we should not abandon it for those that are ready. But beyond that I tend to have the free market orientation that if incentives are set correctly, firms will adapt. We should not underestimate the ability of organizations to evolve to become more efficient. In fact if we do not believe such transformation is possible, no amount of payment reform or other policy changes will solve our problems and we are doomed to a system that operates far below our aspirations. Moreover, the AQC demonstrates that a wide array of physician groups, many with only a handful of physicians can join and succeed in the AQC by banding together to contract in larger groups. Specifically, the AQC has contracts with provider groups of all types, not just the large integrated group practices with affiliated hospitals. Many solo practitioners and small physician practices participate. It can be done.

The AQC is not without its weakness (and Blue Cross Blue Shield of Massachusetts is continually refining the model). For example, the AQC is not tied to benefit design and I believe a greater integration with Value Based Insurance Design would be an improvement. Specifically, Value Based Insurance Design refers to plans that align copayments with value of services or providers, so that patients seek high value. The AQC performance bonuses give health care systems the incentives to encourage high value care, but the patient incentives have not been similarly constructed. Second, while I am a big believer in markets and note that this innovation was developed in the private sector, any private sector model must contend with issues of provider market power. Ultimately the success of the AQC will depend on the ability of Blue Cross Blue Shield to negotiate sustainable payment rates with the providers in their service area and attract enrollees. Because of its size, Blue Cross Blue Shield may be better positioned for success than other smaller plans. So far the evidence suggests that AQC has passed the test of the market, with enrollment growing from 26 percent to 44 percent of the Blue Cross Blue Shield HMO membership as more provider groups have joined.

Certainly Medicare would be able to adopt certain AQC principles and some are evident in recent proposed Accountable Care Organization regulations. Broad application of such a model would be facilitated in Medicare if beneficiaries were incented (or required) to designate a physician, without giving up any existing benefits or rights regarding choice of provider.

In summary, a Fee For Service physician payment system for Medicare, SGR or not, generates inherent problems. In the near term we must work to mitigate those problems, but I am skeptical of our ability to micro manage such payment models and ultimately I believe such a payment system will force a choice, as the SGR illustrates, between reasonable Fee for Service rates and sustainable spending growth. Bundled payment systems such as the AQC offer considerable promise as a way forward. These systems are comprehensive, and give autonomy to providers which ultimately will be preferable to attempts to dictate practice styles in an effort to control budgets. The

Affordable Care Act incorporates a number of provisions that promote different types of bundled payments, including Accountable Care Organizations and demonstrations that implement episode based payment models. As a taxpayer and future Medicare beneficiary I urge you to support these demonstrations, and others like them and to work towards a design of a more rational and effective payment system that allows our expectations and aspirations to be met in a fiscally sustainable manner.

Committee on Energy and Commerce

U.S. House of Representatives

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5. Federal Grants received on or after 10/1/08:

Funder	Grant #	PI	Title	Duration
NIA	R01 AG027312	Chernew/ Landon	Financial Incentives & Variations in the Care of Medicare Beneficiaries	(6/1/08-5/31/10)
ARC/CMS	n/a	Chernew	Understanding Spillover in Health Care Markets	(2/1/09-8/31/09)
NIA	P01 AG032952	Newhouse	The Role of Private Plans in Medicare	(4/15/09-3/31/14)
NIA	R01 AG034417	Chernew	Income Effects and Current Law Forecasts of Health Care Spending Growth	(8/1/09-7/31/14)
NIA	R01 AG034085	Huskamp	Medicare Part D Plan Generosity & Dual-Eligible Nursing Home Residents	(8/1/09-2/31/12)
IOM	n/a	Chernew	Geographic Variation in Value for the Privately Insured Population	(1/1/11-6/30/12)