The Doc Fix: What Happens Next?
Alliance for Health Reform
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ED HOWARD: Good afternoon, my name's Ed Howard. I'm with the Alliance for Health Reform. On behalf of our Board of Directors, and Senator Blunt and Senator Rockefeller, I want to welcome you to this program to look at how we pay physicians under Medicare, how we adjust those payments annually through a formula called the Sustainable Growth Rate or SGR, and how to fix that badly flawed formula. In other words, we're searching for an effective and enactable doc fix.

For the last decade congress and the president have decided that the cuts to physician fees under the SGR were bad policy, so, they've acted every year, sometimes more than once every year, to postpone the cuts. The problem is they didn't repeal them, they deferred them, so they were added to the following year's calculation of what the cut had to be. In other words, we've been kicking the can down the road so long it's become something like a 55 gallon drum. Now, the CBO—the Congressional Budget Office has revised drastically downward its estimate of the cost of getting rid of the SGR entirely.

Remember, the SGR was enacted in the first place because Medicare spending on physicians was rising too fast. The question arises, if we do away with the SGR what, if anything, do we replace it with? The secondary question of course is, even though CBO has lowered the price tag on SGR

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repeal, some people think that 138 billion dollars over 10 years is still a fair amount of money. So, how are we going to pay for that, what are the pay-fors?

We're very pleased to have as a partner in today's program the Commonwealth Fund, a century-old philanthropy that is set up to promote the common will or the common good. You'll hear from Stu Guterman from the fund in just a moment. Let me just do a quick logistical note here. You're going to find in your packets not just background material that's reprinted for you, but also a list that includes everything that's printed and a bunch of things that are only available online at allhealth.org, our website. You'll find a webcast available on that same website next week, followed a few days later by a transcript of the briefing. The green question cards you can use when we get to Q&A, a blue evaluation form that we would be deeply grateful if you would fill out to help us improve these programs. Let me now turn to Stu Guterman, who's going to be co-moderating today's conversation. He is the vice president of the Commonwealth Fund and the executive director of its commission on high-performance healthcare systems. He's also the lead author of the issue brief in your materials, *Paying for Value*, which takes the SGR issue on directly and if you haven't read it you really ought to. Stu, glad to have you with us.

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STUART GUTERMAN: Thank you, Ed.

ED HOWARD: You've got to get pretty close [inaudible].

STUART GUTERMAN: And, thanks everybody for coming. This is an issue that presented a difficult situation for years and it's been—it may be time that it can be dealt with. Because, not only has, as I mentioned, the solution to the SGR gone on sale with new lower estimates from CBO, but also there are more and more proposals for alternative ways of paying and organizing physician care. In the—is there a thing?

ED HOWARD: There you go.

STUART GUTERMAN: First a little background. The SGR is a direct result of the fee-for-service payment system, particularly for physicians. Because, the resource-based relative value scale sets prices for each individual service that physicians provide and congress, even at the time that it passed that system—enacted that system, recognized that if you pay for units of service you're going to get more units of service, if you pay for intensity you're going to get more intensity.

To safeguard against that, Congress had built in a volume performance standard which later was replaced by Sustainable Growth Rate formula and the formula was well-intentioned and made sense at the time. It basically reflected philosophy that as the economy grows, the economy—a certain

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amount of resources are available to pay physicians and that if physician payments rise faster than overall economic growth, that there should be some curb on the amount of payment to physicians. They also recognized that, unlike hospitals, physicians have direct control over the volume and intensity of services that they provide.

It's often been said that the most expensive medical equipment in our system is the physician's pen. So, Congress wanted to safeguard against that kind of growth so they built in this formula. The problem was that, although spending growth in physician services is driven by volume and intensity increases, there isn't any direct way to control volume and intensity. What the formula does is it cuts the price for each unit of service if total spending grows too fast. That was alright in the late 90s when the SGR was first enacted, because the economy was growing pretty fast and in fact, there were some pretty generous increases in physician fees in the late 1990s and early 2000s.

Around 2002, the SGR formula—as the economy slowed the target got lower and also there are some recalculations that were involved and the SGR formula, for the first time, produced a cut in physician payments and then Congress had to figure out what to do. It was kind of taken by surprise in the first year, and so it let the cuts take effect in 2002. In every year since

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then the Congress has stepped in, many times at the last minute—in fact sometimes after the last minute and kind of made it retroactive, to avoid the cuts that the SGR formula has enacted. The problem is that they've left the formula in place and they've left the cuts—the targets in place, and so the next time the formula takes effect the cut is going to be more and more substantial.

This past January physician fees were scheduled to be cut by 27-percent across the board and they were—that was postponed, but again the SGR was left in place. This coming January, physician fees will be cut by an estimated 25-percent, unless Congress steps in and does something. The problem is that getting rid of the SGR makes it costly—it is a costly thing to do now, because the cuts that are produced by the SGR formula are so large. As recently as last year, CBO estimated that it would cost $270—270 billion dollars over 10 years to reduce—to eliminate the SGR. This latest estimate of 138 billion dollars makes it much more feasible to deal with, although it's still, as I said, a large amount of money.

Why do people want to get rid of the SGR? Well, it cuts payments across the board, it doesn't make any distinction between payments for services that are appropriate and services that aren't appropriate, between services that are growing rapidly and driving spending increases and those that aren't,

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between primary care and specialty care, between better coordinated care that's part of a coordinated regimen of treatment and care that's not, so that's one thing. It also—because it still built on the fee-for-service system, it still maintains the same incentives for individual physicians to increase service intensity and volume. It doesn't address the undervaluation of some services like primary care, which people generally recognize needs to be better supported in our health system. It hasn't controlled spending growth. Spending growth has still risen per beneficiary, despite the fact that the SGR formula has produced cuts that have been overridden by Congress. It also, however, has led to increasing gaps between Medicare payments and private payment rate.

It's starting to show up, in at least anecdotal evidence, that Medicare beneficiaries are having increasing problems finding doctors to treat them. It's undermined Medicare's credibility with physicians and it doesn't provide incentives to improve quality. In fact, it counteracts those incentives because it's very difficult to say to a doctor, congratulations, you've performed very well, we're only going to cut your payments by 20-percent instead of 25-percent. That's not quite the kind of incentive that rewards for performance—would need to be effective.

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What else do we do? Even if we are willing to bite the bullet and take on the 138 billion dollars in estimated costs of eliminating the SGR, what we do instead? As Ed mentioned, we put out a paper that was really developed from a set of recommendations made by our commission on a high performance health system that lays out an alternative approach. First of all, the commission felt that it was very important to transmit the message that fee-for-service is not going to be a comfortable shelter from health reform policies anymore. You could—you would freeze physician payment rates at their current level and make the statement that any new payments that are going into the healthcare system are going to go into support more innovative organizational, and healthcare pilots, and attempts to improve the performance of the health system.

One aspect of that is to enhance primary care payments. We want to provide additional payment for primary care physicians, and other primary care providers, either through the support of Patient-Centered Medical Home type model and high cost management teams for people with multiple chronic conditions and disabilities, which is where a lot of the money is, and also for providers working in [inaudible] care organizations and other similar kinds of innovative organizational structures. You want to provide higher compensation for people who perform well, put more money in

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paying for quality. Because, in our health care system we actually have found that we do get what we pay for. We pay for volume, we pay for intensity and that's what we get.

What if we paid for something that was more like what society really wants to see its healthcare system produce? You also want to engage beneficiaries, but not in a punitive way. You want to offer them positive incentives to get their care from primary care providers, or high-cost care management teams, or other kinds of innovative organizational structures. And, you want to make more of those available to them so that, not only is there a positive incentive for them to make the right choices, but they have the choices that are available for them to make. And, then bundle payments for future episodes is on this list too. And, that is to really try to focus on getting providers to think of patients across the continuum of their care, not just what happens when that patient happens to be in your office or your building.

So, that's where we are and we have great panel to discuss their ideas about what we could be doing. We'll start with Gail Wilensky, who is the senior fellow at Project Hope and a former administrator of the Healthcare Financing Administration, which runs Medicare and Medicaid, of course, and, Bob Berenson, who's an institute fellow at the Urban Institute and he'll be presenting his ideas about improvements

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and how we can pay for healthcare. Then Jim Hahn, who is with the Congressional Research Service, is going to be providing some background on what's going on on the Hill, how people have been thinking about the Sustainable Growth Rate and alternatives to that system. I'll hand it over to Gail right now.

Gail Wilensky: Thank you very much, Stuart. I'm going to go quickly over the first two slides, because I think I've heard both Ed and Stuart references a point that I want to make, but I don't think it is made clearly in many of the discussions that we hear. Which is, when we talk about physician payment reform—and I'm going to focus mostly on the on the pilots and a little more on what's going on in the private sector on the pilots—but, when we talk about physician payment reform, particularly in Washington, it has been common to think about it as an SGR problem. That's because, for Congress, that is usually what it is. They are facing this difficulty of having physicians' fees being reduced initially at a rate of about 5-percent a year. As it's been accumulating, it's gotten to two digits and lately been in the 26 to 30-percent range, which of course is not allowed to happen for good reason.

I like to remind people this is not just an SGR challenge. It's a physician payment challenge, but it is

exemplified by the Sustainable Growth Rate. It clearly exacerbates the problem that exists, because it has these across the board fee reductions, which Stuart has mentioned, but, it's the combination of the resource-based relative value scale with the Sustainable Growth Rate that is the problem. The difficulty is if you don't think about it that way, which I'm going to get to in a minute, it's likely to lead you to at best half a solution, if not potentially the wrong solution.

The problem as I see it, with the relative value scale, is not that it's fee-for-service per se, but that the service that it is being paid for is on a very disaggregated basis. You could say that DRGs are fee-for-service, the service though is the discharge from the hospital. Here though, we're talking about a very disaggregated billing system, some 8,000 or 9,000 CPT codes. And, at a time when we increasingly talk about wanting to pay for value not volume, it's very hard to even think about how you would begin to hold physicians accountable and responsible when you have them billing the system on the basis of some 8,000 or 9,000 different codes.

As I see the question of what's the problem, you really need to understand it's that combination of SGR, RBRVS, that's the problem.

If Congress were only to remove the SGR—and there have been many times when, at least if you listen to what groups are

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saying, that is what they are saying they want to have happen, just blow away the SGR. Fortunately, we had the 300 billion dollars, more or less, to say not so fast, but the fact of the matter is if you only remove the SGR, you ought to assume that you are going to again see a more rapid rise in physician services than elsewhere in Medicare. After all, that's why we have an SGR and, as Stuart mentioned, for those of you with long memories, the volume performance standard preceding it, and, we would still be rewarding volume, not value. That is what the fee schedule, as it is structured, would end up doing. The real difficulty is, at the moment, there is not a viable alternative ready for prime time. Of course, we could have had that exact same statement—some of you, again, who have attended a lot of these have probably heard me make that exact same statement for somewhere in the last 5 to 10 years. But, it is a problem, because it's hard to blow something away without having its replacement ready at hand.

This is kind of a good news, bad news where we are now with—I mean, at least part of the bad news is we still don't have, at this very moment, a viable alternative. But, we have a lot of action going on now and that has not been true in the past. There are a lot of pilots, a lot of demonstration. There's actually been a fair amount of activity going on in the private sector since around 2006 or 2007 and in some extent to

the public sector almost as long as some of these private sector activities.

In the public sector, we've heard a lot recently about the bundling demonstrations, which are attempts to find a single, larger grouping of services, for which there would be a single payment. They are physician and hospital, they are hospital and Post Acute, 30 day discharge, 90 day discharge, there's a whole business put together. For me, it has been frustrating that there has not been as much attention as I would've liked to have seen on paying for physicians differently, but not attached to the hospital, another story on concern about the growing power and relative shifts in power that has gone on, in my view, to hospitals over the last decade.

There are some activities going on in CMMI, the—of course, the patient centered medical home has been going on for a number of years, but also the advanced practice demonstration and the multi-payer demonstration, so there are some other places that we can look, even within those sponsored by the government. There are a lot of pilots being done in the private sector and the Commonwealth Fund has nicely given me some funding to try to make—sort out some of these private sector and public sector pilots and see if it leads to some policy conclusions, in terms of where we might go next.

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The Blues Plans around the country are doing a lot of activity. For those of you who have not paid attention to what's going on in Michigan, you ought to do so. David Shear [misspelled?] has testified on the Hill and he works with Commonwealth on their high-performing—whatever you call your study—commission, thank you. They are trying to go beyond where most of the pilot projects do, in that they are looking at the effects that go on in the community and feed that back in terms of how physicians are being rewarded. Initially, it has focused on primary care physicians, they are now slowly extending some of the same ideas to at least a couple of specialties: cardiology, and oncology early on. All of the big private payers are actively doing interesting kinds of pilots, United Health Group, Aetna, WellPoint, Cigna. They almost all have a number of patient centered medical homes. Some of them are involving their specialists more actively, even in terms of centers of excellence or in terms of some kind of designated preferred provider, to which they encourage their enrollees to go.

Some of the concern, just in terms of trying to get on with making a decision about where to go, is that we really are in the middle of a lot of activity. Many of the pilots that I've just mentioned, both in the public sector and in the private sector, are going to be running at least until 2014.

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That's not so long, but it means it will be a while yet until we know some of the results of the pilots. There are some early results that are available. They tend to be, not exclusively, but heavily primary care oriented, that's been true. In part it's because that's been viewed as a key way to try to improve value and a missing factor in our specialty dominated healthcare system. But, the fact of the matter is, most of the money and most of the physicians are specialists, so ultimately you've got to figure out how we're going to involve the specialty population. And, the evaluations, which will be very important since it's easy to say we want to pay for innovative organizations, at some point we're going to have to decide what exactly we think is worth paying more for because it's an innovative organization, and the evaluations are likely to help us here. Going through, it's clear that some of the pilot projects are using much more serious evaluation methodologies than others. It appears that the—at least CMMI pilots will either entirely or for the most part have formal evaluations done with it.

Nicely the GAO review studies or pilot projects that were done by nine different entities that includes some private plans and also some Blues plans, and it covered some 12 different activities. They have come out with four overall conclusions. There are some very interesting reports that are

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in there. If this is something you want to know more about I recommend you look at it. But, the four big takeaways they came up with is that it's much better to think about measuring performance at the practice level rather than the individual physician level, which is kind of clear why that would be the case. It's important to have some nationally endorsed metrics. It'd be really nice if we all could agree on standards set as soon as we're able to do that, especially difficult with some of the specialties. Better, at least as far as the physicians are concerned, to use either absolute benchmarks or a combination of improvement and absolute. It is helpful to pay incentives quickly, which the private plans tend to do. The public programs have a little more time getting their act together to do that.

The real challenge is going to be going from pilots to action. It's a hard thing for many reasons to do, because of the length of time that lapses. But, it's also because there are a lot of issues that are going to come back to haunt us when we look at the results. Self-selection, when you have voluntary pilot projects, is always a problem by definition. At some point. When we're ready to roll out, it's probably not going to be voluntary, but right now our results are voluntary. There's also a Hawthorne effect that many of you heard about, which is that people who know they're being watched tend to

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behave differently and it's hard to know how much that's affecting in addition to the self-selection. And, it's really hard to know the real net net, as you hear people say, of introducing these changes and that's for many reasons. One thing, you need to have a good risk adjustment so you really know whether or not there's patient selection that's been involved. But, you also need to know the cost that somebody else was picking up. There's a lot of money floating around now, a lot of high-tech money, and other money that has been going in to improve the information infrastructure, at least in some practices—probably, by the way, the very practices that are first to step up and volunteer to be pilots. So, we're going to have to figure out how much of the savings that we see are really net savings. We need to know whether or not these are likely to be generalizable to all patients or only to some patients, maybe very sick patients, or whatever. The pilot itself may help us answer that. And, we're going to need to know—one of the big issues we always stumble on in healthcare, which is, are we talking about one time savings or ongoing savings.

Given all these problems, there really does seem to be some convergence of thinking going on among some frequently disparate groups, like Gale Wilensky and the Commonwealth Fund, for example, some of the recommendations that I'm coming to

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seem hauntingly close to some of the ones that their high-performance commission has come out. I've looked at some of the recommendations and ideas that the American Medical Association has been talking about and there seems to be some distinct seedlings of similarity there as well. So, despite all these challenges, maybe, just maybe, we're getting a little closer to being able to make the move. Thank you.

ED HOWARD: Thanks, Gail. Let's turn to Bob.

ROBERT BERENSON: How much time do I have?

ED HOWARD: Eight minutes, officially.

ROBERT BERENSON: Okay, fair enough. Alright, so given that Gail has made a strong case, which I largely agree with, for really moving beyond fee-for-service to better payment systems for physicians, why do I entitle my presentation, *Why the Medicare Fee Schedule Needs to be Fixed?* I'm going to argue that we actually need to fix the Medicare fee schedule in order to move beyond the Medicare fee schedule to new payment models.

The first point I want to make is that fee-for-service, as reflected in a fee schedule for physicians with the 8,000 codes that Gail described, is not inevitably as dysfunctional as ours has proved to be. A number of other countries, the social insurance countries that actually have sickness funds or insurance companies that pay bills to private-sector physicians, largely use fee schedules. They're not nearly as

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complex as ours and they don't have some of the pricing distortions that we have. They do have their problems, every payment system has its problems, but they don't have our problems of generating this huge increase in volume and intensity. Here I do think it is necessary to say that for some reason that we don't quite understand, or we don't understand at all, the last three years we have not been seeing growth, and volume, and intensity of physician services in the physician fee schedule on Medicare. Whether that's a one-time correction with everybody looking at what's going on or related somehow to economic conditions, I'm not sure. But, it is fair to say that, at least that this snapshot in time, the fee schedule is not producing the same kinds of volume increases and that's one reason why the cost of the SGR, why the SGR is on sale right now, while the—why the estimate that CBO has made for how much it would cost to eliminate the SGR has come down in a little over a year from 300 billion dollars to 138 billion dollars.

It's basically two factors, one is the estimate going forward of volume and intensity growth is different and the number of people remaining in traditional Medicare rather than going into Medicare Advantage has been re-estimated. That needs to be taken into account in any reform of physician payment, that at least for now there's been some improvement, but I'm

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going to work on the premise that fee-for-service inherently creates incentives for increasing volume, some of which is not helpful, and try to address how we might deal with that problem.

The next point I want to make is that the problems of lack of coordination, lack of attention to prudent spending are probably inevitable in fee-for-service. It's a reason to move away from fee-for-service. Especially in Medicare, where increasingly beneficiaries have multiple chronic conditions, see many different physicians and other healthcare professionals, may have multiple hospitalizations, fee-for-service inevitably maintains payment in silos and contributes to fragmentation, so it's a reason to move to new payment and delivery—care delivery models. What I'm going to say here is that, albeit imperfectly, some of the—what I meant to say, some of the objectives for achieving higher value healthcare can be fostered even using fee schedules.

Let me go to my next slide, which actually very—I'm not going to go in great detail here, but I just wanted to make a couple of points about fee-for-service. It actually has its positive attributes. It rewards industriousness and there's a reason why virtually all, not virtually all, most capitated or globally paid multispecialty group practices, hospital owned physician practices actually use work RVUs, which is the core

of the fee schedule, to assess whether their docs are working hard. The lesson from the late 90s when physicians were bought out by hospitals and put on salaries is that the docs went fishing. It's a little exaggerated, but the hospitals thought that's what happened. Based on that lesson, they are actually using work RVUs to assess productivity. I think there are smarter ways to use notions of productivity than just encouraging a generation of work RVUs, but it is a positive attribute of fee-for-service.

the second one I'll talk about, if you can crisply define an activity that you are interested in promoting, paying fee-for-service is a good way to get it done. I know a number of states that have Medicaid managed care plans that capitate or globally pay providers, safety net providers, often for a population of Medicaid patients. They may do what's called "bill ups", they pay separately for immunizations to make sure kids get immunized. One, you can adjust the price when the cost of the vaccine varies into, you can actually, by paying fee-for-service, get the behavior you're looking for, So there's probably a role for fee-for-service even when we move to different models, but there are major disadvantages.

What we're seeing in the US is too much activity, not too little. It maintains fragmented care within silos, it has relatively high administrative and transaction costs when you

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have to submit a bill for one of 7,000 codes or 8,000 codes, and it's prone to error as well as gaming, that creates lots of transaction costs. What is not defined as reimbursable is marginalized so, it's not a surprise that we have lots of office visits being provided, probably too short in many cases, for Medicare beneficiaries with multiple chronic conditions, but we don't pay for phone calls, emails, other things. I don't think it's easy in fee-for-service to do that. We don't get the other forms of communication that most group practices that are paid under global payment actually have figured out how to do.

Fee-for-service has to pick winners and losers amongst activities. It is complex and susceptible to gaming and fraud and we are currently seeing an epidemic of up coding of office visits right now, which the OIG and others have documented. It is also susceptible to pricing distortions, it is hard to get the prices right. By pricing distortions, I mean payments that deviate substantially from the underlying marginal cost of production of that service. So, what we are getting in the Medicare fee schedule because of pricing distortions are too many tests, too many minor procedures, and probably not enough time spent with physicians and patients working through their problems, both face-to-face and non-face-to-face.

What do we do about all this? I'm going to argue here that the Medicare fee schedule, the question is, do we end it

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or do we amend it? Somebody used that sometime, I guess, or maybe I came up with that. One, I would say the alternatives are not easy, operationally or politically. A lot of the models that Gail talked about are very attractive theoretically, they are operationally very difficult, such as a bundled episode. I won't get into that at this very second. In the best case it's unlikely we're going to have 100-percent replacement for fee-for-service for all doctors all over the country. It is likely that we will have—and I hope we do, because we will have ACOs taking financial risks, being accountable for populations, that's what I want to have happen. I don't think we're going to have that everywhere and so there's probably going to be a need for fee-for-service at least for some parts of the country, and there's some physicians who probably won't be part of an ACO and somehow need to be compensated. Some probably rightfully should be paid fee-for-service.

Some of the more successful payment models internationally actually still maintain a component of fee-for-service. Denmark actually has a mix of about 40-percent capitation and 60-percent fee-for-service, they get their physicians to be taking after-hours call collaboratively, they seem to have balanced the incentives pretty well, it seems to work pretty well. It may be that fee-for-service remains part of an enhanced or better payment system.

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Another reason is that the way we calculate the rates of a lot of these new payment models, bundled payment models, global payment models, is by basically adding up the individual elements that go into that payment. If those individual elements contain distortions, the bundle contains distortions. There is a divergence in fee-for-service incomes, which go along with the comment I made earlier that we paid too much for tests and procedures, such that some specialties, cardiology, radiology, some others earn two and a half, three times more than primary care. Not only their overall compensation from all sources, but even if you simulate what their incomes would be using the Medicare fee schedule, that's the kind of distortion we have. How does a multi-specialty group recruit cardiologists into a ACO if they're making 100,000 $500,000 or a million dollars very happily in a fee-for-service system or, as what's recently happened, selling themselves to the hospital, which is related to side of service differentials which I'll get to in a minute.

I think you need to make corrections in the fee schedule to help create the environment, so you get a multi-specialty collaboration across the various specialties; try to narrow the winners and the losers. I would argue that the current level of distorted payments are not inevitable and there's sort of a general assumption that if you reduce prices,

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volume goes up to try to compensate for it. While that's true of some services, it's certainly not true across the board. In fact, I would believe it's not true mostly. And, I point to the Deficit Reduction Act of 2005, where to do the doc fix that year the Congress had to find some savings, so what they decided to do was reduce payments for imaging services to physicians to no more than what it costs to an outpatient department.

The GAO did the initial study of what happened in 2007. Prices came down substantially, 13-percent savings, but volume growth actually decreased. It still was going up, but not at the same rate and now five years later, imaging growth is flat. The behavioral response to the price reduction actually was not to increase volume. I think you can actually use price much more creatively to affect volume.

I'm over time, so I'm just going to put this up here and not go through each one of them. I have some suggestions for some immediate steps to improve physician payment as we are anticipating the results of the demos that Gail talked about. The first one is to repeal the SGR now that it is on sale, but in the Qs and As we can talk about some of these other ones, which I think would strongly improve the current functioning of physician payment and set the stage for moving to new payment models. Thank you.

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ED HOWARD: Jim?

JIM HAHN: Thank you. First, thanks Ed and Stu, and thanks to the Alliance and the Commonwealth Fund for inviting me to be here as part of this panel. I am with the Congressional Research Service; however the first thing I need to say is I'm not authorized to speak on behalf of CRS, so that nothing I say should be taken as a position by the organization.

To follow up on what has already been presented with a little bit more detail, little bit more explicit discussion about what could be done to modify physician payments under the Medicare program, and what has been proposed, and what each of these actions might actually mean. When we talk about the Medicare physician payment, there are some fundamental concepts that we need to address. The first is what's the basis for the payment? We've already heard a lot of discussion already about fee-for-service. Other options are to include bundled payments, as Gail pointed out, where each of the items is not so small and minute, but are more aggregated. Other options are to pay on a capitated basis and I would point out that even though the Medicare advantage program pays—plans on a capitated basis, the providers are often still fee-for-service, because that's a separate negotiation between the plans and the providers. It is possible—Kaiser is one place where they do have payment by

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capitation. Another option is to pay on the basis of salary. The doctors in the room might have just had a little tremor, but that's another option that some people have proposed that doesn't tend to get a lot of attention sometimes.

On top of that, you have additional bonuses and add-ons that can often be applied no matter what your fundamental basis of payment is. By this I mean, for instance, the pay for performance bonuses. You could do that on top of fee-for-service, you could do that on top of salary, which we do in other industries, you could do it on top of a lot of different types of fundamental payment structures. Similarly, the value-based modifier that was mandated in the ACA is another modifier that wraps around what is the underlying payment service. Again, quality standards being another type of bonus or add-on. Sorry, I wasn't—you have your slides. I apologize for that.

The second question about after what you have as your basis for payment is how you update from one year to the next, how you're going to pay these doctors. There've been a couple of ways that have been tried. One is you set it to an index and common indices that have been used would be, for instance, the Medicare economic index, which is a measure of the change in the price of inputs required to produce physician services. Another commonly referred to index would be the consumer price index. The other way to increase payments from year to year is

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to balance, against some sort of a target and we've already mentioned a couple of times the volume performance standards. The other thing that we have in place right now is the Sustainable Growth Rate, so that's where the SGR fits into this entire discussion.

The next point I'd like to make is to just get some of these terms out of the way, because I want to make sure that we're all on the same page as we start to get into the discussion phase. I think most of you are already familiar with work being physician work, practice expense, and professional liability insurance components of the three categories that make up the fee schedule. Then, we have the relative value units, which are the weights assigned to each of those categories across the 7,000 different codes. There's something called the GPCI, the Geographic Practice Cost Index, which is how we adjust for geographic differences in the price of inputs. And, then we have the Sustainable Growth Rate. So, with that being said I'm going to borrow a phrase from a movie I think most people in this room have seen, which is to say that the Medicare physician fee schedule is sort of like ogres, which is to say they're sort of like onions, which means there's a lot of layers.

Here's my Medicare physician payment ogre or onion, whichever you prefer. First I'd like you to focus inside the

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square box. So, the vertical label on the left side of that square box says the adjusted fee schedule payment rate. Inside there is what constitutes the fee-for-service payment. It's a combination of these RVUs, these GPCIs, conversion factor, but that's what gets you fee-for-service payment. Outside of that square in the rounded rectangle you have other adjustments. These are the adjustments that I talked about earlier, for instance the EHR meaningful use. Once you have your physician payment for your standard unit, you can then adjust it for policy objectives like the value-based modifier, or if you want to give a bonus to underserved areas, or EHR meaningful use, or MPPR, the Multiple Procedure Payment Reduction policy. Those are what you use on top of that. Again, these types of adjustments can be made to any kind of payment system that you put inside that square box. We happen to have a fee schedule, but again we could have different payment based on bundled payments, based on risk sharing, based on something else and we could still apply these other adjustments in much the same manner that we do it now.

Then you'll notice I haven't said anything about the SGR yet. The role of the SGR is that once you have the payment that you're going to pay providers for one year, how do you figure out what you're going to pay them the next year. That's where the SGR comes in and the update calculation, for those of

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you who want to get technical, it's actually an application to the conversion factor up to the top, but it's the SGR that determines how the payments change from year to year. We've already heard some discussion from Stu and from others about how there's measurement against target rates, and growth rates, and actual versus targets, and all that.

Basically the point I want to make here is when people say, let's just repeal SGR, what you're essentially doing is getting rid of this, which means you have no way to get from payment from one year to year two. Okay? When you literally hear people say, let's just repeal SGR, SGR is the statutory method by which we go from payment in one year to payment in another year. Again, you'll notice that SGR here is separate from the square box. In other words, we could have a different payment based on bundled payments, or capitation, or salary and we could still apply SGR. Now, it turns out that most people don't think that's a very good idea, but what I want to make clear is that in the discussion that we have about what do we do about physician payment rates, when we say let's get rid of the SGR, what I think most people are also saying is let's also change what's in that square box, let's also modify the fee-for-service base or keep around for a while as Bob was saying, but let's maybe put another square box up next to it so that we have a couple of things going on.

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To be clear, when we repeal the SGR, all—if that's technically all you're doing, then all you're doing is you're removing the update factor from year to year. I think what most of the discussion is actually about is how do we reform all of Medicare physician payments so that we have payment system that maybe captures what we like about fee-for-service, but also incorporates the incentives for value, the incentives for quality, that we might get—like in a different kind of payment system and we have along with it a way of modifying the payment to go from year to year, because nobody seems to like the SGR.

Generally, and I should say that I'm not going to be talking with—in specifics as far as such and such bill number does this or so-and-so proposed that, rather I'm going to talk in more generalities to talk about the principles and the ideas of what might be done. There seems to be a coalescence about the general approach now that people are unhappy with the SGR, which is to say that the first thing that needs to be done or the first thing that most people argue is necessary is some sort of short-term payment stability. We had one year, 2010, where there were five different modifications to the SGR override. That is just impossible, from a managerial standpoint, to try and deal with on a year-to-year basis.

Most of the discussion now is in agreement that we need some sort of short-term payment stability. There's disagreement

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as to what short-term means. Some people say two to three years, some say five, some say longer than that. But, the first part is some sort of short-term payment stability. The second is, while that's going on, we need to field test and then evaluate all these different alternative payment methods, the kinds that Gail has been talking about and everybody else on the panel. Because, as we pointed out multiple times, even if we were to say, okay, we're going to get rid of the SGR and put something else in place, we don't have consensus. Not only do we not have consensus, we don't have a very good idea of which is successful and why, when we are actually to let it loose in the wild.

We know that certain things seem to work in particular isolated areas under certain conditions, but we have very little information about what happens when we try to scale up nationwide. The second phase is to get some more information about the types of alternatives that are out there, how successful they are. The third point is how do we transition to the new payment system? We need to think about what time frame we want to have, how we are going to do the phase in, because some of these are going to carry very different adjustments and incentives for providers as well as beneficiaries, potentially. Trying to make the Titanic make a sharp right turn is probably not going to work very well.

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What has been proposed? Recently, the types of proposals—let me hurry up a little bit. The types of proposals that have been put forth include everything from modifying the fee-for-service, much like Bob said, let’s improve the RVU accuracy and perhaps adjust the weights. Capitation, I’ve already made that point. Gains sharing, much like the CMI initiatives that were going on. Bundled payment and others, for instance some people say let’s just allow balanced billing and that will be a way to do it. Then as I note at bottom, there’s also been proposed this idea, let 1,000 flowers bloom or in a different time it might’ve been the 1,000 points of light.

The idea that we don’t know and we currently don’t yet have a good assessment of what works, so let’s just encourage a lot of innovation out there and then see what filters out. All of them, or most of these ideas include, in the end, an incentive to move payment based on something else other than fee-for-service, so again, recognizing as Bob pointed out that there might be a need for fee-for-service in some circumstances or some areas, for most practitioners the idea would be to have it be such that, for instance, there might be a reduction in the fee-for-service payment to make the alternative much more attractive so that there would be a choice by providers to move to a new payment.

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On the point of bonuses and add-ons, as I pointed out, most of these are policy oriented, including the EHR quality value. I will move ahead for time purposes, then the question of, what do we do about the update? I made the point very clearly, not only do we have the basis for how we pay, but we have to think about how we update it from year to year. Some of the proposals have said no updates of all, in other words 0-percent in perpetuity. I don’t think that’s going to be a long run solution, but it’s been proposed. The other proposal that has been put out there, which responds to some of the criticisms that have been made here about how the SGR formula treats every doctor the same, is let’s have multiple update factors.

Those proposals have ranged from let’s have six different categories, which you can see up here and we can have different responses over—across the different types of care or we’ll make it simple and we’ll just have primary care. Other ways of applying multiple update factors take into account value, for instance. There’s also the suggestion that Gail and others have put forward, where you do multiple update factors at the at the practice level. Is that right, Gail? Right. There would be—you could be a GI practice down the block from another GI practice and you would have different update factors, depending on these metrics that you may or may not hit. The

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other thing, which is not up here, is some people have said, let's just reset the base year. I don't know if anybody mentioned, but the current SGR method goes all the way back to 1997, which is BBA, which is when we started, so all the calculations have been made relative to 1997.

One proposal has been, let's just push the reset button and rebase things based on this year and then keep it going forward. The problem, obviously with that, is we haven't really solved anything, we've changed the numbers underneath, but we really haven't changed the underlying incentives and factors. So, I'll just leave you with these four questions.

Answer these four questions and we'll be done. One, what's the basis for payment, what is it going to be for Medicare physician services? Will we allow multiple physician payment, as many proposals have said? Well, let's have some—there might be geographic differences, there might be urban versus rural. So, do we want to have that? Second, how will the payments be updated? And then finally, how will the transitions occur? Just four simple questions.

Ed Howard: Okay, great Jim. Well, maybe we ought to just ask our panelists if they'd like answer any or all of Jim's questions at this point. I sense a hesitation. While you're thinking about those responses, let me remind you of the green cards that you can use to fill out a question and hold it

up and come forward. There are microphones here. If you go to the microphones to ask your question, we would appreciate it if you would keep it relatively brief, and identify yourself, and direct it to whoever you would like to have respond.

Gail Wilensky: I'm not going to answer all four questions, but I do think there is a, maybe, growing recognition to Bob's comments about the need to improve the RBRVS, because it is likely to be around for some time. It may be for some practices, either small practices, around a very long time, depending on whether virtual practices become a concept that's relevant. Doing it with the intent of finding a way to incentivize movement for large numbers of physicians, but recognizing that's not probably a good reason to keep some of the particularly unattractive incentives that are currently in place in the RBRVS.

ED HOWARD: Does the fact that 50-percent or more of physicians are now employed make the RBRVS and the SGR itself less problematic over time?

GAIL WILENSKY: It makes it not exactly Medicare's problem. It makes it the hospital's problem and they can figure out what kind of mix. Most smart organizations don't use flat salaries without some kind of adjustments, either for their bonuses, reflecting productivity, satisfaction, whatever it is that they think is important for their population, but it does

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reduce the numbers. It's still a big enough number that it is going to remain as a substantial issue.

ROBERT BERENSON: I'll agree with that and as I said earlier, virtually all hospitals that are employing physicians are not putting them on salary, they are calculating the work RVUs that are generated. Our current RBRVS system says that an orthopedists' work minute is worth 2.5 times almost, the worth of a family physician and some sort of pretty smart—well, in a case, they are using productivity. So, it is not Medicare's problem, per se, but everybody is using Medicare's fee schedule, either for their own fee schedules—virtually every private insurer now starts with the Medicare fee schedule, tries to have some uniform conversion factors, negotiates individual deals with individual practices, they deviate from those fee schedules. Now increasingly multi-specialty group practices in hospital owned integrated delivery systems are using the work RVUs from the Medicare fee schedule to assess how much work their docs are doing. This is now part of the national health system, it's not just the Medicare problem.

ED HOWARD: Yes, Joyce?

JOYCE FRIEDEN: Joyce Frieden, MedPage Today. I was wondering if any of you could comment on any of the proposals now in Congress to repeal SGR, to replace it, or what's coming

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out of MedPAC in terms of whether you see hope in anything you've seen?

JIM HAHN: Well, the MedPAC proposal that came out in fall of 2011 was their most recent, I believe. Although, I think they are about to issue another one.

ED HOWARD: Actually, today their March report reiterated those same recommendations.

JIM HAHN: That was not very well received on Capitol Hill. So, that proposal—and, just to refresh, essentially they suggested two different categories of services, primary care and all other. They were going to freeze primary care for 10 years, put three years of cuts in all other, and then freeze the other ones for another 10 years. Again if you go back to my schematic, inside that square box about how they pay, they didn't do anything to change the fundamental basis for how we pay. All they did was change the update. So, that—

ROBERT BERENSON: But, MedPAC proposal did have a number of suggestions for correcting a lot of the distortions in RBRVS. It didn't have a recommendation to do away with the fee schedule, but it had a number of recommendations which they've now reiterated for recalibrating how those values are determined.

GAIL WILENSKY: The problem of course, with doing that, is that the most aggressive physicians end up being able to

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compensate for same or reduced fees by putting volume in its place, assuming that is a sustainable strategy given the kind of medicine that they happen to be practicing or that they can use other activities of neighboring areas of medicine in order to compensate. The incentives remain fundamentally unhelpful, it just would try to give a little more money to the primary care physicians.

ROBERT BERENSON: The incentives—and, that's why MedPAC and others have been—if you're doing fee-for-service, you inevitably are then going to talk about, should you be maintaining the Stark in-office ancillary exception, which permits physicians to self-refer for a series of services? There's now pretty good documentation that a lot of physicians—imaging became the cost celeb in this area with physicians who own their own advanced imaging equipment are able to get a Stark exception and drive a lot of volume. I was at a meeting, it was actually a Commonwealth meeting, a few years ago when an administrator of a cardiology group of 11 doctors was talking about how they had a PET scan, an MRI machine, and coronary angiography, and was upset that Medicare was cutting the fees. They had no business with those services and yet they had an exception to be able to drive volume. Now what seems to be happening is a lot of physicians, like dermatologists, gastroenterologists, and others who used to refer their

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pathology out to a pathology lab now hires a pathologist. They do, in some cases, twice as many slices for a benign skin lesion, get twice the payment. That sort of goes with fee-for-service. I guess what I'm saying is you're sort of left with having to regulate a lot of this. You have to maybe say, you don't get to do it or we're going to do prior authorization for areas like imaging, which have shown abuse. You're sort of, in a fee-for-service world, sort of stuck with having to regulate more than you would want.

ED HOWARD: Yes, go ahead.

CAROLINE HOFFMAN: One quick comment on RBRVS.

ED HOWARD: You might want to identify yourself.

CAROLINE HOFFMAN: I'm Dr. Caroline Hoffman. I'm a primary care physician, I'm also an attorney. One comment on RBRVS, one thing we could do is we could open up the procedure. The AMA now has a protected part in the process, it makes recommendations, its proceedings are closed, it chooses the members. There is nothing in the statute that authorizes that. They could open it up, they could bring in economists, patients, other people to comment on the value of procedures. My question is, I was little bit late. Steve Brill wrote a cover story in Time two weeks ago about the prices that we pay and Medicare looked pretty good in that, everybody else was paying far more. Have any of you thought about the implications

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of that article, if you've seen it? If you haven't seen it, you need to.

ROBERT BERENSON: I would daresay we've all seen it.

GAIL WILENSKY: I would also like to remind people it was primarily for middle and upper middle income people who were uninsured.

CAROLINE HOFFMAN: Right.

GAIL WILENSKY: I think after next year they'll probably be somewhat of an endangered species.

STUART GUTERMAN: **S**aying that Medicare looks good relative to the prices that the patients that were highlighted in the article look like, depends on whose perspective you're using. Certainly not from the hospital, Medicare doesn't look good. The question is still how do you get the right prices and how do you pay, what do you pay for. When I made my opening remarks, I used fee-for-service sometimes to refer to unfettered fee-for-service. That is fee-for-service that really pays for the individual, small-scale service and pays more for intensity, regardless of how necessary it is. I think what all the speakers here have talked about is different ways of getting to paying for the right thing. Because, if you define the service as really the service from the perspective of what does good for the patient, you definitely want to pay for that, but, if you pay for that it may be a different set of

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incentives than if you pay just for the production of volume and intensity.

ROBERT BERENSON: My comment would be, first, the Brill article dealt with hospital prices. On the physician side it's pretty well documented, MedPAC follows this every year, that MedPAC on average pays about 20-percent less than private insurance fee schedules. We did a study with the—we, meaning the Urban Institute—with the medical group management Association a few years ago for MedPAC, in which we simulated what physicians' incomes would be if everybody used the Medicare fee schedule and it confirmed that finding that it would be about 20-percent less than their actual—well, with Medicare being 30-percent, it's about 12-percent less, but that's a calculation. It showed that some specialties would be earning in the mid-$400,000 a year level if Medicare's fee schedule was used by everybody. One can make a judgment as to whether that's too high, or too low, or what, but at least there is some—I would say that there is some reason to think that there can be some pressure on certain specialty compensation with some redistribution, not that the primary care, at about 160,000 is hardship, but there's relativity here. But, at least we can cause a judgement. I think there's some room to be relatively hard on—and I was part of the MedPAC proposal that was dead on arrival, as Jim says. Looking at the

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data, I don't think we have an imminent problem of a lot of doctors leaving Medicare. I think it is a balance between assuring access and not, but I think a lot of physicians don't have much of a practice if they don't see Medicare beneficiaries.

CAROLINE HOFFMAN: Exactly.

ROBERT BERENSON: I do think I wouldn't see a 0-percent update for the next 10 years, but I do think it can be relatively lean.

CAROLINE HOFFMAN: Thank you.

ED HOWARD: When you made those recommendations back in 2011, the price tag for the fix was a little higher than it is now.

ROBERT BERENSON: I don't know why the proposal didn't change at all, but I'm no longer on MedPAC, so I no longer have to speak for it.

JIM FASULES: Hello, Ed. Jim Fasules, I'm a pediatric cardiologists. I wish you would put a rebuttal person up there, because there are a lot of statements that have been made about cardiologists and about physicians. First off, before anybody gets this confusion about the RBRVUs, that's the total RBRVUs that are generated. When Dr. Berenson talks about GPs versus orthopedists, I see a patient for an E and M, which is an office visit, I get paid the exact same amount whether I'm a

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general practitioner, a specialist, or whatever. We also have to look at the amount of time that puts into it. Cardiologists are the second-highest hours, 72 hours a day—or, week, excuse me. Where, some of the generalists are under 40, so, you can't—you're getting apples and oranges. You can't listen to everything your hearing. Second, the DRA did not decrease all of imaging, just the high-end imaging things. Already in 2007 we were seeing a reduction in echocardiography and nuclear cardiography and we've seen in the last year an 8-percent reduction in that and a 40-percent reduction over about five years that is not related. Let me tell you what can be done, what is being done in these organizations, something along the lines that David Shear is doing up in Michigan.

First off, unique data. If you're just using claims data it's not going to work, you need clinical data and that's where registries come in and actually tell you what you're doing. And then, getting that data, such as what we do with appropriate use criteria, so you'd know whether the study is appropriate or not and getting that data to the physician and have them compared to how they are doing to their peers, both locally, regionally, and nationally, in their appropriateness. When they do that they actually act and they actually reduce their inappropriate rates by about 50-percent. We also have to get that data to the primary care doctors, because in some

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regions, 50-percent of echocardiography is actually done in the primary care offices. In my practice, about 30-percent was sent into me to be read and I would say that all of that was inappropriate. There is education that has to be done. When you try to just do things on pricing, you get that drastic move like we saw in 2010 with 50-percent of cardiologists' private practice moving into the hospital because their practices were now non-sustainable. We won't into the vagaries of the PPIS (misspelled?) data and the physician—and the practice expenses on that, but I think you have to look a little deeper than this than saying things, that doctors are making a million dollars, doctors are bad, salary doctors don't work. I was a salary doctor and academics professor, I taught the primary care docs, I took call every night, 60-percent of the calls I got were primary care calls, because the primary care docs weren't on call. I agree with what's being said here, I think there's a lot of hyperbole that's being said there. There are a lot of things that the specialist and specialist organizations are trying to do to improve things. Let's not just say it's a problem with specialists.

ED HOWARD: Jim, before you go, do the cardiologists have an institutional proposal to deal with the SGR?

JIM FASULES: One of the things we worked with is getting the registries into the Taxpayer Relief Act so that the

registries can be used now for the PQRS and even going on to the value-based payment system, so that the measurements that they're going to be looking at and compared to will be measurements that are pertinent to the cardiologists. Second, we would use what we would say decision-support tools that I just talked about that are out there. Blue Cross Blue Shield has put them into place in Delaware and we've seen a reduction. We can identify the outliers and then we can actually work on the outliers who are doing the inappropriate testing.

The problem with the pricing and all this—let's just ask a question here on the SGR for instance. We've had a 30-percent reduction in mortality from acute myocardial infarctions in the last decade. That means we have more people living. That means we have more people living with coronary artery disease. That means we have more care. That means we've actually had improvement in quality, but increased the volume. The volume increase that you're seeing is being attributed by—to feathering the nest. The volume's gone up and we've actually, in the past seven years—don't use 1996 to 19—2007 when your—the growth of a procedure is increasing and it's just like a child reaching—going from pre-puberty through adolescence to adulthood and then plateauing when it's disseminated and it's in use. From 2007 on there's been a consistent decrease, and I'll refer you to an article in the

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Journal of American College of Cardiology persistent decrease in standard cardiac imaging over the last seven years.

ROBERT BERENSON: Two quick comments. I don't—I could get into a debate, but I don't want to. I would just clarify two things—one thing, actually, is that the study we did comparing relative returns under the Medicare fee schedule also did it per hour and it showed the same kinds of differentials of returns per hour under the Medicare fee schedule, about 2.5:1. I think all physicians provide valuable services. I'm not sure that I would say that the problem in Medicare—that our need to provide a mix of services for Medicare beneficiaries should support that kind of a differential. I'm all in favor of what specialty societies are doing, indeed I'm quite skeptical about our ability to measure with three measures from PQRS what an individual physician does. And, I would look to specialty societies to take the lead on improving quality and giving credit to physicians who are actively involved with their specialty societies and those kinds of innovative programs that Jim mentioned. So, I don't—I think probably we have polarized our discussion more than needs be. I do think there is a basic issue of reasonableness of rates of return of physicians.

STUART GUTERMAN: Let me point out that I think we'll have success in our health system when we've appropriately balanced primary care, and specialty care, and put them both in

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a position where they work together to work toward the interest of the patient. Some people conceive of primary care, Patient-Centered Medical Home, and other primary care oriented policies as saying that only primary care physicians ought to be providing services to patients and that's wrong on two counts. One is, it's not only physicians and secondly one of the roles of Patient-Centered Medical Home is to be able to hook up the patient to a specialist when he or she needs that specialist and to hook them up to the right one that can help them best. The last thing we want is a specialty war in healthcare.

ED HOWARD: Yes, Bob?

BOB Rourke: Bob Rourke [misspelled?], EMJ. How are integrated systems like Kaiser Permanente, Geisinger, how are they reimbursed for Medicare patients? And secondly, what is the quality measure—what are the quality outcomes from there? Finally, internally for that patient population, are they losing money or making money on these patients at these current rates of reimbursement?

GAIL WILENSKY: Those are big complicated questions. Let me attempt to give some response with regard to Geisinger, which I know better than Kaiser. How they get paid depends on how their patients enroll, because almost all of these places take both traditional Medicare where it's fee-for-service and participate in Medicare advantage. And, so there—if they do

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they can be paid in two different ways. A place like Geisinger has a mix of populations that are capitated and those that are fee-for-service. And, I would assume that's true for many of the other integrated delivery systems. What is interesting is how they pay their physicians and again, it depends on whether you're talking about their employed physicians. There is an article recently, I think last fall in Health Affairs, that Tom Lee wrote with Al Botha [misspelled?] and Glenn Steele describing what Geisinger uses, which is a tiered type of payment, a base salary amount that reflects market conditions among other things. And, then a component for productivity, and I believe a component for patient satisfaction. But, they also have some physicians that they use that are not their direct employees and then they pay them usually whatever—however they are otherwise being paid. Their statistics are quite good. Typically, if you look at the star quality ratings, the integrated delivery systems tend to do better. They can reach their physicians more effectively and make sure that they're complying and that the patient is receiving the types of screening and preventive care that is primarily driving the star system easier than those that are just network-based physicians. How they do depends on who's paying. It is clear that they do better with some payers than other payers and engage in cross subsidies like much of the rest of healthcare.

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BOB: And, do they make money?

GAIL WILENSKY: Well, they seem to be all growing and thriving. They're not-for-profit, so within the funny concept of the not-for-profit world, their revenues exceed their expenditures. And, as an economist, I assume there's an appropriate return to capital somewhere in there as well.

STUART GUTERMAN: If I can make two points that have come up in the course of this discussion and I think are relevant to how we think about these things. The question about whether some of these initiatives are successful in terms of making money for the folks who are doing them raises a question that comes up every time you talk about pilots or new initiatives. And, that is how do you evaluate a pilot that's intended to change the way we provide healthcare in a system that's inherently hostile to those kinds of changes? And, I think that's something that we'll continue to have to take into account as we look into these things. How do they work and how do they promise to work if you actually can change the system, which is the end goal of all of these things. And, that's going to be a real challenge, especially for the innovation center at CMS, which is required to convince the chief actuary that these things can save money if they're going to extend and expand those pilots. The other is this notion has to do with rivalry between specialties, but also generally the environment in

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which we pay for healthcare. I've heard a lot—it hasn't been mentioned here, but I've heard a lot of people referring to health reform as representing a shrinking pie in terms of providers fighting over shrinking pie in healthcare revenues. Think about it, the most optimistic projection of what we'd like to see health spending grow by over the next decade is GDP growth, right? Well, GDP, even with moderate projections of growth, something like 40-percent over the next 10 years and hopefully more than that. And, I would posit that only in healthcare would a 40-percent increase in industry revenue over 10 years be called a shrinking pie. We have to start to look at things a little differently. We have to look at the fact that we're projected to spend something on the order of 40 trillion dollars on health care over the next 10 years and talk about how we can best use those resources to support the kind of healthcare that our system needs. There should be room under that for everybody to make plenty of money and for us to, in fact, get better health care than we get right now from our system. So, that's really the kind of context in which all of these things have to be viewed.

BARBARA KORNBLAU: Hi, my name is Barbara Kornblau and I just—I wanted to point out two things. One, I'm a past president of the American Occupational Therapy Association and I want to remind everyone that the physician fee schedule is

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also used for physical and occupational therapists. So, it's not just people that make a real lot of money, it's people that make a living wage. And, one of the things I would hate to see is if we do capitation, what happened in the 80s when capitation first came in was that a physician would get the amount and they would pay—they would be in charge of paying for the therapy if they were referred to therapy, so people just didn't get any. So, whatever system comes in has to take that into account. And, the other thing is with an n of one, my husband and I moved here, he went on Medicare and we were only able to find a primary care physician to treat him by going to ZocDoc.com, which I highly recommend if you're on Medicare and you want to find someone who will take Medicare. I have no financial interest in them, but after 20 phone calls to primary care physicians that were recommended to us we weren't able to find anyone to treat him other than from ZocDoc. It is a real problem and the reply was always, well if you are an existing patient and you turn—you become Medicare eligible, we'll keep you and we'll let you know every six months if we're going to dump you are not, because it depends on the SGR. So, it's a real problem that needs to be addressed.

GAIL WILENSKY: And, that—this issue about accessing primary care for new patients is one that has been documented. In general, the evidence thus far is that Medicare

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beneficiaries do not have difficulty accessing physicians. But, particularly in some metropolitan areas if you're a new patient, accessing primary care physician can be difficult. Most physicians will continue to see, even if they make threatening statements like that, their existing patients when they age into Medicare, but of course that doesn't mean that there's no problem for a new patient. We know—you hear a lot of discussion about what we're going to do to try to increase the capacity of primary care delivery going forward, because we know with an aging population that there is going to be increased demand to say nothing of the up to 30 million uninsured who are going to gain access over the next few years, that there is going to be a lot of increase in demand for primary care type services. We better start being a little more imaginative in terms of how we think that can be appropriately provided, because otherwise we're going to put many people in danger of having very missed expectations, but I think we can do it. But, that was a good qualification.

ROBERT BERENSON: Yeah, I'd add one other point. I think your point raises one of the major constraints that Jim's boxes demonstrates. The CMS has to determine what the resource costs are of the—how much it takes to produce a service. It's a combination of all these factors, the practice expense, and the liability, and the work of the physician, and it's—doesn't take

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into account—it statutorily isn't supposed to take into account, can we get access for beneficiaries to the right mix of docs and providing the right mix of services? So, I could argue and do believe that there should be some ability for CMS to use some discretion and say, if we've got some areas where we can't get anybody a primary care doctor that we might be able to adjust the fees to try to help do that. It's tricky. What the Congress did in the Affordable Care Act was for five years there's a 10-percent bump up in primary care. We now do that through statutory action. We are—CMS is constrained by the law now, it has to only change relative values through this arcane process, which is politically difficult with—as we've heard with fierce defenders of the status quo and I do think we will have, and do have, a primary care access problem. If you go to Manhattan you have a lot of docs of all kinds who don't even see Medicare patients, they are—they don't participate—I'm sorry, it's not that they don't participate, they opt out. They have nothing—and, increasingly in DC and some other affluent areas. This is not the broad pattern across the country, but it is certainly true in some geographic areas.

ED HOWARD: Yes, go ahead.

JANET PHOENIX: Janet Phoenix, George Washington University, School of Public Health. My question really has to do with that balance between access to primary care and access

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to specialty care. One concern I have is that there are areas, especially areas where we're going to see a growth in access to care as a result of Medicaid expansion where access to primary care may actually be adequate, but access to specialty care is very difficult, especially for underserved populations. And so, the question I have is whether, as we move forward, in terms of proposals that we evaluate for the doc fix, that we can take into account that what we do may aggravate the problem in terms of access to specialty care, especially for populations who need—because of a burden of chronic disease, who need to be able to access specialists more easily and need to be able to access specialists earlier in the course of disease, so that overall the cost of their care can come down. But, this is going to be a burden that the entire system will have to bear if what we do makes it more difficult for people who have not traditionally had access to specialists as easily, because specialists had been unwilling to accept the reimbursement or because of geographic disparities in care, the erosion of the safety net system. Specialists being in wealthier parts of cities, not so available in less wealthy parts of cities. So, that's my question.

ROBERT BERENSON: Well, I think you're probably referring, in most cases, to the Medicaid fee schedules in many states. Because, again, I don't think there's a problem of

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access to specialty care for the most part in Medicare. There certainly is in Medicaid and you've got some states whose fee schedules are pegged at about 40-percent of Medicare. And, I don't—I'm not surprised that a lot of specialists don't participate in that. Typically, you do get better primary care participation and often there's relationships with community health centers, safety net hospitals for primary care. So, that is, I think, a special problem, which I agree has to be dealt with. I think if there were a way of getting—well, I don't know what the solution is. With states being so hard-pressed with their budgets to—there have been attempts by some states to raise the specialty reimbursements, but then you've got pressures—budgetary pressures. It is one of the advantages—I have mixed feelings about moving to physicians employment by hospitals, but one of the advantages of it is you probably do get more specialty participation because they're no longer making an independent practice judgment as to whether to accept the Medicaid fee schedule, they are now part of a system which is going to make a decision to participate and accept Medicaid fees. And so, that is one of the positives, I think. I don't—it would be better if we had more adequate fees and Medicaid for specialists.

ED HOWARD: We've got a quick question here that someone is raising in terms of the sale that we are now

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experiencing on the price of the SGR. The question is, when does the sale end?

GAIL WILENSKY: Senator, it may well be as soon as the economy recovers. I think that people have been very careful today in talking about what our unusually slow rates of growth in spending in Medicare and in healthcare in general. We need to recognize, as Bob and all of my colleagues have done, we don’t understand why that’s going on. And, I think that it is highly likely we will see some bump up when the—we get to a period of between 5- and 6-percent unemployment, real unemployment, a lot of the hidden unemployment out, that we will know whether or not we are in a really different period or not. But, if I were trying to get this fixed, which I have been unsuccessfully for the last decade, I would say this is probably about as good as a time as we’re going to see and we ought to move forward.

ED HOWARD: Take the deal now.

GAIL WILENSKY: Next year may be a different—because, you can do a 10 year horizon and that’s really the danger. As soon as you start seeing a bump up that makes the projection outlook not so nice. If you look at CBO longer-term forecasts, Medicare and Medicaid and the entitlements in general are not looking so great in 2030, 2035 period. So, at least there is

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some appreciation that our current experience ought not to be or is—may not be generalizable for the next couple of decades.

ED HOWARD: Okay, before we go to the next question I would just say we have only a few minutes left. I would ask you to listen to the Q and A with your pen in hand and your blue evaluation form underneath that pen. Yes, go ahead.

MALE SPEAKER: [Inaudible] Georgetown Medical Center. A lot of the hopes rest on physicians changing their practice patterns. A lot of those hopes, I think, are related to physicians relating to integrated medical systems like ACOs. ACO is predominantly—[inaudible] substantially will be hospital-based organizations with hospital administrators who have an overwhelming concern for the fiscal well-being of the hospital, which is not well associated with decreasing hospital admissions, which would decrease expenses substantially. I would appreciate it if you would comment a little bit about your thoughts about our future relative to ACOs and the risk associated with them being monopolists, oligopolists, and being able to maintain high prices.

GAIL WILENSKY: Well, I would make a distinction. I'm very concerned about the general problem you've raised. I don't regard it as particularly an ACO problem, but we are seeing, as has been referenced, a significant increase in the number of hospitals that are employing physicians. There are a number of

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the ACO’s that are hospital led, there are also a number of ACO’s that are physician led. One of the reasons that I have been so interested in looking at the kind of private pilot studies that are being done is that I am concerned that Medicare is focusing too much on bundling physician and hospital payment and not at other strategies that might have similar outcomes or to try to encourage a real integrated delivery system like the Geisingers and the Kaisers of the world.

I’m very worried that if we end up with even more empowered hospitals, unless we drastically change the reimbursement system that we have now, we will be having hospitals who make money by keeping beds filled. Integrated delivery systems, multispecialty physician practices, depending on how they’re reimbursed, can do well by keeping people well and out of the hospital. Unless we do something that changes the existing incentives, I think we can be setting ourselves up for a very difficult time ahead. Whether ACO’s, as they’re currently structured, are going to be a part of our future, I don’t think we know yet. I’ve regarded them as likely to be transitional organizations, getting physicians who have not been working with other physicians or working with the hospital other than in an adversarial way, working together. And, that it will hopefully lead to a more stable, long-term arrangement,

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as opposed to a step in that direction. We'll see how involved patients are in ACO's. It's not clear, at least in the Medicare world of ACO's, how involved they will be in trying to have better value healthcare. And, that's going to be an important part of our future, as well. So, I—the phenomenon you've raised is one I worry about a great deal, because I think there's been a dramatic shift in relative power to hospitals over the last decade and the employment of physicians is just adding to it.

ROBERT BERENSON: Just a couple of quick comments. I think this was characterized or called "Big Medicine" by Atul Gawande in the Cheesecake Factory and he painted, I think, the rosy scenario, pointing towards efficiencies of largeness, about new capabilities, the right mix of innovation at the local level versus system—routinizing things. I'm not convinced and I'm very worried about hospital dominated healthcare. Although, in small communities the hospital is the logical place, I think, to be the organizer of care. I don't think that's right in large metropolitan areas. I'm worried about the monopolization. I heard a presentation the other day by Jeff Goldsmith, who many of you probably know, he's worked with hospitals for more than 30 years and I hope he writes this up, but he thinks actually the current hiring employment of physicians is a losing strategy for hospitals, that we will see the same thing that we saw in the 90s, which is unwinding these

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arrangements, that it is not economically sustainable, even with the current side of service differential that pays hospitals entirely too much for the same service that you can get in a physician's office. So, I don't know how sustainable the fee-for-service oriented hospital owning physician IDS is and I think I share with Gail some skepticism that the hospital is the right place to really do population health, keeping people healthy. They're sort of a—Steve Shortells's term was the acute care paradigm, they want to fill beds. So, I was encouraged when I saw that a significant number of the shared savings ACO's and pioneer ACO's are in fact physician organizations, not just multispecialty groups which are hard to organize and manage, but IPAs. So, I don't know where this is all going to come out, but I don't think you equate ACOs with hospitals, necessarily. Although, clearly a lot of the young docs want to be employed and a major employer, if they look around, is the hospital. I do think there are other viable candidates in that public policy should—clearly should not tilt in favor of the hospital ACO, in my opinion.

GAIL WILENSKY: **O**n my optimistic days I am hopeful that the 1990s will be repeated for the hospitals.

STUART GUTERMAN: Let me try and look on the bright side of this. First, I think the consolidation of market power is something that needs to be dealt with and it needs to be

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dealt with in a 21st-century context, which unfortunately, much of antitrust [misspelled?] policy is not in. But, that's one issue that needs to be dealt with. But, as Gail said, this trend started before ACO started and it really is an attempt by hospitals to do two things. One is to consolidate market power when they're negotiating with payers and another is because of the quirk in Medicare payment and the differential in providing the same service if you're providing it nominally in a hospital as opposed to in a physician office. The bright side of it is that if this is going to be happening, at least the ACO model shifts the focus from just generating revenue to trying to serve a population, take accountability for both the cost and quality of care provided. If we're going to have a consolidation of market power, let's try to do—take what's best out of that consolidation, which is the ability—the increased ability to integrate care and coordinate care across settings. Hopefully some of the changes that are in the ACA and are being tried out in the private sector will help push in that direction. That's kind of the positive spin on that trend.

ED HOWARD: One last question that came in from one of the registrants in advance, I want to try to squeeze it in. One of the aspects of this that we haven't touched on is the fact that Medicare beneficiaries also will pay for any doc fix through increased part B premiums. The question is, if we

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agreed that SGR needs to be fixed, it should be paid for, shouldn't we figure out a way to hold beneficiaries harmless and if so, how much is that going to cost?

GAIL WILENSKY: It depends how you do it as to whether beneficiaries will be impacted. Those are really separate questions, they may become part of one, but we've got to decide first what we want to do about changing how we pay physicians and then we need to look at the intended and unintended consequences, as we always do, and to the extent that there is an impact on beneficiaries. There are separate policy measures that can hold some or all of them harmless, but that would increase the cost. Those really are two separate issues and it depends completely on how you do it as to whether or not there will be a direct effect. To the extent you do something that adds 138 to what could go up to be 250 million to the deficit, seniors will be impacted by that too.

ED HOWARD: Stu?

STUART GUTERMAN: I guess I'm playing Pollyanna here, but the good side of the repeal of the SGR being on sale is that it's also on sale to beneficiaries. Beneficiaries pay a premium for part B that's set to be a quarter of anticipated spending under that part of Medicare. If 138 billion is the cost of the Medicare program, then 46 billion would be the cost to beneficiaries. That's a lot easier to deal with than a 90 or

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100 billion dollar cost that was previously projected. It is clearly something you want to take care of, because you don't want beneficiaries to be penalized. On the one hand, congratulations, you've got more access to the care you need, on the other hand it's going to cost you substantially more.

ED HOWARD: **I**t's good to end on a relatively optimistic note. All we have to do is make the sale. Let me take this chance to thank folks at Commonwealth and this folk from Commonwealth, specifically, for thinking through this program and helping us put it together. Let me thank you for being so attentive and asking such good questions. Let me ask you to help me thank our panel for responding to those questions in such a great way [applause]. As you leave, scribble on the blue form even if it's illegible. Thank you. Very nice.

[END RECORDING]

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