



Proposals to Senate Finance Committee  
Supplementing Policy Options to Improve  
Patient Care and Reduce Health Care Costs

May 15, 2009

The Honorable Max Baucus, Chairman  
The Honorable Charles Grassley, Ranking Member  
Committee on Finance  
United States Senate  
Washington, DC 20510-6200

**Re: Comments on Senate Finance Committee Policy Options for Transforming the Health Care Delivery System**

Dear Chairman Baucus and Ranking Member Grassley,

Over the past nine months the Center for Payment Reform -- a coalition of consumers, purchasers, labor, physicians and other health care providers and payers focused solely on payment reform -- was formed based on a shared vision that improving quality and affordability in health care requires a transformation in our payment systems. We appreciate this opportunity to comment on the policy options outlined in the Senate Finance Committee's ***Policy Options for Transforming the Health Care Delivery System***.

The proposed options mark an important step along the way to meeting the nation's need to control health care costs and reform the system. The policies chart a clear and decisive path to change the way we pay for health care, which is a critical component of comprehensive reform and is central to improving the quality and affordability of care delivered to patients. The options identified are thoughtful steps that begin the transition from paying for the volume of services to focusing more on the value of care delivered to patients. Enhancing public reporting and expanding how we pay for value across all clinicians and in all settings is critical if we are to create a sustainable and high quality health care system. In addition, we believe that the proposal to expand the ability of the Center for Medicare and Medicaid Services (CMS) to embark on rapid-cycle testing, evaluation and evidence-based expansion of reforms through the Chronic Care Management Innovation Center is an important structural innovation that will enable CMS to expand proven payment innovations.

We believe that payments for the prevention, diagnosis and treatment of disease should be based on the extent to which they promote and reward high-quality, patient-centered care that is cost-effective and reduces disparities; ensure patients receive the "right care, at the right time, from the right provider," incorporating the values and preferences of patients; foster improvement and innovation; and effectively slow the growth of the costs of health care.

We applaud you and the Committee for spearheading efforts to transform our healthcare system, and are pleased that many of the options under consideration align with the Center for Payment Reform's principles (available at [www.centerforpaymentreform.org/Principles](http://www.centerforpaymentreform.org/Principles)). In addition, we recommend ways to build on your proposals, and have attached briefs providing our rationale and specific suggestions in the following areas:

- Developing decision-making processes for payment reform;
- Promoting use of payments that reflect the actual value and coordination of care delivered by primary care physicians and other primary care providers; and
- Fostering coordination and integration, while ensuring competitive markets.

We appreciate that these principles are reflected in the leadership demonstrated by your Committee, and we value the opportunity to comment on the options to transform health care delivery. We look forward to working with you and the Committee on this important issue. If you have any questions, feel free to contact any of the Leadership Committee members listed below.

Sincerely,

**Robert A. Berenson, MD**, Institute Fellow, The Urban Institute

**Suzanne F. Delbanco**, President, Health Care Division, Arrowsight, Inc.

**Anna M. Fallieras**, Program Leader, Health Care Initiatives, General Electric Company and Interim Executive Director, Center for Payment Reform

**Robert S. Galvin, MD**, Executive Director, Health Care Services and Chief Medical Officer, General Electric Company

**Douglas E. Henley, MD**, Executive Vice President, American Academy of Family Physicians

**David Lansky**, President, Chief Executive Officer, Pacific Business Group on Health

**Peter V. Lee**, Executive Director for National Health Policy, Pacific Business Group on Health

**Debra L. Ness**, President, National Partnership for Women & Families

**Len M. Nichols**, Director, Health Policy Program, New America Foundation

**John C. Rother**, Director of Legislation and Public Policy, AARP

**Gerald M. Shea**, Assistant to the President for Governmental Affairs, AFL-CIO

**Andrew Webber**, President and CEO, National Business Coalition on Health

## **Recommendation 1: Ensure Integrated and Balanced Decision-Making on Medicare Payment Policies**

### **Integrating Provider-Specific Payment Policies within CMS**

The legislative structure of the Medicare program is oriented around specific payment structures for specific sets of providers, and, not surprisingly, the Centers for Medicare and Medicaid Services (CMS) has tended to organize its staff and decision-making processes along similar lines. Hospital payments are governed by certain sections in Title 18 of the Social Security Act, with corresponding staff and rulemaking processes, while physician payments are governed by other parts of Title 18, with their own staff experts and rulemaking processes.

Consistent with its operational responsibilities, this alignment of staff and process with Title 18 is understandable, but stands in contrast to the future direction of payment models, which should favor an integrated approach to considering value, payment structures and levels. At present, the Medicare program faces statutory constraints on its ability to develop and implement new payment models on a widespread basis, a limitation addressed in part by several of the Committee's options, including the Chronic Care Management Innovation Center (CMIC). Expanding CMS' authority to foster such innovation is likely to increase the ability of Medicare to advance payment reform, understanding that with expanded authority would likely come additional oversight and reporting requirements. Such authority may ultimately reside within CMS as envisioned by the CMIC, or, potentially, be vested in another organizational model. Some have suggested that such authority may reside outside of CMS – for example, within a Health Board of some type, or under the auspices of an enhanced MedPAC.

Regardless of the model, flexibility, transparency, and meaningful stakeholder input is essential to assure that changes to payment policies are considered in the context of their impact on patients, providers, and health care purchasers.

The Committee's establishment of the CMIC is a strong first step in this regard. To complement the CMIC, and absent creation of a new or enhanced entity to define and implement broadly applicable payment reform, we suggest that the Committee consider the following:

- CMS should be directed to establish a mechanism to develop and implement a multi-year, multi-sectoral payment policy review and approval process. This mechanism would be charged with developing an integrated approach to updating existing and emerging payment models to assure aligned incentives across providers, and in the context of any state-driven and/or private sector-driven trends and initiatives.
- This new mechanism should solicit input from external stakeholders through both establishing formal multi-stakeholder advisory processes (see below) and using

the rulemaking process, with annual opportunities for interested parties to comment on ways to improve the inter-provider consistency of provider-specific payment policies.

- The timing of this public input process should be structured to enable public input and agency decisions to inform the various provider-specific payment updates processes (e.g., the IPPS update, the physician payment rule, etc).
- All provider segments, including post-acute providers, should be encapsulated in this annual notice and comment process.

## **Incorporating Patient and Third-Party Payer Perspectives Into Medicare Payment Policies**

A cursory review of the roster of respondents to CMS's proposed rules governing payment to providers underscores the imbalanced nature of the perspectives received through the notice and comment process: the overwhelming majority of comments derive from affected providers. While patients and their advocates, and third-party payers can and do comment, the highly technical nature of the rules and policies, coupled with the rather limited impact on any single patient or payer has inadvertently resulted in an unlevel playing field. As a result, CMS staff, in reviewing comments, often lack meaningful input from stakeholders outside of the provider community.

While this phenomenon is present in all payment systems, it is most apparent in the area of CMS's annual efforts to update the Physician Fee Schedule, and resource-based relative value scale (RBRVS). The relative values of the services are determined by CMS using its rulemaking authority. In practice, CMS relies heavily on recommendations (provided through the notice and comment rulemaking process) by an outside committee housed by the American Medical Association (AMA): the Relative Value Scale Update Committee or the RUC. The RUC is made up of physicians that represent nearly every specialty. Many of the RUC's recommendations are based on expert panels and qualitative, subjective assessments of the physician work and practice expense components of the RVU value. In response to CMS' request for comments, the RUC offers its recommendations on values for new services, and recommends adjustments to values for existing services on a periodic basis.

Given the cost of analyzing and proposing new or revised RVU values, great weight is given to the RUC's recommendations. (In March 2006, the Medicare Payment Advisory Commission (MedPAC) noted that CMS's five-year review "does not do a good job of identifying services that may be overvalued." They further stated, "CMS has relied too heavily on physician specialty societies to identify services that are misvalued." Five-year reviews have led to "substantially more increases in RVUs than decreases, even though many services are likely to become overvalued over time."<sup>1</sup>) The perspectives of other healthcare stakeholders are notably absent and the broadly dispersed "public good" of assuring valuation for physician services that meets patient-centeredness and

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<sup>1</sup> MedPAC, *Medicare Physician Payment*. March 2006.

affordability goals are not goals that particular constituents will fund or engage in absent funding and facilitation.

The Center for Payment Reform applauds the AMA for committing substantial resources to better inform policy decisions, and respects the substance and process by which the AMA is able to present and reconcile the sometimes-varying views of its many members.

Nonetheless, a means to ensure meaningful input from other stakeholders is urgently needed. As a discrete complement to CMS' regulatory decision-making process, we recommend establishing a federally chartered body that includes patients, third-party payers and provider representatives to inform CMS' annual update processes. This standing, FACA-compliant independent Consumer and Health Care Purchaser and Provider Update Committee (CHUC) would be charged with providing independent input to CMS in its decision-making role with respect to Medicare payment levels, across all provider sectors. The new advisory group should include patients, purchasers, providers and payers – with majority representation by those who receive and pay for care -- and serve as a forum for broader multi-stakeholder input, as well as collection and analysis of relevant information. This new group would be advisory only.

The Consumer and Health Care Purchaser and Provider Update Committee should be funded with \$5 to \$10 million annually to cover operational costs, conduct independent quantitative studies/surveys on physician and hospital costs and expenses, and facilitate broad input into rate setting from the array of stakeholders.

## **Recommendation 2: Promote Appropriate Payments for the Value Provided by Primary Care and Care Coordination**

Payment reforms must recognize the value provided by primary care in managing the health of individuals and populations. We will not create a delivery system that is patient-centered and well-equipped to deliver high quality care while controlling costs without changing payments to recognize the value of care coordination and the management of patients, particularly those with complex chronic illnesses.

The Center for Payment Reform (CPR) believes that having an adequate primary care workforce is central to delivering high-quality, cost-effective and coordinated care. This will require improving payment to primary care physicians and other primary care providers and linking those payments to demonstrated value. We also support enhancing primary care payments in at least a budget-neutral, if not budget-positive, fashion. This means that increased payments for primary care should be funded by either the relative reduction (or reduced increase) for other specialty services and/or by the documented efficiencies and savings from other areas of the system.

Health care payment reform should both address near-term payment gaps and provide a clear pathway for a longer-term strategy to alter physician compensation such that the value of primary care services, team-based care, care coordination and cognitive medical skills are better recognized. The specific policies below address both near-term options and processes to ensure that there is a path for assuring primary and other specialty care payments are based on the value of the care provided to patients.

### **Near-Term Value Adjustments for Primary Care**

The Center for Payment Reform supports the Senate Finance Committee's concepts that propose a combination of payment adjustments aimed at improving the payment levels and how they are calculated for primary care providers, including:

- Increasing payments for providing primary care services;
- Establishing new fee-for-service mechanisms to pay for transitional care and/or care management activities;
- Using the Center for Chronic Care Innovation to consider expansion of the medical home model upon demonstration of such programs' alignment with the *Joint Principles of the Patient Centered Medical Home*, the *Principles for Patient and Family Centered Care: The Medical Home from the Consumer Perspective*, and evidence that the model demonstrates value; and
- Expanding CMS' performance-based reporting and payment programs to foster accountability and better rewards for primary care providers for the quality, efficiency and outcomes of care they deliver.

Going beyond those elements outlined, the Center for Payment Reform believes that there is an urgent near-term need to initiate multi-year improvements to primary care

payment to better align those payments with patient value. Policies should be aggressive and include the following:

- Payments for primary care services should be increased by at least 10% in 2010 and by 5% for each of two years thereafter, so that the cumulative increase by 2013 is at least 20%. These increases should be funded from direct offsets from other areas.
- CMS should develop and implement a process – to be completed in the next two years – that would establish appropriate valuation of specific services and of overall average compensation of primary care and other specialties, which would include:
  - Restructuring of the RBRVS formula to consider not only cost inputs, but patient and societal value of services provided (see below);
  - The process proposed should be budget neutral; and
  - The process should support the goal of achieving a sustainable supply of primary care providers.

### **Longer-Term Value Adjustments to Physician Payments: Adding ‘Value’ Into the RBRVS Calculation**

Under the current Medicare payment system – framed by the resource-based relative value scale (RBRVS) – physician payments are based primarily on the resource cost of providing a service. This approach is followed by the private sector. Current law directs CMS to determine payments based on the relative “cost” of the service or procedure from the perspective of the physician providing the service. Under the current system, payments cannot reflect a judgment of the value of a service to patients or society. As a result, providers are implicitly discouraged from delivering ‘low resource-using’ services that might be highly valuable to a patient or from a public health standpoint (e.g., counseling, care coordination, etc).

The Center for Payment Reform supports rapid movement to a physician payment system that rewards patient and societal value and resource use. The Senate Finance Committee should direct CMS to develop a new framework for payments such that provider costs are not the only factor, but instead there are also express considerations of broader value. The health reform legislation should require CMS to establish a task force to formulate a proposal – within two years – to supplement the existing cost-based approach to pricing services. The new ‘value’ factor should consider policy priorities, patient preferences, and payer and purchaser perspectives and be informed by additional considerations such as utilization patterns and geographic variation, among other factors.

The redesign of the RBRVS formula should be linked to expanding a value-based payment program for certain services and providers to reward evidence-based care. However, these rewards should not be “one size fits all.” The current physician payment mechanism does not take into account the clinical appropriateness of the

services provided. Rather, it rewards growth in the volume of services: a service provided to the right patient at the right time receives the same payment as a service provided without an evidence-based justification. The CMS proposal for revising RBRVS should include mechanisms to have differential performance-based rewards that would be substantial supplements to revised RBRVS-based fee-for-service, and available only to the identified services and providers. Physicians and other ancillary providers (e.g., nurse case managers, nurse practitioners, and physician assistants) should be eligible to receive the enhanced payments for performance in areas that are identified as having higher potential positive impact.

### **Reforming Medical Education to Ensure an Adequate Workforce**

The Center for Payment Reform strongly supports the development of a fuller set of policies that will foster the training, education and recruitment of physicians and other providers into primary care. There is currently a shortage of primary care physicians, and that shortage and the demands on primary care physicians is expected to grow in the coming years.

While we believe that the Senate Finance Committee Policy Option of making additional residency training slots available for primary care is a step in the right direction, it is unlikely to have a significant effect. Beyond reallocating training slots, the Center for Payment Reform believes that there needs to be a fuller review and adjustment of payments for medical education that are targeted at fostering an adequate primary care physician pool. We recommend that the health reform legislation include commissioning the Institute of Medicine to formulate a National Workforce Plan with specific milestones and goals that the nation should achieve by 2025. Policies that should be considered in this plan include:

- Redistribution of the funding allotted to residency programs in different specialties to ensure adequate funding of slots for primary care;
- Loan forgiveness programs so that graduates who choose primary care have no/less debt; and
- Dramatic expansion of the National Health Service Corps to encourage greater participation.

### **Expand Eligibility for Enhanced Payments to Non-Physician Primary Care**

The Center for Payment Reform supports efforts that acknowledge that ancillary providers, such as nurse practitioners and physicians' assistants, often perform care management and coordination services. In the face of primary care physician shortages, and while MedPAC and CMS explore options to boost the supply of physicians, Medicare should develop mechanisms to reimburse non-physician providers for care management and coordination services for patients, especially those with chronic conditions.

### **Recommendation 3: Foster Coordination and Integration, While Ensuring Competitive Markets**

The Center for Payment Reform strongly supports payment reforms that encourage coordinated and integrated care delivery. At the same time, we believe that policies that assure there are functioning markets – where informed patients and purchasers can fairly negotiate terms with independent providers – are also essential. The Senate Finance Committee needs to address how policies can be developed to assure there is an appropriate balance between promoting both coordination and competition.

Aligning incentives across providers and sites of care is essential to the appropriate focus on “end-to-end” quality, affordable care. In many markets, providers have formed multi-provider organizations, ostensibly to advance their clinical and financial goals, forming multi-hospital systems, multi-physician organizations, and combined hospital-physician entities. In some cases, these collaborations have resulted in higher quality and lower costs for payers and patients by focusing on generating clinical and financial efficiencies. In some instances, however, these new organizations have leveraged their market power in ways that may increase costs to patients, payers, employers and other health plan sponsors, with ambiguous impacts on quality.

Because of the concerns about potentially anti-competitive impacts of some forms of integration and coordination there are a broad array of laws and regulations governing competition, anti-kickback, self-referral, and related issues. Some argue that portions of existing law and regulations need to be “loosened,” as they inhibit providers’ ability to coordinate care effectively. However, many others suggest that loosening existing laws and regulations is unnecessary to deliver more efficient care and could result in both higher costs and reduced choice for consumers.

Four inter-related issues suggest a need for the development of a comprehensive strategy to promote integration, coordination, and competition in health care:

1. Oversight responsibilities are spread across many actors with different rules and jurisdictions (e.g., the federally among the Department of Justice, Federal Trade Commission and CMS’ Office of the Inspector General; and at the state level with regulatory agencies and Attorney Generals);
2. Applying traditional anti-trust concepts to health care is very complex (defining the “market,” untangling the impact of multiple forms and responsibilities of third-party payers regulated by both state and federal governments, etc.);
3. The health care market place is subject to rapid change; and,
4. Changes in payments for services in both the commercial and public sector markets have the potential to realign dramatically the relationships between providers.

Given the complex inter-relationship between competition and coordination, the Center for Payment Reform urges the Senate Finance Committee to establish a framework that will assure that both goals are promoted. We recommend that legislation call for:

The Secretary of Health and Human Services shall produce or commission a report to Congress that shall examine how policies and payment can best balance the need to both promote coordination and competition. In doing so, the Secretary shall engage representatives of the Attorney General, the Federal Trade Commission, the Comptroller General, CMS' Office of Inspector General and the Agency for Healthcare Research and Quality as well as representatives of consumers, private purchasers and providers. The report shall be provided within 12 months and should address, at a minimum, the following:

- Are new laws or regulations needed to guard against the provider-based entities having or exercising market power to the detriment of consumers' interest in higher quality, less costly health care? The report should consider issues such as whether there should be limits on the market-share held by these entities, whether payment policies should include explicit cost and/or quality performance targets to assure viable and meaningful competition across entities, and potential limits on entities' ability to impose pricing or contractual structures on private or public payers.
- Do existing anti-trust laws and pro-competitive regulations need to be revised or amended? These laws and guidelines include provisions relating to self-referral, anti-kickback, joint negotiation, and collective bargaining, among others.
- Are there existing state or federal laws that have the affect of creating inappropriate barriers to healthy competition that need to be examined? Such potential barriers include but are not limited to: scope or practice laws that impose barriers to entry for certain healthcare providers; laws that may inhibit providers from offering telemedicine services; laws that may limit providers' ability to move to another state and practice medicine; or ineffectively operated certificate of need laws.
- What is the empirical research on health care markets and market competition that should inform policy development? Little is known about providers' post-integration pricing strategies, payer and consumer responses to those strategies, and the implications for enhancing the quality of care. Similarly, little is known about the competitive affects of relatively small physician groups or regional monopoly hospitals that can demand higher rates from payers.
- What is the role of promoting transparency with respect to quality and price in fostering better market functioning? Transparency initiatives design should be assessed to determine the extent to which they give providers, payers and consumers useful information while at the same time limiting unintended consequences relating to inappropriate price signaling.

- How can the regulatory and legal oversight promoting competition best be structured? There is an array of federal and state agencies involved in promoting competition (e.g., DOJ, FTC, CMS-OIG and state agencies). The report should assess and recommend options for assuring these functions are adequately resourced, better coordinated, served by common or shared research infrastructure and have aligned policy goals.