STATEMENT OF

JONATHAN BLUM

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

ON

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

BEFORE THE

U. S. SENATE COMMITTEE ON FINANCE

JULY 10, 2013

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

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

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

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

the update is reduced. If expenditures are less than the target, the update is increased. The current, statutorily mandated system for updating Medicare payments to physicians has required significant cuts to physicians in recent years as a result of the SGR. The Congress has repeatedly intervened to prevent these negative payment updates from occurring with temporary adjustments to the payments, but has not yet changed the underlying SGR formula. Absent Congressional intervention or reform of the SGR methodology before the end of this year, scheduled cuts of an estimated 24.4 percent[1] will go into effect in January 2014, although this figure may change once we have more information on 2013 spending.

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

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

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

Increasing Value for Beneficiaries and Taxpayers

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

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

As I noted in my testimony before this Committee earlier this year, Medicare beneficiaries are already starting to enjoy better quality of care through innovative care delivery systems designed to improve their health outcomes and reduce costs. Affordable Care Act reforms are contributing substantially to recent reductions in the growth rate of Medicare spending per beneficiary[2] without reducing benefits.

Moving from Volume-Based Payments to Value-Based Payments

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

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

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

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

Care Coordination and Primary Care

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

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

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

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

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

Potentially Misvalued Codes

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

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

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

In addition to identifying and reviewing potentially misvalued codes, the Affordable Care Act[4] specifies that the Secretary shall establish a formal process to validate RVUs under the Physician Fee Schedule. CMS has entered into two contracts with outside entities to develop validation models for RVUs. During a two-year project, the RAND Corporation will use available data to build a validation model to predict work RVUs and the individual components of work RVUs: time and intensity. Under the second contract, the Urban Institute will actually measure the time it takes to furnish specific services. After gathering data, a clinical panel will review the time data. Given the central role of time in establishing work RVUs and the concerns that have been raised about the current time values, we are eagerly anticipating the results of these projects.

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

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

Multiple Procedure Payment Reduction

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

Using Data to Improve Quality and Value

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

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

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

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

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

As we collect data from physicians, we are also working to allow consumers to use this information as they make health care decisions for themselves and their families. Providing consumers with information on care quality to make informed decisions about their health care is an important element in making information transparent and incentivizing the delivery of high quality care. In December 2010, CMS launched the first phase of the Physician Compare website[5]. In this initial phase we posted the names of eligible professionals who satisfactorily submitted quality data for 2009 PQRS, as required by the Affordable Care Act.

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

[5] http://www.medicare.gov/physiciancompare

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

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

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

We are now instituting our plan for a phased approach to public reporting of performance information on Physician Compare. The first phase of our plan was finalized with the 2012 Physician Fee Schedule final rule with comment period[6], where we established that PQRS Group Practice Reporting Option (GPRO) measures collected through the GPRO web interface would be publicly reported on Physician Compare. These measures will be publicly reported on Physician Compare in CY 2014. We are also phasing in these reporting requirements on Physician Compare for Accountable Care Organizations (ACOs) since they are considered a GPRO under PQRS.

In addition, in the CY 2013 Physician Fee Schedule final rule with comment period[7], we also finalized our decision to publicly report Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) data for group practices of 100 or more eligible professionals, and for ACOs participating in the 2013 GPRO. We anticipate posting these data on Physician Compare as early as 2014. Moreover, the 2014 Physician Fee Schedule encourages all groups of physicians with 25 or more eligible professionals to participate in the CG-CAHPS survey, and proposes to publicly report results on the Physician Compare. We believe that assessments of patient experience and satisfaction are an important component of evaluating the

[6] http://www.gpo.gov/fdsys/pkg/FR-2011-11-28/pdf/2011-28597.pdf
[7] http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf

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

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

Physician Value-Based Payment Modifier

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

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

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

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

Improving Accountability through New Payment Models and Other Initiatives

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

Accountable Care Organizations

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

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

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

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

Innovation Payment Models that Increase Provider Accountability

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

The Comprehensive Primary Care initiative[8] is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. Medicare is working with commercial insurers and state Medicaid agencies and offering enhanced care management payments to primary care doctors who better coordinate care for their patients. Primary care practices that have chosen to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients. The Comprehensive Primary Care initiative

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

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

The Multi-payer Advanced Primary Care Practice Demonstration[9] is testing the patient-centered medical home model to improve the safety, effectiveness, timeliness and efficiency of health care. The Multi-payer Advanced Primary Care Practice Demonstration takes a multi-payer approach to creating more advanced primary care services or "medical homes" that utilize a team approach to care, while emphasizing prevention, health information technology, care coordination, and shared decision making. CMS pays a monthly care management fee for Medicare fee-for-service beneficiaries receiving primary care from advanced primary care practices participating in the demonstration. The following states are participating in the demonstration: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota.

The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration[10] is also testing the patient-centered medical home model to improve quality of care, promote better health, and lower costs. Participating FQHCs in the demonstration are expected to achieve National Committee for Quality Assurance (NCQA) Level 3 Patient-Centered Medical Home recognition by the end of the demonstration as well as help patients manage chronic conditions and actively coordinate care for patients. To help participating FQHCs make the needed investments in patient care and infrastructure, CMS is paying a monthly care management fee for each eligible Medicare fee-for-service beneficiary receiving primary care services. In addition, both CMS and the Health Resources Services

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

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

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

Created by the Affordable Care Act, the Independence at Home Demonstration[11] is testing a service delivery and payment incentive model that uses home-based primary care teams designed to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions. The home-based primary care teams are directed by physicians and nurse practitioners to furnish primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations. CMS will award incentive payments to healthcare providers who succeed in reducing Medicare expenditures while maintaining or improving quality of care by reducing the need for hospitalization, improving patient and caregiver satisfaction, and leading to better health and lower costs to Medicare. The Independence at Home Demonstration is testing whether home-based care can reduce the need for hospitalization, improve patient and caregiver satisfaction, and lead to better health and lower costs to Medicare. CMS announced in April and August 2012 the selection of 15 independent practices and three consortia to participate in the Independence at Home Demonstration.

Conclusion

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

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

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