



**TESTIMONY OF**  
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**IN THE**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**  
**BEFORE THE**  
**SENATE COMMITTEE ON FINANCE**  
**ON**  
**IMPROVING QUALITY IN MEDICARE:**  
**THE ROLE OF VALUE-BASED PURCHASING**

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Chairman Grassley, Senator Baucus, distinguished members of the Committee, thank you for inviting me here today to discuss the use of pay-for-performance reimbursement systems within the Medicare program. The Administration is exploring innovative approaches to achieving better patient outcomes at lower costs, and we hope that several CMS initiatives which are now underway could help move us toward that goal. The Administration recognizes that pay-for-performance proposals are in the early stages of development and a great deal of work must still be done to construct a full set of widely applicable quality performance measures useable across the spectrum of health care settings. Supporting the desire of health professionals to improve the quality and efficiency of care for people with Medicare is the motivation behind CMS' various efforts to develop pay-for-performance models and we should work together to move toward this goal. I would like to recognize Senators Grassley, Baucus, Enzi, Hagel and Kennedy for your leadership on this issue in sponsoring S. 1356, the "Medicare Value Purchasing Act of 2005" and look forward to working with you to move Medicare toward a pay-for-performance environment. When clear, valid, and widely accepted quality measures are in place, pay-for-performance is a tool that could link reimbursement to efforts to improve quality. Furthermore, as demonstrated by our Hospital Quality Initiative, small percentages in financial incentives can be sufficient to encourage provider interest in providing evidence-based, quality care.

### **Incorporating Performance Based Payments into Medicare**

Government policies should support a health care system that provides doctors and patients with the ability to make effective decisions on the basis of the best scientific evidence about benefits and costs. In cases where there are clear opportunities to pay for better results rather than simply for more services, performance-based payments may be an important element in our efforts to support the right services and higher quality for our beneficiaries.

Current Medicare payment systems pay physicians and other health care providers based on the number and complexity of the services they supply. As the surgery specialties have noted, in surgery in particular, more care rarely means better care. The current

Medicare reimbursement structure does not target resources to support specific efforts to provide the highest quality care. When providers improve the quality of care, for example by preventing acute health problems that require expensive hospital admissions and lead to greater utilization of services, they are not rewarded financially.

Complications and hospitalizations, possibly resulting from low quality care, may result in greater usage of services with a commensurate increase in provider reimbursement.

For example, patients with a new condition that has yet to be diagnosed often see multiple specialists during an intense 'work-up' period. Currently, we pay for each of these consultations in its own silo. Multiple, sometimes redundant and uncoordinated evaluations can result in higher cost without better care for patients.

As another example, 21 percent of our beneficiaries who are hospitalized with heart failure are readmitted within 30 days, and studies show that about half of these readmissions are preventable. Yet Medicare's payment system does not encourage physicians to take steps to prevent readmissions.

There are too many examples like these, where we pay more when patients utilize more resources, but experience worse results. That's because Medicare's current physician payment rates for a service are the same regardless of its quality, its impact on improving patient's health, or its efficiency.

Providers who want to improve quality of care find that Medicare's payment systems may not provide the flexibility to undertake activities that, if properly implemented, have the potential to improve quality and avoid unnecessary medical costs. Linking a portion of Medicare payments to valid measures of quality and effective use of resources would give providers more direct incentives to implement the innovative ideas and approaches that actually result in improvements in the value of care that people with Medicare receive. Eliminating unnecessary services could have positive financial repercussions for Medicare as well.

CMS has initiated a number of demonstration projects; several required by Congress under statute, aimed at encouraging quality care and designed to lay the groundwork for pay-for-performance systems in the future. These projects are helping us to examine our current systems to better anticipate patient needs, especially for those with chronic diseases, and explore how incentives can be better aligned with the kind of care we want. The desired outcome of these efforts is that quality of care can increase, hospitalizations decrease, and both the beneficiaries and taxpayers realize the accompanying financial benefits.

In the FY 2006 budget, the President recognized the potential for payment reforms to improve the value of care delivered to people with Medicare by exploring programs that promote quality in a budget-neutral manner. In its March 2005 Report to Congress, MedPAC offered several recommendations including the development of measures related to the quality and efficiency of care by individual physicians and physician groups. We would like to work with the Congress to move towards payment systems that promote quality in a budget neutral manner when providers take steps to improve the quality of care in the most appropriate settings.

### **Developing Standardized Quality Measures**

The ability to evaluate and measure quality is an important component to delivering high quality care. To do so, CMS is collaborating with a variety of stakeholders to develop and implement uniform, standardized sets of performance measures for various health care settings. For example, CMS is working in collaboration with hospital associations, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Agency for Healthcare Research and Quality (AHRQ), consumer groups, major payers including the AFL-CIO, representatives of health care purchasers, health professionals, and the National Quality Forum to refine and standardize hospital data, data transmission, and performance measures.

CMS is already engaged with the physician community in the development and improvement of specific quality measures. CMS has worked in collaboration with the

American Medical Association's Physician Consortium for Performance Improvement and the National Committee for Quality Assurance Ambulatory care to develop measures of improvement in care. This partnership resulted in a set of proposed measures that were submitted late last year for endorsement to the National Quality Forum, a voluntary private consensus setting organization. As part of the Ambulatory Care Quality Alliance (AQA), led by the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans and the Agency for Healthcare Research and Quality, CMS and other stakeholders, including the American Medical Association and other physician groups, as well as representatives of private sector purchasers and consumers, selected a subset of these measures (26) as a starter set for implementation. Additional measures that assess dimensions of specialty care and efficiency will be added to this starter set. In addition, the AQA is now developing approaches for reporting results to individual patients and physicians and evaluating strategies to minimize physicians' burden of reporting.

The entire starter set of ambulatory care measures are now in the final stages of endorsement. These measures are designed to reflect performance in primary care and also apply to certain specialists, insofar as those specialists are involved in the furnishing of care to patients with common chronic diseases, including diabetes and heart disease. In addition, measures of effectiveness and safety of some surgical care have been developed through collaborative programs like the Surgical Care Improvement Program, which includes the American College of Surgeons. By preventing or decreasing surgical complications, the Surgical Care Improvement Program will result in decreased hospital days and decreased use of resources. We are also collaborating with many specialty societies, such as the Society of Thoracic Surgeons, to develop quality measures that reflect important aspects of the care of specialists and sub-specialists. The Society of Thoracic Surgeons has already developed a set of 21 measures that are risk adjusted and track many common complications as outcome measures. They are conducting a national pilot program to measure cost and quality simultaneously, while communicating quality and efficiency methods across regional hubs to reduce complications and costs.

CMS is also working closely with oncologists to develop measures of the adequacy of treatment planning and follow-up that oncologists furnish as part of their evaluation and management services; with cardiologists on measures of cardiac care for heart attack or heart failure conditions; and with cardiovascular surgeons on measures related to cardiac surgery. As part of this effort, on July 14, 2005, Dr. Mark McClellan, CMS' Administrator sent a letter to a number of specialty societies, summarizing some of the work to date and requesting an update on their efforts to develop quality and performance measures. Historically, CMS has had productive exchanges with most medical specialty organizations, and if an organization has not entered discussions with us, I would encourage them to initiate a dialogue with us as soon as possible so we can work together to develop clinically valid measures and obtain our goal of improving the care we provide to people with Medicare.

CMS is preparing to implement the MedPAC recommendation to use Medicare claims data to measure fee-for-service physicians' resource use and to share these results with physicians confidentially to educate them about how they compare with aggregated peer performance. We are using existing claims data to simulate and test the measurement and quantification of individual physician patterns of practice, incorporating both services they order (including facility services) as well as services they furnish. Resource use is often measured for episodes of care and periods of time (e.g., 3 months). The most widely used measure is total expenditures per episode or period of time. Other measures of resource use are possible, such as examining the percent of a physician's patients who have a particular service ordered. This can indicate potential variations in practice that may affect costs significantly without evidence-based benefits for patients. For example, MRI scans may be ordered for patients with non-specific lower back pain, a condition that often does not warrant the test. By comparing relative use of such a service among physicians, a data-driven foundation for identifying opportunities to avoid some medical costs without harming patients may be developed. As a next step, we are planning to begin pilot projects to share the results with physicians confidentially to educate them about how they compare to peers in an effort to decrease the use of inappropriate services.

CMS is also supporting the development of more evidence-based care. For example, CMS recently launched the “Fistula First” initiative, which is designed to give patients with end stage renal disease the ability to receive life-sustaining dialysis through a method that performs better than other procedures while requiring less maintenance. By funding and overseeing this initiative, CMS is using its leadership position to partner with the medical community and improve the lives of patients.

### **Quality Improvement Demonstrations and Pilots**

In addition to our work on establishing quality measures, we have begun a number of demonstration and pilot projects to test pay-for-performance principles. Pay-for-performance initiatives are currently underway in a variety of health care settings where people with Medicare receive services, including physicians’ offices and hospitals. Because patients with chronic conditions often require treatment across several settings of care, CMS is pursuing pay-for-performance initiatives to support improved coordination of care. CMS will seek input concerning actions we can take administratively to best implement a pay-for-performance system to achieve our goals of promoting better quality and reducing program costs. We want to provide the public with an opportunity to present ideas and suggestions about how pay-for-performance payment mechanisms should be structured, including a public dialogue on key technical and statutory issues.

The Physician Group Practice demonstration is assessing large physician groups’ ability to improve care that could result in better patient outcomes and efficiencies. Ten large (200+ physicians), multi-specialty physician groups in various communities across the nation are participating in the demonstration. These physician groups will continue to be paid on a fee-for-service basis, but they may earn performance-based payments for implementing care management strategies that anticipate patients’ needs, prevent chronic disease complications, avoid hospitalizations, and improve the quality of care. The performance payment will be derived from savings achieved by the physician group and paid out in part based on the quality results, which CMS will assess. Providing

performance-based payments to physicians has great potential to improve beneficiary care and ensure fair and appropriate payment in the Medicare program.

In addition, CMS is preparing to implement the Medicare Health Care Quality Demonstration. This demonstration program, which was mandated by the MMA, is a five-year program designed to reduce the variation in utilization of health care services by encouraging the use of evidence-based care and best practice guidelines. CMS also is implementing the Medicare Care Management Performance Demonstration, a 3-year pay-for-performance pilot, mandated by the MMA, with small and medium sized physician practices that will promote the adoption and use of effective health information technology that achieves improvements in the quality of care and reductions in preventable costs for chronically ill people with Medicare. This demonstration will provide performance payments for physicians who meet or exceed performance standards in clinical delivery systems and patient outcomes, and will reflect the special circumstances of smaller practices. It also will give CMS the opportunity to provide technical assistance to small providers in adopting information technology that is effective in improving quality and avoiding costs, as CMS has already been working to do in limited pilots. This demonstration project is currently under development and will be implemented in Arkansas, California, Massachusetts, and Utah. We are supporting an evaluation of this demonstration with AHRQ and insights from health IT implementation that produces improvements in quality and efficiency will be shared broadly through AHRQ's National Resource Center.

### **Quality Improvement Organizations Assist Physicians' Offices**

We recognize that taking advantage of performance-based payment reforms may be more difficult for small providers, rural providers, and providers in underserved areas.

Consequently, CMS has enhanced its efforts to give such providers assistance with proven system advancements and quality improvement initiatives. Beginning August 1 of this year, under our new three-year contract with the quality improvement organizations (QIOs), the QIOs will begin offering assistance to physicians' offices who are seeking to achieve substantial improvements in care through the adoption of health

information technology, patient-focused care processes, and clinical measures reporting. In each state, QIOs will use the tools and methods developed in the Doctors Office Quality - Information Technology (DOQ-IT) two-year pilot project to help primary care physicians make changes to clinical processes to improve quality. This initiative is part of CMS's overall commitment to supporting physicians and other providers who are committing to success in our developing programs of public reporting and pay-for-performance.

Over the past year, the CMS California QIO, Lumetra, has been piloting CMS DOQ-IT assistance efforts for over 500 physicians and their offices in California. Many of these physicians' offices are small offices with one or two physicians and are located in rural or underserved areas of California. Lumetra staff and consultants provide consultation and assistance for these offices, supporting the clinical process changes and improvements resulting from the incorporation of health information technology in their offices, which in turn will allow them to utilize electronic health records, electronic prescribing, decision support and clinical practice guidelines relevant to their patient population, and electronic billing and communications. In addition, QIO staff will assist these offices in implementing office redesign to enhance patient management, and increase office efficiency. All of these efforts are designed to result in enhanced patient safety and better quality of care. Our goal is to help support effective physician office enhancements to become standard in all medical practices in the coming years and CMS QIO efforts will help ensure that physicians' offices can accomplish these enhancements.

The QIOs also have implemented quality improvement projects that lead to better care in rural and underserved areas. For example, Qualis Health, the CMS Alaska QIO, has worked with the almost exclusively rural Alaska providers to increase the rates of preventive services available to rural Alaska residents. Mountain Pacific QIO, the CMS QIO in Hawaii, is working to implement telehealth services to bring care not otherwise available to rural Hawaii beneficiaries.

Another example of QIO support to small physician offices is their role in developing the VISTA-Office Electronic Health Record Software planned for release on August 1, 2005. CMS staff has been working with Veteran's Affairs' (VA) staff to develop an inexpensive software package that will allow implementation of a basic electronic health record (EHR) in physician offices. A simplified version of the EHR used in VA Hospitals & Clinics will be stand-alone and allow an in-office EHR that contains computerized medical records, a medication formulary with refill and drug-drug interaction notifications, a reminder system for preventive services and diagnostic tests, and the potential to communicate electronically with other systems in the future. It uses the VA product base which is in the public domain and therefore affordable to small practices taking care of rural and underserved populations. It also is scalable and allows major software developers to devise add-on enhancements. The QIOs will be instrumental in explaining and facilitating the use of this quality improvement tool.

### **Medicare's Hospital Performance Based Payments Have an Impact**

The experience with MMA section 501(b) – under which hospitals that report on ten quality measures receive an update that is 0.4 percentage points higher – suggests that relatively small payment incentives can have a significant impact on provider behavior. Virtually all hospitals are submitting the required data. There is an increasing belief that linking a portion of Medicare payments to valid measures of quality would support better health care.

Evidence exists that some hospital admissions are preventable. Heart failure patients have a readmission rate of 21% over 30 days, yet research shows that about half of the readmissions are preventable. For example, providing angiotensin-converting enzyme inhibitor (ACEI) drugs to heart failure patients is an example of high quality care, yet ACEI prescriptions are found in only 66% of audited patient records. Giving beta-blocker drugs to patients with acute myocardial infarction (AMI) can reduce rehospitalizations by 22%, but only 21% of eligible AMI patients receive a prescription for a beta-blocker. Pneumonia is a very common cause of hospital admissions for people with Medicare, but many of these cases could be prevented through pneumococcal and

influenza vaccinations. Studies have shown that proper adherence to vaccination protocols can reduce hospitalizations for pneumonia and for influenza by about half, with reduced diseases, mortality, and potential savings for the Medicare Program.

If physicians are supported in their efforts to better manage patient care, preventable and costly hospitalizations, readmissions and admissions for complications may be avoided. Too often, costs of avoidable admissions are greater than the costs of services for physicians better managing beneficiaries on an ambulatory basis. As Congress considers modifying the payment system for physicians, we should work together to ensure that the physician payment system supports and encourages physicians to achieve Medicare savings by avoiding unnecessary services such as preventable admissions. If savings can be achieved, they could be applied in developing an improved physician payment system, without increasing Medicare's costs.

The Premier Hospital Quality Incentive Demonstration is a demonstration project that tests if providing financial incentives to hospitals that demonstrate high quality performance in a number of areas of acute inpatient care will improve patient outcomes and reduce overall costs for Medicare. We believe that creating incentives to promote the use of best practices and highest quality of care will stimulate quality improvement in clinical practice and result in cost savings. Under the Premier demonstration, a hospital can receive bonuses in its Medicare payments based on how well it meets the quality measures. Poorly performing hospitals will face financial penalties in the third year.

Preliminary analysis of the demonstration has shown that quality of care has improved significantly in hospitals participating. The demonstration tracks hospital performance on a set of 34 widely-accepted measures of processes and outcomes of care for five common clinical conditions. The 17 measures included in Medicare's national hospital quality reporting program are a subset of these measures. The preliminary analysis shows improvement in all five clinical areas being tracked in the three-year demonstration. The analysis of first-year performance found median quality scores for hospitals improved:

- From 90 percent to 93 percent for patients with acute myocardial infarction (heart attack).
- From 86 percent to 90 percent for patients with coronary artery bypass graft.
- From 64 percent to 76 percent for patients with heart failure.
- From 85 percent to 91 percent for patients with hip and knee replacement.
- From 70 percent to 80 percent for patients with pneumonia.

In addition, data from the first quarter of the second year show continued improvements over those achieved during that first year.

Overall, these conditions account for a substantial portion of Medicare costs. If we achieve improvements in aspects of care that are proven to help patients avoid complications, patients are less likely to require more costly follow-up care for such conditions, and they are more likely to have a better quality of life.

### **Promoting Coordinated Care and Disease Management**

CMS recognizes that many patients require care in a variety of settings. Therefore, CMS has projects in operation or in the planning stages that will use pay-for-performance systems to support better care coordination for beneficiaries with chronic illnesses.

- *Medicare Health Support Program* – This program is testing a population-based model of disease management. Under the program, nine participating organizations are being paid a monthly per beneficiary fee for managing a population of beneficiaries with advanced congestive heart failure and/or complex diabetes. These organizations must guarantee CMS a savings of at least 5 percent plus the cost of the monthly fees compared to a similar population of beneficiaries. Payment is contingent upon performance on quality measures and beneficiaries and provider satisfaction. The program will generate data on performance measures that will be useful in improving the Medicare program as a whole.
- *Disease Management Demonstration for Severely Chronically Ill People with Medicare* – This demonstration, which began enrollment in February 2004, is designed to test whether applying disease management and prescription drug coverage in a fee-for-service environment for beneficiaries with illnesses such as congestive heart failure, diabetes, or coronary artery disease can improve health outcomes and reduce costs. Participating disease management organizations receive a monthly payment for every beneficiary they enroll to provide disease

management services and a comprehensive drug benefit, and must guarantee that there will be a net reduction in Medicare expenditures as a result of their services. To measure quality, the organizations must submit data on a number of relevant clinical measures.

- *Disease Management Demonstration for Chronically Ill Dual-Eligible Beneficiaries* – Under this demonstration, disease management services are being provided to full-benefit dual eligible beneficiaries in Florida who suffer from advanced-stage congestive heart failure, diabetes, or coronary heart disease. The demonstration provides the opportunity to combine the resources of the state’s Medicaid pharmacy benefit with a disease management activity funded by Medicare to coordinate the services of both programs and achieve improved quality with lower total program costs. The demonstration organization is being paid a fixed monthly amount per beneficiary and is at risk for 100 percent of its fees if performance targets are not met. Savings above the targeted amount will be shared equally between CMS and the demonstration organization. Submission of data on a variety of relevant clinical measures is required to permit evaluation of the demonstration’s impact on quality.
- *Care Management For High Cost Beneficiaries* – This demonstration program will test models of care management in a Medicare fee-for-service population. The project will target beneficiaries who are both high-cost and high-risk. The payment methodology will be similar to that implemented in the Chronic Care Improvement Program, with participating providers required to meet relevant clinical quality standards as well as guarantee savings to the Medicare program.

### **Private Sector Initiatives Pave the Way for Improved Quality and Efficiency**

The private sector also has recognized opportunities to improve quality and efficiency of care through better measurement of the delivery of care in coordination with better reimbursement models. In fact, the Leapfrog Compendium on Pay-For-Performance includes over 100 projects related to physicians. For example, the Bridges to Excellence (BTE) program, a not-for-profit organization of employers, providers, and plans has three programs to promote and reward improvements in the quality of patient care for physicians’ offices, diabetes care, and cardiac care. To date participating employers have paid over \$1.65 million in bonus payments to over 800 physicians in the four participating markets for exceeding National Committee for Quality Assurance performance criteria. Thus far, results indicate that physicians can and do participate and report their performance accurately.

A large health plan in New Hampshire launched a quality improvement incentive program in 1998, rewarding primary care physicians for the provision of quality care. The metrics for its quality improvement incentive program are the Health Plan Employer Data and Information Set (HEDIS) measures. The program uses claims and administrative data from its disease management program to assess physician practice performance. Incentive payments are awarded to practices scoring greater than the network average. In 2001, the average physician bonus payment was \$1,183 and the highest bonus payment was \$15,320. In the first year, the plan's average rates for mammography, immunization, and pediatric exams showed increases. Adult female patients receiving Pap smear tests rose from an overall rate of 80 percent in 1999 to 98.5 percent in 2000 for the top quartile of physician practices. For all performance measures for which 1999 baseline data were available, the average incentive program physician practice conformity with performance measures rose from 51.2 percent to 65.6 percent in 2000.

In 2003 a large health plan in Massachusetts launched a group practice incentive program for groups of specialists. Group practices are measured in three categories: patient satisfaction and access, quality of care, and cost. Group practices that perform better than average on the quality measures earn a bonus that could total up to fifteen percent of the regular fees paid to that physician group.

An Illinois coalition of employers initiated a program in 2000 that provides incentives to physicians for monitoring diabetes patients. Compensation is awarded to physicians in the program who meet annual goals in diabetic treatment thresholds. To gain physician buy-in into the program, a committee of physicians developed the performance goals. The coalition and medical group administrators negotiated the amount of the financial incentives a medical group could receive if they met the goals. Results reveal that diabetic care for patients in the program is significantly better than state averages and cost trends for diabetics are better than trends for all other conditions.

A Hawaiian medical association launched a voluntary practitioner quality and service recognition program. Practitioners who enroll share in a multimillion dollar budget earmarked to recognize practitioners for adhering to recognized standards of quality and clinical practices proven by research to improve clinical outcomes. Each program participant receives an award based on his or her scoring in each of the program components – quality indicators, patient satisfaction, and business operations. Practitioners are measured on a total of 68 clinical measures. Analysis of data on key clinical quality indicators over the six years of the program demonstrates statistically significant improved performance.

In Minnesota a health partner's program recognizing outcomes offers annual bonus awards to primary care clinics that achieve superior results in effectively promoting health and preventing disease. Eligible primary care groups are annually allocated a pool of bonus dollars that is awarded if a group reaches specific comprehensive performance targets. Since 1997, bonus awards have totaled over \$2.5 million. The impact on quality of care has been substantial. The proportion of diabetes patients meeting optimal care standards nearly tripled since 1999 and the rates of optimal coronary artery disease patients reaching all treatment targets doubled. The rate of members receiving all preventive care doubled. Tobacco use assessment at all visits increased from 45 percent to 85 percent over four years and more patients are routinely provided assistance to quit. Tobacco use rates dropped ten percent to an all time low. Diabetes eye and kidney complications rates dropped by nearly 50 percent and costs are trending significantly below costs for all other patients. In Minnesota death from heart disease dropped to the lowest rate in the nation and continues to decline.

A health care leadership association of health plans, physician groups, and health systems in California, recently implemented coordinated, state-wide pay-for-performance initiatives. Based on a comparison of data from the first year (2003) and test year (2002) nearly 150,000 more California women received cervical cancer screenings, 35,000 more California women received breast cancer screenings, 10,000 additional California children received two needed immunizations, and 18,000 more Californians received a

diabetes test. The program paid an estimated \$50 million to 215 California physician groups in the pay-for-performance program in 2003 (paid out in 2004), and an estimated total of \$100 million to the same physician groups under all of the association's quality programs.

The American Society of Clinical Oncology's Quality Oncology Practice Initiative (QOPI) is an oncologist-led, practice-based quality improvement initiative. QOPI's goal is to promote excellence in cancer care by helping practices create a culture of self-examination and improvement. The process employed for improving cancer care includes measurement, feedback, and improvement tools for medical oncology practices. Practicing oncologists and quality experts developed the QOPI quality measures, which are derived from clinical guidelines or published standards, adapted from the National Initiative on Cancer Care Quality (NICCCQ), and are consensus-based and clinically relevant. Although the measures are not yet linked to financial reimbursement, QOPI is an example of a specialty society-driven quality initiative that can be easily linked to a pay-for-performance program.

Results of these and many more provider-led initiatives, including those in the private sector, lay a sound foundation for CMS to move forward collaboratively with the Congress and with leading provider organizations toward adapting performance based payments for Medicare.

These approaches are also aligned with emerging requirements from medical specialty boards for maintenance of certification. While recertification has traditionally involved demonstrating cognitive knowledge only, all boards are moving to link maintenance of specialty certification with demonstrated efforts to improve clinical care quality and performance. We recognize that providers need to be actively engaged in establishing this new direction and will continue close consultation and collaboration to assure improved quality and reduced burden for busy practitioners.

**Conclusion**

Mr. Chairman, thank you again for this opportunity to testify on pay-for-performance within the Medicare program. We look forward to working with Congress and the medical community to develop a system that ensures appropriate payments for providers while also promoting the highest quality of care, without increasing overall Medicare costs. As a growing number of stakeholders now agree, we must increase our emphasis on payment based on improving quality and avoiding unnecessary costs. I would be happy to answer any of your questions.