The American College of Physicians (ACP), representing physicians practicing internal medicine and its subspecialties, is pleased to have this opportunity to appear before you today to present our views on further steps that should be taken to improve the quality and efficiency of clinical care. The topic goes to the core of the College's mission which, for 75 years, has been to uphold the highest standards of medical care.

We should begin with a brief assessment of where we are today, and where we have come in the three years of this Commission's operations. In the 1987 report, you set forth the criteria for future reform and you confirmed what those of us in internal medicine had long believed, that primary care was undervalued in relation to non-primary care services. This work became a critical element in our own efforts to argue that short-term budgetary actions should be consonant with the direction of longer-term payment reform. Congress responded, not only by reducing overvalued services but also by protecting primary care services from further freezes and reductions in the Medicare Economic Index. The recognition of this historic imbalance and the addressing of it in the short-term through a differential in the annual update of prevailing charges moved us along the pathway of payment reform.
In your 1988 report, you endorsed the concept of a Relative Value Scale as a means of developing a rational and equitable payment system. When we appeared before you last November 1988, shortly after the formal publication of the Hsiao study, we urged you to reject efforts by others to use "use the technical problems and limitations of the study in an attempt to derail its implementation" and urged you to "recommend that Congress use the Harvard RBRVS, with necessary improvements, as the basis for a new Medicare fee schedule."

In your 1989 report, after a full review and analysis of the Hsiao work, you recommended a three-part reform package focusing not only on payment equity but also on the questions of utilization and volume and on financial protection of beneficiaries. We firmly believe that your strong support for moving forward with an RBRVS fee schedule, and your efforts to craft a thoughtful solution to the politically volatile issue of beneficiary protection, were essential to making payment reform a reality.

Of course, as of November 22, 1989, key elements of your recommendations on payment reform have been enacted into law. A new Medicare fee schedule will be developed, utilizing the Resource-Based Relative Value Scale. The Medicare Volume Performance Standard will continue to focus attention on the volume of services, and a new research agency will help to expand the knowledge base necessary for making judgments about appropriate utilization. And lastly, beneficiaries will be protected from excessive financial liability. It is a remarkable record for an advisory panel such as this. The College commends each of you and the staff, and we look forward
to further cooperative efforts with you as we address the policy challenges that still lie ahead.

For the purposes of today's discussion of next steps in improving quality and efficiency of health care it is useful to begin with one of the most far-reaching challenges of the new legislation, the provision for a Medicare Volume Performance Standard. As you may recall, we were not supportive of the original proposals with regard to expenditure targets; although we did attempt to keep our opposition to this concept at a civilized level of debate. In large measure, our concerns about the early expenditure target concept were based on two factors. First, on our concern that we do not possess the knowledge base to accurately determine an appropriate level of growth. And second, on our fear that the tools for appropriate control of aggregate expenditures -- apart from the judicious application of guidelines in selected instances -- are not available. As we said on numerous occasions, we feared that across the board reductions in fees, as a result of failure to meet targeted levels, did not assure that we would in fact distinguish the "good from the wasteful." We are perfectly willing to examine the need for societally determined limitations on health care expenditures, but this budgetary task is distinct from determinations of appropriateness.

However, despite our past differences of opinion as to the policy remedy for inappropriate growth in expenditures, we have always been united in our belief that the problem must be tackled. It seems that we now face two critical tasks, particularly in light of the new provisions. These are tasks where we believe this Commission can make a significant contribution.
The first task is to accelerate efforts to fully analyze the reasons for increases in expenditures in Medicare Part B. The second task is to accelerate our efforts to develop the necessary tools for assuring that appropriate services are delivered. Throughout all of this, we would continue to caution that assuring that all services are in fact clinically appropriate may not result in the types of cost savings that some have envisioned.

In your 1989 report, you provided important background information on the growth of Medicare Part B expenditures. It is the College's view that this is only the beginning of the type of analysis which must take place if we are to understand present expenditures in a meaningful fashion. The purpose of this is to determine appropriate services, not first to control costs. The present state of unexamined information with regard to expenditure growth conveys to some policy makers and others that the system is riddled with inappropriate use of services. We need to develop the information that will permit us to determine whether this is in fact the case. We strongly urge you to build your previous analysis in your next report and to indicate how we can approach the task of understanding not only what is happening with respect to Part B, but why.

Asking questions about Part B is critical to providing a means for setting priorities for further research and for focused efforts to assure appropriateness. In some instances this may lead to savings through the elimination of inappropriate services. It would be a critical task under any circumstances, but is made even more so with volume performance standards. The profession cannot adequately respond without this information.
We need to begin to examine the growth trends in Part B in as disaggregated and specific a fashion as possible. Which components are growing most rapidly? What are the clinical and other explanations for these changes? Are these satisfactory explanations? Do they represent improvements in medical care or inappropriate use of services, or some of each? How can we tell the difference? Where do we think the inappropriate services are concentrated? How much of the spending increase is accounted for by costs that do not directly relate to providing medical care? What is the role of changes in the locus of service delivery?

Fortunately, the new legislation provides mechanisms for then building on this information in order to meet the next set of challenges. Through establishment of a new Agency for Health Care Policy and Research, and a Forum for Quality and Effectiveness in Health Care, we believe that we will greatly enhance and better coordinate efforts to set priorities for research and for guidelines development. The research sponsored by this agency will enable us to develop the knowledge base necessary for the determination of appropriate levels of service. Only with that kind of data can we make judgments about the medical necessity and cost efficiency of services, or judgments about whether a given target permits the "appropriate" rate of growth. This is not to say that we must await perfect information. We can begin now with the data already available.

Some of the questions which you have raised in preparation for this meeting, have been answered by the establishment of this Agency. Its charge with respect to: fostering and coordinating development of practice guidelines; setting a broadly-based research agenda; identifying needs and
priorities for technology assessment; developing performance measures and
review criteria; and developing better methods for dissemination of relevant
clinical information, will over time help assure a better health care system.

However, despite the creation of this new Agency, we do not believe that
it will obviate the need for this Commission's ongoing analytical work,
including contributing to the setting of research priorities. This
combination of efforts from the Commission and from the Agency will assure
that the necessary steps are taken. The Commission can lead the way on the
examination of current expenditures; this information can then be part of
the basis for priority setting by the new Agency.

This combined effort forms the necessary backdrop to the practical task
of guidelines development. It provides targets of opportunity for the
development of guidelines, and will enhance the ability of medical societies
to make those contributions which are uniquely theirs.

The College has long been committed to the development of
scientifically-grounded clinical guidelines. Beginning in the 1970's, we
have steadily expanded this effort, even though we were criticized by many
of our sister organizations as promoting "cookbook" medicine. We are
pleased that this year they, as well as this Commission and the Congress,
have endorsed the utility, indeed the necessity, of giving physicians these
kinds of guidelines.
We remain concerned, however, that guidelines should not be sold, by the profession or by others, as the solution to the issue of volume; what guidelines do is to give us a handle on what is appropriate and what is not. What we should all be after, in the long run, is to change physician and patient behavior so that it is based more on data and less on habit. Guidelines, appropriately done, can be the mechanism to this end.

We have discussed the College's process with the Commission in the past, so I will only review our work briefly at this time. The essence of our Clinical Efficacy Assessment Project (CEAP) is to assure quality care by bringing the best scientific information available to the question of which interventions are effective and which are inappropriate or obsolete, under what circumstances they are appropriately utilized, and when they are unnecessary. Our studies give us a scientifically-derived benchmark on indications for use, that may in turn guide physicians' decisions on managing the particular clinical circumstances of individual patients.

The CEAP studies range from assessments of a particular technology in all of its uses (e.g., the uses of intravenous pyelograms), to assessments of diagnostic testing in a specific clinical circumstance (e.g., testing after an acute myocardial infarction), to assessments of alternative approaches to studying an anatomic area (e.g., how to study the gall bladder). The studies consist of detailed reviews and synthesis of the literature, backed up by comprehensive review by experts within and outside of the College. Various techniques such as meta-analysis, decision analysis, and Bayesian probability assessments may be applied to the published data in order to develop practice guidelines.
Two documents are produced in a CEAP assessment: a detailed review of the literature in the form of a background paper, and a policy statement which is a short summary of the background paper and the clinical practice recommendations which emerge from it. The documents include a description of the technology, its safety, data regarding its efficacy and effectiveness, indications and contra-indications for use, data on cost, and conclusions and recommendations for appropriate use. The policy statement, but not the background paper, is subject to review and approval in the College governance structure, a process culminating in formal adoption as College policy by our Board of Regents.

This is not an easy task, and using technology assessment to derive clinical guidelines is not an exact science easily applicable to all medical technologies and services. Obviously it is a task complicated by all the factors that make medicine art as much as science, whose practice allows for reasonable and honest individuals to differ about what constitutes effective intervention under widely varying circumstances. The principal reasons for variability are legitimate distinctions among patients and those situations in which the applicable science is incomplete. Guidelines must always be applied with care and flexibility to take these legitimate factors into account.

It is this critical need for appropriate flexibility that is so important as we move toward an expanded government role in the development and use of guidelines. Physicians are willing to develop guidelines, but government and other payors must recognize the ambiguities, the subtleties, the absolute necessity for flexible application of those guidelines.
depending on the clinical circumstances of patient variability and the
certainty of the science. Nothing will defeat this effort faster than the
misuse of guidelines. Guidelines can be used as payment screens to help
identify outliers, but the process by which this is done, and what happens
once such a potential outlier is identified are as important as the
credibility of the guidelines themselves.

It is for this reason that, while we have endorsed the use of guidelines
in efforts to reduce inappropriate utilization, we have also urged caution.
We have argued that guidelines are not the only answer and that given the
present state of the art of utilization review, their use may risk bringing
the heavy hand of government down on practitioners. Thus, at the same time
that we go forward with an expanded federally funded research effort and the
development of guidelines, we must also move forward with a fundamentally
new way of reviewing medical necessity and utilization.

This brings me to a discussion of the other major challenge that faces
us. Present efforts at utilization control appear to be failing. Current
approaches to utilization control are antagonizing the physician community.
The anger generated by many utilization review requirements, by
inappropriate second-guessing of professional judgment, by intrusion into
the doctor-patient relationship, is felt by physicians who share with you
Medicare's goal of providing cost-effective health care for elderly
Americans. It is felt by physicians who do not question the responsibility
of the federal government to protect the public health and ensure a sound
fiscal basis for Medicare. And it is felt by good and caring physicians
who, as a matter of practice and philosophy, oppose wasting resources on the provision of inappropriate or unnecessary services.

Just as you have played the critical role in long-term reform of physician payment, we hope that this Commission will undertake a similar role in long-term, fundamental reform of utilization review. We would like to sketch out some preliminary thoughts on this kind of reform, for further exploration with you in the months ahead.

Utilization review must move away from its current punitive approach and towards a model based on what has been characterized as the continuous improvement of medical practice. The approach of the past has been one of audit and inspection, of "catching the crooks," and the net has been cast across all physicians in order to find those few who are outliers. Increasingly, the underlying tenor of utilization control seems to be to question the integrity and wisdom of all practitioners. This must change. It threatens the breakdown of the system.

We must begin to use our utilization review systems to educate physicians, to improve their practices on a continuous basis. The College believes that a restructured utilization review system should be oriented toward what we know about how physicians change their behavior. Physicians change their practices when they receive valid information from a credible source. That source may be the medical literature; it may be highly informed, respected members of the medical community. But, I would emphasize that the community or peer norm of behavior must be well-informed, and appropriate guidelines, developed seriously with a critical base in data,
are necessary to enhance appropriate behavior. Physicians want to practice like their peers, they want to be in the norm, as the Maine medical assessment work has shown, and they will respond when they see the norm evolving. We need to foster a peer standard based on reliable information, and then utilize the community of physicians to fully disseminate this standard.

Although reducing clinical uncertainty through better research is important in its own right, not enough attention has been paid to how we properly disseminate this valid scientific information. We would suggest that Medicare can, with appropriate rethinking and restructuring, serve as an agent for education and change, particularly as new research and guidelines development initiatives yield results. What is tremendously exciting about this prospect is that it means that the federal government would be playing a role in actually improving medical care for Medicare patients, and not simply paying their bills. To move in this direction will require a rethinking of what Medicare is or should be: prudent manager of health care resources or simply a fiscal checkpoint. Given the shape of changes in all aspect of the Medicare payment system, this is an historic opportunity to undertake this reexamination.

This is not to say that Medicare should give up its audit and inspection function: looking for the outliers. This must continue in order to assure fiscal integrity, but it cannot continue to be based on a case-by-case review of physicians' decisions, it should be done through the use of aggregate data on practice patterns that can flag aberrant behavior. It will also require as indicated better methods of following up on those patterns
of practice identified for further scrutiny. Immediate denial absent full analysis is not appropriate; review must determine whether the aberrant pattern reflects bad habits or is in fact, clinically justified.

In summary, it may be useful to begin to think about dividing Medicare's functions into bill payer and health care manager. The bill payer function is the traditional one, but it has been increasingly combined with the managerial function when carriers review medical necessity. This is a difficult line to walk, but at present the overlapping of these functions heightens the suspicion among physicians that decisions on appropriateness — that is, clinical decisions — are in reality fiscal decisions. In contrast, we conceive of the managerial function of the future as one devoted to the continuous improvement of the product, which is medical care for the patient. In this role of product manager, Medicare, with the help of the PPRC, the new research agency, and the physician community, would serve to bring the best information available to physicians and other health care providers, and show them how to change practice because it is scientifically valid to do so.

We would further suggest that the role of Medicare as bill payer is best carried out at the national level. The process of sending in claims, making payments for covered services, collecting data, and identifying patterns of practice needs to be centralized. Dissemination of valid, scientifically based standards for care works best when it contains an element of local participation. This is consonant with the Commission's notion of a local physician community working together to control volume in response to local expenditure targets. It also fits with the notion of education by peers,
and with the few research studies on the efficacy of guidelines vigorously applied in individual hospitals.

One final point; we hope that the Commission will review the assumptions underlying the division of utilization review responsibilities between peer review organizations (PROs) and the carriers. As the Commission pointed out in the 1989 report, we must clinically review an entire episode of care, rather than simply individual services. Doing this properly may require consolidation or reconfiguration of these review functions.

Mr. Chairman, we have used this opportunity to think broadly about your agenda for the next year or two, about pressing research needs, and the need for new thinking about how we assure quality. We do not claim to have explored these ideas about utilization review reform to their full conclusion, and recognize that with further evaluation some may turn out to be dead ends. However, we do believe that absent further change and reform along the lines outlined, that the promises of physician price reform will be undermined.

We would urge to you take reform the critical next steps by:

(1) more fully analyzing the factors contributing to the rate of growth in Medicare Part B expenditures;

(2) using this information to help shape a research agenda;
(3) using this information for targeting of selected guidelines
development for optimal short-term advances in assuring appropriateness;

(4) opening up the theoretical question of Medicare's role in the
health care system of the future: manager or bill payer;

(5) helping to shift us away from the punitive tone of much of
present day utilization control in part by examining ways in which
the continuous improvement approach can be brought to bear on
Medicare; and

(6) examining the appropriateness of maintaining historic distinctions
among review entities.

Again, in closing we congratulate you on your excellent work to date and
look forward to further reform and further progress. Thank you.