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IMPROVING QUALITY IN MEDICARE: THE ROLE OF VALUE-BASED PURCHASING

HEARING

BEFORE THE

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IMPROVING QUALITY IN MEDICARE: THE ROLE OF VALUE-BASED PURCHASING

WEDNESDAY, JULY 27, 2005

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Present: Senators Hatch, Kyl, Thomas, Baucus, and Wyden.

Also present: Republican staff: Kolan Davis, staff director and chief counsel; Ted Totman, deputy staff director. Democratic staff: Pat Boulisman, Bill Dauster, Kate Kahan and Janellen Duffy.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning, everybody. I want to honor four staff people before we start our hearing. We have four of our committee staff who have achieved 20 years of service to the U.S. Senate.

If they would stand, I would appreciate it: Kolan Davis, staff director and chief counsel; Ted Totman, deputy staff director; Carla Martin, our chief clerk; and Mark Blair, our hearing clerk.

It is very unusual for staff to meet this sort of benchmark of 20 years, especially since it is so easy to go out into the private sector in this area of the country and make a lot more money.

It shows how dedicated these people are to public service, and we owe them very much a debt of gratitude. So, I thank all of them for their service.

[Applause.]

The CHAIRMAN. Today's hearing will focus on improving quality and improving value in the Medicare program. I am a stickler for getting the most out of every tax dollar spent, and right now we are not achieving that in Medicare. That is not just my judgment, that is the judgment of a lot of the experts in the country, and especially those who are before us today.

The Sunday *Washington Post* article, "Bad Practices Net Hospitals More Money," highlighted this issue. The article describes the Medicare reimbursement system as being "upside down. Hospitals and doctors who order unnecessary tests get more money than those who provide efficient, high-quality medicine."

Right now, Medicare pays the same amount regardless of quality. As this article stated, it appears to actually reward the delivery of poor-quality health care. So, something is wrong when delivering

low-quality care leads to greater revenue for providers. It is the exact opposite of what we want and what we need for Medicare, the taxpayers, and the beneficiaries.

Of course, our Nation is blessed with millions of dedicated and qualified health care providers. These individuals care deeply about the quality of care that they provide.

What we have is a systemic failure of the Medicare payment system to reward quality and to provide incentives to invest more in health care information technology. Until we pay providers more for providing better quality care, we are not going to see any improvements.

The Institute of Medicine, in its report, "Crossing the Quality Chasm," set forth a broad strategy to improve quality. The Institute of Medicine stated that, among other steps, we need to "better align the payment system to promote quality and achieve greater value."

The Medicare Value of Purchasing Act, which Senator Baucus and I introduced, creates such a framework for linking Medicare payments to quality. The Medicare Value of Purchasing Act builds on small steps taken in the prescription drug bill of 2003.

That legislation required hospitals to report 10 quality measures in order to receive full payment. Now, almost 99 percent of our hospitals are reporting that data. The Center for Medicare Services is tracking improvements in quality among participating hospitals.

We also wanted to make sure that beneficiaries can view the quality information about their hospital and their health care provider.

Finally, I want to recognize the progress the private sector has made in developing and adopting quality measures. There are several value-based purchasing projects under way around the country. We do not want to reinvent the wheel. Instead, we want Medicare to learn from and build on these initiatives.

Now, some will ask why Medicare should take the lead. Well, Medicare spends more than $300 billion a year. Medicare happens to be the largest purchaser of health care in our country. It is like the old E.F. Hutton commercial. We know from the past that, when Medicare talks, the health care community listens. Senator Baucus and I believe that adopting quality payments in Medicare can, and in fact will, influence the level of quality in all of the health care, not just to Medicare beneficiaries.

In just a few days, Medicare will celebrate its 40th anniversary, a tremendous milestone. It has positively affected the lives of millions of seniors and disabled citizens.

We set a goal for ourselves 40 years ago to improve access to care. Providers and policymakers came together to make that goal a reality. It is time now, after 40 years, to set a new goal to ensure that Medicare beneficiaries, and all Americans, get the best possible care, and that we as a Nation get the highest value for our health care dollars.

The committee appreciates the expertise on this issue offered by today's witnesses. The witnesses and their organizations here today will play a large role in helping to accomplish our goal.

Senator Baucus?

**OPENING STATEMENT OF HON. MAX BAUCUS,
A U.S. SENATOR FROM MONTANA**

Senator BAUCUS. Thank you, Mr. Chairman.

This is a hearing that, frankly, is long overdue. I think it is going to be one of the more far-reaching, and almost benchmark eras in American health care. That is, we now are beginning to reward quality as opposed to rewarding or paying for whatever health care is provided.

Today, Medicare, the largest purchaser of health care, reimburses according to what the health care services are, irrespective of outcomes, whether the outcome is good or the outcome is bad. Clearly, that is a bit wasteful.

We are here today, beginning to change, I think in a monumental way, in a dramatic way, almost, the way Medicare reimburses providers, doctors, hospitals. It is beginning to be based much more on the quality of health care, not on just health care, generally.

We pay, today, whether the outcomes are good or bad. We want to move toward paying for outcomes that are good and not paying as much for outcomes that are bad. This is a revolutionary concept, frankly, one that is necessary and is needed. It is not going to be easy to implement, obviously, but we must begin. We must set about finding a way to get this done.

We know all kinds of instances where many hospitals, regrettably, have very, very high rates of infection, even in a doctor's office. One of the biggest problems in hospitals, generally, is infection. Whenever somebody is ill in the hospital, again, that person gets reimbursed, if it is a Medicare patient, under Medicare. We want to change that.

A major change in the beginning, here, is more reporting. With a lot more data, we are going to be in a better position to then address outcomes. We just need to have the data. What are the outcomes? What are the procedures that hospitals and/or doctors' offices are providing?

Beta blockers for heart patients, lots of different kinds of standards that should be addressed here. That is really the question here, and that is getting the data to know what hospitals are or are not doing.

Then once we get the data and once we begin to reimburse hospitals more according to whether they are providing the data—that was a provision in the 2003 Medicare bill. That is, all right, hospitals. We are going to start paying you more, or at least not paying you less, if you begin to provide data on outcomes. Just the data. Not whether the outcomes are good or bad, just the data. That is a start. That is a beginning.

Then once we have done that, the next step is, all right, we are going to start reimbursing you not only on whether or not you provide the data, but on what your outcomes are.

Once you start providing good outcomes and your data shows that you are providing good outcomes, we are going to start paying you, under Medicare, more for those good outcomes than just paying you irrespective of the outcome. That is what we are trying to do here.

I, frankly, believe, Mr. Chairman, that this is very important in so many ways. One, it is going to help reduce health care bills.

That is clear. It is also going to avoid unnecessary taxpayer dollars being paid under Medicare.

But more than that, it can start to set the ethic in our health care system even more, that we are going to focus even more on quality and quality of care. In so doing, I think we will then begin to address a competitive problem that we Americans have with respect to other companies overseas. That is, our health care costs today are so high, it is a competitive disadvantage for American companies compared with other countries' companies.

What is it, Mr. Chairman? It is like, $1,500 from each car goes to pay for General Motors' health care. That is $1,500 a car.

I think the Chinese cars that are coming off the line now and going over to Europe, the average health care bill attributable to that car is about $500 for a Toyota. For new Chinese cars, clearly, it is much less.

I am not saying that this new, revolutionary method of reimbursing Medicare is going to completely solve that problem. It is not, of course. But I am saying it is going to start us down the road of better health care that is based more on quality and start to root out some of the inefficiencies, unnecessary costs in health care, which we can no longer afford in this country, either from a taxpayer's point of view or from a competitive point of view.

So, I am very pleased, Mr. Chairman. I have joined with you, and you and I are writing this bill, and also with the Health Committee. They are making a lot of progress here, too. But this is exciting. We are going to make something happen here, and I am just very pleased.

Also, I am particularly pleased to have the witnesses here who know a lot more about all this than we. They can help guide us and steer us through all of this, tell us what they think is going to work, tell us what pitfalls to avoid. This will obviously be a work in progress as we move forward.

I want to thank both witnesses for starting out in this journey here today, because we are going to continue working with you and with others as we do our very best to make this happen.

So, thank you, Mr. Chairman.

The CHAIRMAN. Yes. Thank you.

We welcome our team that is here, our first panel.

Senator BAUCUS. I have a statement I would like to have put in the record, if I might.

The CHAIRMAN. Yes. The entire statement will be put in the record.

Senator BAUCUS. Thank you.

[The prepared statement of Senator Baucus appears in the appendix.]

The CHAIRMAN. Any other members who want a statement in the record, they will be received.

Senator BAUCUS. It is much more articulate than what I said, so I want to put it in the record.

The CHAIRMAN. All right.

Herbert Kuhn is Director of the Center for Medicare Management at the Centers for Medicare and Medicaid Services; and Mark Miller is Executive Director of the Medicare Payment Advisory Commission.

These two witnesses and their teams have been interested in improving quality in the Medicare system for a long period of time, and we welcome you.

So, we will start with you, Mr. Kuhn.

STATEMENT OF HERB KUHN, DIRECTOR, CENTER FOR MEDICARE MANAGEMENT, CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), WASHINGTON, DC

Mr. KUHN. Thank you, Chairman Grassley, Senator Baucus, and distinguished members of the committee. I appreciate the opportunity to testify on value-based purchasing for Medicare.

CMS is committed to establishing payment systems that reward and promote quality outcomes and superior performance, and this will be one of the most important issues we face in the Medicare program.

I am pleased that all of us are working together. At a time when we are bringing Medicare's benefits up to date and when we have more opportunities than ever to help seniors and people with disabilities to live longer and better lives, we need to support the participation and leadership of physicians and other providers through our payments as they seek to make the necessary investments to improve the quality of health care they supply.

Health care providers are in the best position to know what can work most effectively to improve their practices, and their expertise, coupled with their strong professional commitment to quality, means that any solution to the problems of health care quality and affordability must involve their leadership.

A fundamental problem with many of the Medicare payment systems is that they reimburse providers on a per-service basis. The more services provided, the greater the reimbursement. There is not necessarily a financial incentive built into our payment systems to provide the best care.

For example, a physician who calls or e-mails a diabetic patient to help them promptly change their insulin dosage to keep their blood sugar under control gets no financial support from Medicare, but we will pay a lot more if the physician requires the patient to come all the way into the office, even though this approach uses more resources and may lead to worse sugar control.

We pay oncologists much more to give patients with metastatic cancer additional chemotherapy drugs than we pay to help a patient and his or her family understand the prognosis and achieve more comfort and a better quality of life.

As another example, 21 percent of our beneficiaries who are hospitalized with heart failure are readmitted within 30 days. Studies show that about half of these readmissions are preventable. Yet, Medicare pays much less when physicians take steps to prevent these readmissions.

There are too many examples like these where we pay more when patients have higher costs and worse results. It is time to provide better support to the provider community.

Linking a portion of Medicare payments to clinically valid measures of quality and of effective use of health care resources would give physicians and other providers more financial support to take

steps that actually result in improvements in the value of care that people with Medicare receive.

In the fiscal year 2006 budget, the President recognized the need for payment reforms to improve the value of care delivered to people with Medicare. By building on the current administration efforts to pay for better quality, MedPAC has made many recommendations to implement measures of quality and efficiency and to pay for value.

CMS is engaged with the provider community on a number of fronts to establish quality measures that can begin moving us forward in a pay-for-performance environment.

Using these quality measures, CMS is conducting a number of demonstrations and pilots of payment reforms to pay more for better quality, better patient satisfaction, and lower overall health care costs in the Medicare fee-for-service program.

Mr. Chairman, it has taken a lot of collaborative work to get us where we are today, to see a payment system that everybody talks about changing, to find a better alternative to rapid and costly increases in the volume of services on the one hand, and the continuing threats of lower payments, even if the quality of care is better. It will take more work together to make the payment system transitions, but it is time to move forward in this direction.

We look forward to working with you, and others in 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. I look forward to answering your questions.

The CHAIRMAN. Thank you, Mr. Kuhn.

[The prepared statement of Mr. Kuhn appears in the appendix.]

The CHAIRMAN. Dr. Miller?

STATEMENT OF DR. MARK MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION (MedPAC), WASHINGTON, DC

Dr. MILLER. Chairman Grassley, Senator Baucus, distinguished members of the committee, the Commission has been working on pay-for-performance, that is, linking Medicare payments to the quality of care, for a couple of years now. With my allotted time, I want to walk you through some of the thinking and the recommendations that we have brought to Congress.

The Commission believes that Medicare payment systems must change. They do not promote quality. They are, at best, neutral, and in some instances negative, towards quality.

What is needed is a new generation of reimbursement strategies that differentiate among providers based on the quality of care that they provide. Furthermore, the Commission believes that Medicare must lead in this area.

It is obviously a large purchaser, as mentioned in some of the opening statements, but also our extensive discussions with the private sector repeatedly pointed to the need for Medicare to lead in this area in order to effect broad-based change.

A few years ago, the Commission embraced a principle of linking Medicare provider payments to quality, and that started a process over the last 2 years where we reviewed available measure sets for

different types of providers—hospitals, physicians, managed care plans—and tried to evaluate whether there was enough critical mass and validity in these measure sets to begin to link payment to performance. We also consulted with quality experts and quality organizations.

We had a set of principles we were trying to maximize: were the measures well-accepted? For example, meaning, is there clinical evidence to link them to quality? Are they validated by independent experts? Are they familiar to providers?

We wanted to be sure that plans and providers could improve. Does that mean that this part of their care is under their control, for example, as part of what they do?

Some measures need to be risk-adjusted for the complexity of the patient. Measures that are used that reflect that, need to be adjusted. But I would also point out that there are measures that do not need to be adjusted: they are good medicine regardless of how sick a patient is.

Finally, we wanted to be clear, or at least cognizant, of the burden that we are imposing on both providers and on CMS in undertaking this endeavor. We recognize that this is a big change. It will impose burden. But we think the cost of doing nothing is greater than moving forward.

So, this brought us to our March, 2004 report and our March, 2005 report, in which we made a set of recommendations of what areas of Medicare are ready to move forward on pay-for-performance.

So, at this point in our process, we have looked at measure sets and believe that there are enough initial measures to start, and here are the areas that we have made recommendations on: physicians and facilities who serve dialysis patients; Medicare managed care plans; home health agencies; hospitals; and physicians.

For dialysis, managed care plans, and home health agencies, Medicare is collecting data, either through the claims process or other processes, that allow these areas to move forward. I am not going to say more about those, but I am happy to take questions on them.

I would like to focus for a couple of minutes on hospitals and physicians. We also think that there are sufficient measures to move forward on hospitals and physicians.

Right now, there are more than 20 process measures for hospitals that have either been passed as part of the MMA legislation that was referenced in the opening statements, or have been endorsed by quality organizations since then.

So, we think there is a set of process measures, and by that I mean things like beta blockers after a heart attack, or giving antibiotics to prevent surgical infection, that could move forward now in the hospital area.

We also think there is a selected set of safe practice measures that have been endorsed by various quality experts and that involve things like verbal order read-back or a pressure ulcer prevention program, those types of things. Finally, we think there are a few outcome measures in the hospital setting that could be ready to go.

For physicians, it is a little bit more complex. Medicare does not have as much data and experience in this area. There is much more highly specialized services and specialties, and certainly more physicians.

But physicians are central to pay-for-performance in improving quality, and they need to be involved in any effort. To navigate this complexity, the Commission has a two-step idea here.

The first is to incent physician practices on IT functionality. The notion here is, reward them if they can do things like produce patient registries or patient notification systems, those types of things.

I want to make clear here, the Commission's view on this is that you incent what you want IT to do, as opposed to pay for the purchase of IT. Again, I can discuss that if there are questions about it.

That also positions you for the second phase of pay-for-performance, which is for Congress to set a date certain that Medicare would pay on process measures in the physician setting. There are process measures available for physicians that cover a wide range of conditions that Medicare beneficiaries have. However, more complete measure sets are needed.

Through our research, we believe that through a consultation process, perhaps run by the Secretary with specialty societies and quality organizations, a broader range of process measures could be identified and be ready in another 2 to 3 years.

So, in summary, for physicians, anyway, it would be two steps: incent IT functionality, and move to process measures in a couple of years.

I want to comment, briefly, on our policy design principles. We think that a policy like this should reward both attainment and improvement. So attainment, whether you meet or exceed a benchmark, and improvement, if you significantly improve on that benchmark.

We believe that we should give providers every opportunity to get performance payments, and we think that this is the way to effect broad-based change in beneficiaries' quality of care.

The second principle is to begin with a small percentage of dollars, 1 to 2 percent. I want to be clear, this is from existing dollars. This is a budget-neutral policy. We think that this is small enough not to be disruptive to providers' revenue streams, but large enough to begin to effect change.

The Commission's view is that this percentage should increase over time as providers in the program become more familiar with pay-for-performance. We assume that this pool is redistributed. It is not held back. It goes back to providers.

Then the last principle that I will mention is that there needs to be a process for maintaining and updating measures. You need an independent, inclusive entity to pull together payors, providers, quality organizations and CMS for the purposes of making recommendations for Medicare pay-for-performance measures. So this is new measures, retiring old measures, making adjustments as necessary.

One other function: to coordinate private and public efforts, to effect the broadest change and streamline burden for providers.

In closing, I have two comments. Some people also include efficiency or resource use measurement as part of pay-for-performance. I want the committee to know that this is part of MedPAC's agenda to look at these types of measures. We have made one recommendation to the Secretary on this point.

We have called for measuring physician resource use and confidentially feeding that data back to physicians so that they can become aware of their practice styles relative to their peers and begin a process whereby the program and physicians can collaborate on looking at resource measurement.

In closing, the Commission recognizes that pay-for-performance is a large change, and it surfaces issues and complications, but the Commission believes that the problem is urgent and supports going forward. The status quo, where we pay the same for both good and bad quality, is not acceptable.

I would like to thank the committee for their leadership in this area, and thank you for asking for the Commission's views on this. I look forward to your questions.

[The prepared statement of Dr. Miller appears in the appendix.]

The CHAIRMAN. Yes. Thanks to both of you for your testimony. We will have 5-minute rounds. The order will be: Grassley, Kyl, Wyden, Thomas, and Hatch, at this point.

I am going to start with Mr. Kuhn. CMS has been conducting several demonstrations—you have referred to these—in the hospital arena. It is my understanding that CMS has partnered with Premier, a nationwide organization of not-for-profit hospitals, and is rewarding top-performing hospitals by increasing their Medicare payments.

In the physician arena, a physician group practice demonstration for physicians in large practices tests a hybrid methodology for paying physicians that combines Medicare payments with a bonus pool derived from savings achieved through improvement in the management of care and services. In addition, CMS is developing other demonstrations for physicians.

So my question to you is, what are the results of the above-mentioned demonstrations? Have they shown that linking payment to performance is an effective way to improve quality of care?

Mr. KUHN. Thank you, Mr. Chairman, for that question. Let me start with the physician group practice demonstration. That one began on April 1, so we do not have any of the results yet. But our findings thus far, in terms of building that demonstration, give some pretty good indicators on three important areas.

One is how we collect the data, and how we do that in a way that is as seamless to the physicians as possible so we can collect it in a manner that is not burdensome or costly to their practice.

The second was the development of the measures. We are using a set of 32 measures for that particular demonstration.

Finally, on that demonstration, we have been able to look at what kind of payment methodology might work. So, those are three early findings from that demonstration before we have even harvested the information.

On the Premier demonstration, there are about 300 hospitals across the country, looking at 34 indicators in 5 disease categories. We have not yet audited the data that they have shared with us,

but thus far, we have received 4 quarters of the data, and I understand they have the fifth quarter.

What we are seeing, at least in the release of the information they have, is exactly what we would all hope to see, real performance improvement by that cohort of hospitals.

Not only is the entire group of hospitals improving their quality of care across all the indicators, but the entire group, from the top decile to the bottom decile, are moving closer together, so the variation among the best performers and those at the lower end is not as great.

So, that particular demonstration is showing the results that we all want to see, and what we have all talked about at this hearing thus far is real improvement, and real quality improvement for the beneficiaries.

The CHAIRMAN. Too often, we think spending more money on something might give better care, in this case, health care. A recently-published article in *Health Affairs,* called "Medicare Spending, Physician Workforce, and Beneficiaries' Quality of Care," concluded that more money does not necessarily bring better care.

Then we have a document, *The Dartmouth Atlas of Health Care.* This one is not quite as recent, but back in 1999 it reports, "Improving the overall quality of care in the Medicare program cannot be achieved by spending more. The task is to improve quality of clinical science, the quality of clinical decision making, and the quality of resource allocation."

Then we had the *Washington Post* article, pointing out that there are striking variations in the amount that Medicare pays for care across the different States.

What is your reaction to these studies that suggest more money is not necessarily a solution to the potential problems with the quality of health care in America, and how would you recommend making sure taxpayers get more value for their health care dollars?

Mr. KUHN. Let me just make a couple of observations on that. First, I think we would all agree here that medical decision making should be based on the science, and hopefully not on the various payment systems out there.

But I think, as evidenced by the information that has already been presented here today, and certainly by numerous studies, that payments do drive practice.

As a result, we see great variation in different parts of the country, variation as a result of the number of specialists in an area, the number of hospitals, and the kind of behaviors that are out there.

I saw recently some information that was presented by the Agency for Health Care Research and Quality that looked at hospital payments. This was for 2003. Seven hundred and fifty billion dollars, from Medicare, private payors, et cetera, is how much is spent for hospital care in this country.

But if you look at that in the top three areas—heart attacks, coronary artery disease and congestive heart failure—$100 billion is spent.

If we began to make some improvements in those areas, such as dealing with some of the surgical areas in terms of not only over-

use of surgery, but, importantly, in terms of infection rates and readmissions, we could begin to gather savings.

So, my point is, I do not know that the answer is that more money is necessary. I think it really is a redistribution issue here. We can get better savings if we get better efficiency here where we are.

The CHAIRMAN. I am going to go to Senator Baucus now, because my time is up. But I will have a question for you, Dr. Miller, on the second round.

Senator BAUCUS. Thank you very much, Mr. Chairman.

First, I very much commend you, Mr. Kuhn and Dr. Miller, both MedPAC and CMS. You have done a lot of good work. You have obviously thought a lot about this and are trying to help.

Dr. Miller, our legislation has certain dates for various groups, hospitals, physicians, health plans, et cetera, dates for pay-for-reporting, and dates for pay-for-performance. We have heard from some of these groups that they feel that the timeline is a little tight, a little short. Surprise, surprise.

I am curious what you think. I do not know if you have had a chance to see the dates themselves under the matrix for reporting and for performance, but I would like you to tell us what you can.

When do you expect the groups that you have listed in your MedPAC analysis to report data on quality to CMS, and when is it feasible to begin tying those payments to quality?

Dr. MILLER. Our entire objective, and what I tried to touch on in the short opening statement, was to identify measures where you could move forward as quickly as possible. I would like to reemphasize a couple of points, just to make them clearer.

For example, in managed care plans, dialysis, and home health agencies, the data that we looked at that we think is robust enough to begin to link payment, is being collected now by Medicare, either through the claims process—for example, dialysis claims come in, and in addition to the claim they have the results of certain tests, hematocrit levels, adequacy of dialysis.

Those can actually be captured now and used to measure the performance of a dialysis facility. Managed care organizations report HEDIS process measures and patient satisfaction measures.

In hospitals, as I said, I think there is a set of 20 measures that I think people agree upon now that could be used, and then I have identified some other measures that have been validated, but are not necessarily being collected, but we think are within easy reach to be collected.

The physician area is a little bit more complex. We laid out a two-step process, and so we think you could, in the short-term, very immediately, begin to collect information on how a physician office's IT works.

That, we think, could be immediately collected. If you needed broad-based process measures for the physician world, we think that is a couple of years away, and that is why we set up a second step.

We recognize within the Senate bill you do have this kind of two-step process. So what I would say, and I think this represents the Commission, there is a set of measures across all of these areas that we have talked about now that can start immediately within

the next year or so. Then there is certainly some evolution, in addition, of measures that have to happen.

Senator BAUCUS. So we are just trying to get a sense of how strong to push, how much to push, and how much not. Do you think the dates and the deadlines here are about right or are they a little bit too aggressive in some areas, a little too lenient in others? I am just trying to get a sense here.

Dr. MILLER. I am not sure I have the matrix of dates all organized into my head completely. But my sense is, you are moving forward on reporting within the next couple of years.

Senator BAUCUS. Right.

Dr. MILLER. And then the pay-for-performance, a few years after that.

Senator BAUCUS. I will just tell you, for reporting, for hospitals it is ongoing, for physicians, 2007. Again, this is all just pay-for-reporting. It is not for performance, just for reporting. Health plans already report that dialysis already; home health, 2007; skilled nursing, 2009. That is for reporting.

Now, under the heading of pay-for-performance, hospitals, 2007; physicians, 2008; health plans, 2009; dialysis, 2007; home health, 2008; and for skilled nursing, we do not have anything here because apparently MedPAC did not have a recommendation.

Dr. MILLER. That is correct. My sense is that most of that is achievable. I think our greatest reservation is how fast a full range of process measures can come online for physicians.

Senator BAUCUS. How can we help, in terms of resources?

Dr. MILLER. Particularly in the physician area or more broadly?

Senator BAUCUS. It is your call.

Dr. MILLER. All right. We will do both.

Senator BAUCUS. All right.

Dr. MILLER. I should not say this principle is specific to physicians. This principle was articulated also in our work, the notion of paying for IT functionality as one of the places that you want to start.

You might have a measure set that includes some process measures, because they are already agreed upon and endorsed by various quality organizations, and a set of IT functionality measures, so you are going for the low-hanging fruit on the process measures and then making payments to the provider on the basis of their IT functions. You have created that pressure for them to invest in IT, which gives you the ability then to collect your process measures.

So if you are asking us, our point would be, the strategy is to grab the easy process measures that are available now, start incenting on IT functionalities for physicians and other providers, and that will give you the critical mass to get more measures.

Senator BAUCUS. Just on a percentage basis, how much of the fruit is low-hanging currently today?

Dr. MILLER. I am not sure.

Senator BAUCUS. Just a rough guess. Is this peanuts or is this real?

Dr. MILLER. I do not think I could really give you a good answer. I really do not know the answer to that.

Senator BAUCUS. Thank you.

The CHAIRMAN. Thank you.

Now, Senator Kyl. After that, Senators Wyden and Thomas.

Senator KYL. Thank you very much, Mr. Chairman.

Part of the reason for this exercise, of course, is that since the government is the big payor here, there is always a tension between our desire to ensure the best quality of care for those who participate in government programs and to be concerned about the cost of the programs, because we are using taxpayer dollars.

I think everyone agrees that practices can be improved. Physicians, for example, are constantly trying to keep up with best practices. Theoretically, the approach that is being recommended here, as I understand it, is to attach payment to quality, to identify better practices and better outcomes and to pay more for those.

But looking at the real impact of the bill rather than its theoretical concept here starting out, we actually reduced payments by the withholding. We withhold 2 percent, for example, from some physicians. This is starting out.

I had thought that there was a consensus that the reimbursement to physicians was going to have to be addressed by this committee later this year because it was inadequate because of the market basket measurements that are deficient. I thought there was a fairly clear consensus on that.

I would like to get both of you to comment on that. Dr. Miller, you in particular said it was your view that this would be just fine because of your opinion that the withholding was small enough not to affect physicians. I doubt that you can find very many physicians that will agree with that. I would be curious about what data you have.

I will tell you, I am really worried about a lot of the physicians in Arizona, where we already have a shortage of physicians, especially in rural areas. I think this will be perceived as an enormous problem.

Dr. MILLER. I understand your question, and I understand your concerns. In an opening statement, you can only cover so much ground, so let me back up and clarify this for you.

What the Commission does, in addition to pay-for-performance and a bunch of other things that we are asked to do, is every year we assess the adequacy of payment for different provider groups and make a recommendation to Congress. We look at a whole range of things: access to care, growth in volume, supply of providers, whether the capital markets are looking at these providers.

Senator KYL. Do not filibuster me here. Just kind of get to my point of view question. I asked your opinion.

Dr. MILLER. We look at a whole set of factors, including how well Medicare payments cover the cost of providers, and we make a recommendation to Congress on what to pay. You have to understand our proposal in that context.

We made a recommendation, if you are talking about physicians specifically this year, that there should be an update for physician payments. It is in that context that we are talking about pay-for-performance.

Senator KYL. So that if we followed your recommendations and increased the reimbursement for physicians first, are you suggesting then that the 2 percent would come out of that increased amount?

Dr. MILLER. And that is the strategy that we are talking about overall here. You make a decision on adequacy overall, and then do the pay-for-performance and redistribute among providers.

Senator KYL. So, you are, first of all, encouraging us to make the readjustments, and only after that is done, then to provide for this withholding.

Dr. MILLER. I am encouraging, in all instances, that Medicare should pay adequately. Absolutely.

Senator KYL. Of course. We all agree with that.

The question is, do you assume that we will have put into place the recommendations for improvements in the reimbursement before the withholding would take effect so that it would be a net, rather than a gross, amount?

Dr. MILLER. The Commission's position is that there should be an update for the physicians, and then pay-for-performance.

Senator KYL. Fine. Thank you.

Mr. Kuhn?

Mr. KUHN. Senator, the current SGR system, the sustainable growth rate, is not sustainable. Nobody can sit here with a straight face and say that these cuts as far as the eye can see for physicians are right and appropriate and would lead to good care. But pouring more money into the old system, because the old system does not work, is not right either.

So what we are talking about here is linkage between these two. There is a pivot here, as we begin to look at pay-for-performance and value-based purchasing, concerning how we begin to transition toward paying physicians and other providers in this new way, and how we do it so that it is seamless for physicians so they do not take a hit on payments next year, the following year, or the year after.

Transitions in the Medicare program from one payment system to another are issues that we have to continue to work through. Currently, we do not have any detailed recommendations on that transition, but I think you have hit the key issue here, the transition, and can we make it right, and can we make sure that beneficiaries do not lose the care they need and the providers are paid appropriately.

Senator KYL. All right. So then both of you do agree with what I had assumed was the consensus, that the reimbursements today are inadequate, they are going to have to be improved. What you are both saying is, in the course of doing that, pay-for-performance should be one of the elements in the payment methodology.

Mr. KUHN. That is correct.

Senator KYL. A key element for it.

Mr. KUHN. That is right.

Senator KYL. All right.

Mr. Chairman, thank you.

The CHAIRMAN. Next, is Senator Wyden.

Senator WYDEN. Thank you very much, Mr. Chairman.

I want to thank both of you as well for your good work. I want to ask you about Medicare and end-of-life care, because I think we all understand that much of the spending in Medicare takes place in the last 6 months of a senior citizen's life.

What the best doctors and best hospitals are always saying is that often they can spend enormous sums of money and not do anything to improve quality or be medically effective. It seems to me that we have to do more with hospice and the comfort and care area.

I want to ask you about two areas. One is to assess your ideas with respect to linking pay-for-performance for doctors and hospitals to this whole issue of hospice and comfort care.

The reason I asked about that is, if your doctor does not tell you about hospice and you have a terminal illness, you might not be likely to get into hospice soon enough to take advantage of the full benefit and you might be more likely to use more hospital services, again, because you are not in the hospice program.

So, what can be done to link folks into hospice sooner in order to promote this idea of hospital and physician pay-for-performance?

Mr. KUHN. Mr. Wyden, I think those are awfully good thoughts. Particularly, I think the example I used in my testimony of someone with metastatic cancer, where the incentives right now are to continue chemotherapy treatments versus trying to get more comfort and a better quality of life for the patient, illustrate why we must begin to move that process forward.

The linkage of pay-for-performance into payments for the doctors, the hospitals, and the entire post-acute care setting, whether it is home health, whether it is skilled nursing, whether it is hospice and the others, is something that I think we have to look through in this transitional process.

The agency has begun to do a lot of thinking about post-acute care, and whether there are better ways that we can do better assessments of the patients, and as a result of that, put in the quality indicators and move the patient to the right setting at the right time so they can get the care they need.

I think this is an area that is ripe for work. It is one we started to think about overall in post-acute care. We have not drilled down to the level, I think, in terms of what you are talking about there.

But it is an important one, and I think it does really enhance the quality of life of the patient, and make sure that they and the family get the comfort and the care that they need at this time.

Senator WYDEN. I hope the Department would fund demonstration projects in two areas. The first would be in this question of linking, what happens with doctors and hospitals with hospice and comfort care.

Second, we need some demonstration projects just on this question of quality of care in hospices. In other words, people are going to need to know more about the quality in those individual hospices. I would like to see you both working in that area.

Mark, do you want to get into this?

Dr. MILLER. The only thing I was going to add, because I agree that there is a need to develop measures that help the providers focus on this, but also, to the extent that you move to patient satisfaction and patient experience measures, you can also include measures as to whether the provider has provided a complete range of discussion with the patient on what their options are, and try and get movement that way as well.

Senator WYDEN. Now, one other long-term care issue. Senator Smith and I have introduced S. 708, the Long Term Care Quality and Consumer Information Act, so as to start linking this whole pay-for-performance to the nursing home area. Of course, the nursing home industry collects more data than most other providers on patients and quality.

What do you think about the idea of a bipartisan effort in the long-term care area? Because, since there is so much data on it, would this not be a pretty good place to start as we get into pay-for-performance?

Mr. Kuhn?

Mr. KUHN. I could not agree more. I think the area of long-term care is a good area. Through the minimum data set, a good amount of data are collected. We have already posted 15 of those measures on our website now publicly, so we have reporting. It is time to move to the next step of pay-for-performance.

In our current regulation that we have out for skilled nursing facilities, we ask this very question from the stakeholder community: give us thoughts, how should we begin to move in that next area?

So we, as an agency, are thinking about that, and we would love to work with you as we move forward in this area, because it is an area that I think is ready. I think we can get some real improvement in this area.

Dr. MILLER. If I could just add a couple of things. One issue within the skilled nursing facility setting, specifically, is the notion of delineating between short-term and long-term patients, because Medicare patients have very distinct experiences. We think, if you are going to develop measures and link pay-for-performance, there are probably some sub-populations you need to focus on there.

The only other thing I would say is, to the extent that your comments reach broadly across long-term care, we went through a process just recently in which we were trying to see whether there could be common assessment instruments so that when you looked across this population you would have uniform measures, as opposed to what we have now, which are measures tied to each setting.

There are some real issues that, off-line, we should talk about, about how to build that kind of common assessment instrument. There are some real difficulties there.

Senator WYDEN. Thank you, Mr. Chairman.

Senator BAUCUS. Thank you, Senator.

Senator Thomas?

Senator THOMAS. Thank you, Mr. Chairman.

Thank you, gentlemen. This is certainly an area that I think everyone agrees they like the idea, it is how you implement it, and the difficulty there.

I presume, in the private sector—in any sector—choice has something to do with it, does it not: where you go, what kind of a provider you go to? What about competition? Is there not any effort in the private sector to do some of this, "I do it differently than you do," to do it a little less expensively? Is that a function? I do not know.

Mr. Kuhn, you were fairly general in your opening statement. Give me one or two ideas specifically on how you measure performance.

Mr. KUHN. There is a level of specificity in how we measure performance. In the hospital area, with the Hospital Quality Alliance and the HQI, the Hospital Quality Initiative, currently we have 17 indicators of quality.

That information is posted on our website, and it looks mostly at process measures, that is, the process that the institution goes through to deliver better care, and not necessarily outcomes.

Under the Premier demonstration, we have 5 disease categories and 34 indicators where we have a combination of both process and outcome, so you get even more granularity in terms of how you look at the patient and the experience that is out there.

Another dimension of quality that we hope to be able to measure soon is patient satisfaction. So that if you get the quality measures that are out there with process outcomes, and then ultimately move towards a patient satisfaction survey, you can get a pretty good representation of the overall patient experience in that facility, and that, too, we hope to make public.

So you put all those things together and you can begin to connect the dots and get a better picture of quality and what is being delivered at those facilities.

Senator THOMAS. I see. So, outcome is not the only component of a measurement.

Mr. KUHN. That is right. Both process and outcome are absolutely key. Others are structural measures that you can look at: do they have things in place like the IT systems, et cetera? Then, ultimately, patient satisfaction. So, I think those 4 dimensions are all areas that you can use to measure, to record, and make public.

Senator THOMAS. Sure.

Dr. Miller, I presume different providers have different procedures. So if you measure procedures as opposed to outcome, or in addition to outcome, do different providers have the flexibility to do different procedures that they think are more effective than others?

Dr. MILLER. Yes. If I understand your question, I think that part of the process, and the process that we went through and the process that we would envision the program going through, would be a collaboration among the providers and the program quality organizations of identifying the measures that capture the dimensions of care for a specific set of providers.

So in the hospital, it may be giving a beta blocker after a heart attack. In a physician's office, it is, did you run the HC–1A for your diabetics? The process measures would be specifically identified for the providers in question and, indeed, for potentially different categories of patients.

Senator THOMAS. So you are suggesting that everyone follow pretty much the same procedures.

Dr. MILLER. No. I think what I am saying—now I think I have a better sense of what you are going after here—is that there are process measures for each of the different settings we are talking about where there is widespread agreement that, when a patient comes in, this should be done.

Senator THOMAS. I see.

Dr. MILLER. So it is not sort of a cookbook, you have to go A, B, C.

Senator THOMAS. Right.

Dr. MILLER. But you see my point.

Senator THOMAS. Yes, I do.

Just generally, are there providers, physicians on your Commission?

Dr. MILLER. Oh, yes. There are five, if I am not mistaken. Well, there are five physicians. There are people who run hospitals, people who run post-acute, those types of things.

Senator THOMAS. Yes.

Now, we have State programs, Mr. Kuhn, that I understand are fairly into this whole process.

Mr. KUHN. Yes. There are a lot of other areas where innovation is occurring in this area. Some of it is going on with the Medicaid programs, and we are trying to understand what the Medicaid programs are doing. Can we learn from them in terms of better ways to do things, and can we also share that with other States so they can move in that area?

Senator THOMAS. Good.

Dr. MILLER. Likewise, the private sector is way ahead of us in this area. We are looking at their programs and are working with them as well.

I think the real key issue here, and we heard it in the opening statements, and time and time again, is that this is something that everybody agrees ought to be done, and it is a real collaborative effort. That makes it much more easy to move forward.

Senator THOMAS. So we are not imposing something new on everybody. This is already in place.

Dr. MILLER. This is in place in many, many areas. That is correct.

Senator THOMAS. Do we need legislation to accomplish this job?

Mr. KUHN. Right now, under our current authority, we think we can move in a lot of areas so far where we are. We are continuing to evaluate, and we hope to be able to have some stuff out later this year where we can talk about, do we need some additional authority to move forward? We feel pretty comfortable with some of the authority we have right now, but we may need additional authority as we move forward in these payment systems.

Senator THOMAS. Any comment on that?

Dr. MILLER. The Commission's view is that there is a very significant change in authority that is needed through law, which is the ability to pay differentially across providers in Medicare payment systems, and, with many of the recommendations, the assumption is that that would take legislative authority.

Senator THOMAS. I see. Thank you.

The CHAIRMAN. Senator Hatch?

Senator HATCH. Well, thank you, Mr. Chairman.

I appreciate the testimony of both of you. You are very, very good servants of the people, as far as I am concerned.

But as far as pay-for-performance is concerned, Mr. Kuhn, why should we be paying Medicare providers more money for that which they should do anyway, and what type of impact will pay-for-performance have on rural providers, like we have in all of our

States, and in my home State of Utah? From your perspective, what has been the reaction of the providers when it comes to pay-for-performance? I would be happy to hear from both of you on that.

Finally, how will CMS's work on quality coincide with the quality of performance work that is being done in the private sector?

Mr. KUHN. A lot of good points there; things to raise. In terms of the providers, the private sector, we hope it will be complementary to and help support things that they are doing, and then hopefully the things that we do will support what they are doing.

We are not out trying to reinvent the wheel and create and erect new kinds of incentives out there that would be inconsistent with what is going on in terms of evidence-based efforts that are already going on.

The last thing we would want to do is for a clinician or a hospital to say, well, this is private pay and we have to do this for them, and this is Medicare, we have to do something different. We want everybody pushing and pulling in the same direction as we go forward.

Your first question, however, I think is a good one in terms of, why should we pay differentially when we should be getting quality care that is already out there? I do not think it is so much paying for higher-quality care. It is to a degree, but right now, the way the current system is designed, we do not really enable providers to deliver the quality care that is out there.

Senator HATCH. I take it you do not have the incentives, you are feeling.

Mr. KUHN. That is right. The incentives are not aligned right. Take, for example, a group of physicians who are dealing with patients who have chronic conditions; diabetics, for example. They really invest in those patients. They deliver high-quality care.

As a result, they reduce the number of hospitalizations and overall the Medicare program saves money. What happens to the physicians? They actually lose money because they do not get paid for those other interventions. Therefore, because the patient is not going to the hospital or needing additional care, it costs them at the end of the day.

So the incentives are to deliver more care, more redundant care, reward complications, errors, things like that. Instead, if we pay in order for them to invest in quality systems and invest to deliver higher quality of care, yes, it is paying for them to deliver higher quality care, but I think the incentives are driven in a more aligned, more appropriate way.

Senator HATCH. Dr. Miller?

Dr. MILLER. Just a couple of reactions. First of all, I completely agree that the incentive structures are wrong. I mean, it is do more, and it is also, if you have money to invest, invest in some kind of technology that generates revenue as opposed to electronic medical records or decision support systems.

To your rural question, there are a couple of issues that I think need to be addressed there. One is, you always want to be very conscious in these measures that you have enough "N", enough sample size, enough cases, in order to robustly evaluate a given provider.

In the rural setting, if we have a very small hospital or physicians' practice, one way to overcome that problem is to combine years, to take multiple years to develop your measure, whereas, in an urban area you may be able to work with 1 year.

Another thing to think about in the rural area is, sometimes rural providers have very specific functions. There are hospitals that are just designed to stabilize patients and move them out. So, you may want to emphasize certain measures or a more narrow measure set for those kinds of providers in evaluating them.

We do not think this should not go forward in rural areas, but we think there is probably some tailoring that needs to be dealt with in order to address a couple of specific issues in the rural setting. Maybe I will stop there.

Senator HATCH. Thank you.

Let me just ask a series of questions about the *Washington Post* articles. They have run a series of articles on Medicare that has been highly critical of the program, at least the way I view it. So, let me ask these questions: what is the agency's response to some of the points that were raised, Mr. Kuhn?

Do you think they were justified? How can things be improved in the agency to ensure that Medicare beneficiaries are receiving the best care possible? I am specifically interested in how those organizations that actually review quality of performance of Medicare providers develop their criteria. Last, but not least, does CMS review the work of these organizations on a periodic basis?

Mr. KUHN. A very good question. Two areas. One, let me start a little bit with the Joint Commission, because that was one area. Then let me talk about the quality improvement organizations.

We have already initiated three things to improve in that area, and I would like to share that with the committee. First, one of the issues that was raised in the article is the sample size and how we go about validating whether the Joint Commission is doing good work in terms of accrediting these facilities. We are moving to increase the sample size that is out there, and we think that is appropriate.

The second area is really the complaint data. A lot of follow-up investigations of hospitals and other providers are based on complaints. But are there some indicators in those complaints that can give us some signals that might indicate that there are problems in other institutions?

Complaints could be a flare that we are not seeing very well, and we need to recognize that. So, we have a contractor working to help us understand that.

Then, finally, the issue had to do with a disparity. That is, when we go back and we look at what the State surveyors found versus what the Joint Commission found in terms of accreditation, whether the facilities were meeting their conditions of participation, we are going to go back, perhaps, and look at some regulatory changes on how we look at those levels of disparities and how we can work with the Joint Commission to make changes. So, I think that is an important area.

In terms of the quality improvement organizations, as characterized in the paper, these are enforcement agencies, but they really are not. They truly are quality improvement organizations and

their role is designed to have interventions with providers to help them improve the quality of care.

So, the focus was looking at them as kind of a "got-you" system, as an entity that could go after an organization, but, in fact, their role is to help providers improve the level of care and to work with them in a collaborative way, and an educational way, to make changes.

The important thing about these organizations is that they really are a change over the last decade from what we saw previously in terms of health care. Early on, what we had in a regulatory mode was an effort to kind of count and punish.

That is, let us count the number of errors, count the number of problems that were going on with providers, then let us punish them, whether they be nurses, physicians, facilities, or whatever.

But a decade ago, we began to pivot. We said what we really need to do is begin thinking about educational opportunities, helping these facilities improve. Yes, where there are bad actors, let us catch them, let us deal with them.

But more and more, it is, let us get a level of improvement. Let us work with these institutions to help them provide better care. That is the change that you see here in the quality improvement organizations, and we think, quite frankly, they have been pretty effective in terms of doing that.

Senator HATCH. All right.

Dr. Miller?

Dr. MILLER. I cannot speak to the QIO issue. But I would say that the *Washington Post* article really captured issues and problems that the Commission and others have been speaking about for years, this dramatic variation in the utilization of services which has no clear linkage to quality, at least at a population level, the incentive structures in the program that just promote the wrong type of care or promote more services, or investing in certain types of services as opposed to others.

So my view, when I picked up the paper on Sunday, was that it was pretty consistent with messages that we have been trying to get out, and policy directions that we have been trying to promote to address some of those issues.

Senator HATCH. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Miller, Senator Baucus and I, in developing our bill, wanted to be budget neutral, and that was recommended by MedPAC. I ask this question because we have a lot of attention given to putting more money into the program.

So could you elaborate, for my colleagues who are not familiar with the Commission's deliberations on this issue, why the Commission endorsed a budget-neutral approach?

Dr. MILLER. Again, I may have not handled this question particularly well from Senator Kyl. We, on an annual basis, assess adequacy of payment, looking at a whole series of factors.

So, the Commission makes a decision—or at least makes a recommendation, let us put it that way—to the Congress about how much payments need to flow to a provider in order to assure access and to get quality of care.

But then within that, the concern was that they wanted something budget neutral that was redistributive in nature, so that it

is not for a provider that does not provide high-quality care. It is not business as usual.

For a provider that, in fact, does provide high-quality care, they can actually be rewarded and benefitted from this system. We think that begins to reverse or change this incentive that is in place right now, which is the same for everybody, regardless of what you do.

So we think that that is pretty key. But to Senator Kyl's and your questions, we do assume that there is an adequate set of payments out there to start. I think, actually, Herb nailed it: we really see the updating process and the payment adequacy process and the pay-for-performance process as one package.

So I think that was our thinking about that. To be blunt, we also wanted to be fiscally responsible. We have a fairly tough budget environment, so that was certainly something to think about. So, I guess that is my take on that.

The CHAIRMAN. All right.

Then another point about Senator Baucus's and my consideration of the bill as we were putting it together: we were aware of the fact that there are lots of data already being collected in this area.

We clearly do not want to over-burden providers with reporting requirements and have CMS unnecessarily inundated with a lot of data. That is why we want measures to develop by consensus, with consideration given to measures already available.

So, considering what we have done, what other steps do you think that we need to take to make sure that we do not over-burden providers and CMS?

Dr. MILLER. I think that there are a couple of key things, and I do not know that these are additional steps. I think, number one, which I think you have just referred to, is the notion of having this collaborative process where there is an agreement with providers and other actors on what are the relevant measures that are key to the care that they provide, and come to consensus on those measures.

Second, within that process, to coordinate with the private sector so that you do not have two different streams headed off in different directions. Once again, that would streamline some burden.

I would like to emphasize that there are information systems collecting much of this data now, and some of those information systems could be enhanced in a way that does not necessarily involve a significant new burden, but sort of rides on the current systems to enhance those data systems.

One other thing I would say is, if you get outside claims systems for the purposes of collecting data and ask beneficiaries to respond specifically, the private sector uses web-based response mechanisms, which is another way to reduce some of the burden.

The CHAIRMAN. All right.

The last question goes to Mr. Kuhn. The road map that CMS issued this week stresses the importance of having valid, reliable quality measures. It also stressed that that be done collaboratively with outside groups.

Why is this collaboration important? In our bill, Senator Baucus and I worked hard to promote this collaboration. So, can you offer

a qualitative judgment of whether or not you think that is on target, and do you have suggestions for improvements to that process?

Mr. KUHN. Thank you, Senator. I think Mark mentioned this as well, that collaboration is really the key, and the linchpin to make this work, because you have to have measures that providers understand and that they believe in, and believe that they can work toward in order to make real improvement.

So, we need an inclusive process. What this collaborative effort also does is bring out the leadership in the provider community and all the other stakeholders.

Then, finally, it brings about the experts who know this. If you can bring them all together in a consensus process to get a product out there, and one that they believe in, it just makes the effort to achieve the objective that much easier, but also it makes sure that everybody understands what those measures are and that providers are moving aggressively to try to hit those new metrics.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

I wondered what the role of hospital accreditation might be here. There are a lot of ways to get at that, but one thought is that accreditation might be somewhat conditioned on some actions that the hospitals should or should not be taking here.

Your thoughts?

Mr. KUHN. Yes. The Joint Commission is already collecting a lot of quality information from hospitals right now. I think MedPAC might have had in one of its charts a comparison of the various measures that are used by different groups, and I think the Joint Commission's was part of that.

So, an opportunity to try to synch all that up and to make sure everybody is looking at the same measures and we are all working collectively to move the hospitals and their care patterns in the same way, is a good suggestion and something that we are already trying to do right now in the current process.

Senator BAUCUS. I understand part of it, though, is some people think that JCAHO has got a bit of a cozy relationship with some hospitals and there is not quite the independence there that a lot would like to see. That is an ancillary part of all this. But it just seems to me there ought to be some independent review here.

Mr. KUHN. Yes. I think the efforts, as we talked earlier, to increase the sample size in terms of our validation surveys will be to make sure that they are doing the job right.

But to give you a bit of data that I think helps drive this home, we get complaints from beneficiaries who ask us to go in and look at what happened to them in a hospital, an experience they might have had.

When we go back into facilities where the Joint Commission has been, I think the rate that we are finding in terms of problems with the conditions of participation are in the 1- to 2-percent range. When we go into facilities that are not Joint Commission accredited, it is in the 10-percent range.

So, I think one thing is, that data point shows that they are doing a pretty good job in terms of the accreditation process in the facilities. But as we move forward to look at our sample size, as

we look at some of these other regulatory things we have been talking about here, I think that could help improve the process.

Senator BAUCUS. I read something. I do not know what it is. Vista.

Mr. KUHN. Yes.

Senator BAUCUS. It is software that some hospitals use, as I recall.

Mr. KUHN. That is correct.

Senator BAUCUS. What is all that?

Mr. KUHN. Sure. It is a system used by the VA. It is electronic health records.

Senator BAUCUS. That is what it was. Yes. Right.

Mr. KUHN. And we have made note that we are excited about this. We are excited about electronic health records within providers overall.

You heard Mark talk about, one of their recommendations is to really begin to move the IT systems, because it can help with prescribing, it can help with patient notifications, and it can help with decision support with the physicians. So, there is a lot of real value with IT systems.

Anything that we can do to improve quality and to reduce costs, we want to move in this direction. So we have begun discussions with the VA and others. Is there an opportunity to take this public domain software and begin to make it more available to physicians in smaller offices that might want to use it? So, it is something that we will have more announcements on soon, but it is a project that we are excited about and hope to be able to roll out soon.

Senator BAUCUS. This might be a little too esoteric, but any thoughts on open-source technology development versus non-open-source, that is, Microsoft versus Linux kinds of approaches here in developing software development in this area?

Mr. KUHN. That is a good question. I do not know if I can answer that completely. What I do know is that hopefully when we have the information for Vista, we can answer some more of those questions.

But the key here is that there is an opportunity for vendors and others to support these software packages and add features to them. But this is something that has already been developed. Many people are using it. If there is a way to get it out to others, we hope to be able to look at those opportunities.

Senator BAUCUS. Can you just comment a little bit on standards, interoperability, and private sector initiatives? How do you see the Senate getting together so that the right hand knows what the left hand is doing, kind of thing?

Mr. KUHN. Yes. Our focus right now is in the ambulatory care setting with physicians. In the MMA, we had the authority to move for e-prescribing and get standards out there to deal with the Stark law and try to move to try to get some more standardization on interoperability.

What we have recognized is, the marketplace has changed a lot in the last 2 years. No longer do software packages for e-prescribing stand alone. They are more embedded in terms of EHR, the electronic health records.

So we hope to have a proposed rule very soon that begins to address that issue, because we want to make it current. We want to make it so that it is relevant to what the current marketplace is, because the marketplace in this area is changing so rapidly.

So what we think is one of the best ways to move aggressively in the ambulatory care setting is to get physicians on board, because they drive what is going on in the hospital, and they drive what will be in the skilled nursing facility, and that is where the focus is right now. We must make sure we get some standardization in terms of the Stark rule, but also interoperability. That is where the focus is with the agency.

Senator BAUCUS. My time has expired. Thank you.

Senator HATCH. As I understand it, Senator, you have no further questions.

Senator THOMAS. No, Mr. Chairman.

Senator HATCH. All right. If I could just ask a couple of questions. I will not keep you much longer.

Dr. Miller, how did you determine which providers should be analyzed on pay-for-performance? Do you believe other Medicare providers should be eligible for pay-for-performance, like hospice or skilled nursing facilities? Should pay-for-performance be limited to just certain Medicare providers?

I agreed with several of the points raised about developing quality measurement standards for the hospice industry, by the way. So, I would just kind of like to have your view on those.

Dr. MILLER. Yes. That is a completely fair question. There are two parts to the answer. One is that we had a process that we went through for different areas, and we established a set of criteria to determine whether there were measures available that were robust enough to move forward on. We did that over a 2-year period.

As we satisfied ourselves that the measures were available, logical, linked to quality, endorsed by others, they did not represent a significant burden, standards like that, we would say, this area is ready to go. We did two in March of 2004 and three more in March of 2005.

This gets to the second part of the answer. No, we do not think that there are some areas where you should and you should not. We are not a gigantic operation. We are just kind of working through as we can review measures, saying, all right, we think this area is ready to go, and the next area.

Skilled nursing facilities is one that we looked at and did not feel was quite ready, but we are still working on it. The questions that you and Senator Wyden asked about hospice, we are completely open to those kinds of things and working through those areas. We are just not there yet.

Senator HATCH. In your testimony, you talk about the four criteria that MedPAC used to evaluate each setting. Now, I just wanted to ask a little bit about data collection.

How do we ensure that the data collection is not unduly burdensome for the Medicare providers and for CMS? I get complaints all the time from almost everybody in the health care field, that they are just over-burdened with paperwork.

Some of them do not even want to take Medicare beneficiaries because of that. I think that has to be one of the most difficult hurdles to overcome when measuring quality. How would risk adjustments or outcome measures be determined?

Mr. KUHN. I will let Mark talk about some of the risk adjustment issues. But in terms of data collection, you are absolutely right. Not only do we have to utilize measures that physicians understand and believe in, but we have to make it easy for them and other providers to share those data with us.

So in the physician group practice demonstration and others, we are learning about how we can use the claims data that they give us already for us to pay a claim, and use these data to get further information for quality purposes.

Are there other ways, in terms of medical charts and chart abstraction, that we can collect data from? Because we cannot make this burdensome or else it is just not going to work.

So, we are looking at new ways of reporting, trying to find different ways that we can collect information that is already out there, but use the information in a different way to move in this area. But I could not agree with you more, it has got to be easy or else we are going to have problems.

Dr. MILLER. Let me pick up there. I think there are a couple of things. I would just restate that, particularly for some of the areas that we have said we are ready to go on, the data that are being collected now are enough to start with.

It may not be where you want to end up in 5 or 10 years, but there is enough to start with now that Medicare is already collecting. To Herb's point, we think that there are streams of data that can be enhanced so that there is at least no significant additional burden.

You asked about risk adjustment. I think with certain measures, there is a significant amount of research and analysis that needs to go into adjusting certain kinds of measures. So our point is, they should not be used until that research is done and well-accepted.

In some instances it is, but I would just take you back to, there are other measures that should be done regardless of the illness state of the patient, and those are process measures, patient experience, and those you can start with and not have such a risk adjustment problem. So, the notion would be to try to build on existing data streams to the extent possible.

Then to the extent that you impose new ones, or new ones are imposed, the idea would be to try to tailor it to their work practices, like allowing them to respond through web-based types of surveys and that kind of thing.

Senator HATCH. One last question. That is, have you had the opportunity to review other countries' payment policies and whether or not other countries reward good performance of providers? Is there anything we can learn from the experiences of other countries?

Dr. MILLER. I would prefer Herb to take this. [Laughter.] But since he just turned to me, the only thing I can tell you is, we had a physician in from the U.K. who talked about the system that they use for their primary care physicians.

They have an incredible list of detailed types of measures that they go through which affects the payment that they get. I would be very hard-pressed to walk through it with you, but we did at least have that exercise that we went through.

Mr. KUHN. We have been meeting recently with a number of Ministers of Health from different countries who have been coming to the United States for a variety of reasons, but sitting down and talking to them about some of the changes that we are bringing about in our health care system as a result of the MMA, sharing with them some of the things that we are doing in terms of evidence-based medicine and what we are doing to try to do pay-for-performance.

They, too, are beginning to share information that they are trying to experiment, but they are trying to learn from us as much as we are trying to learn from them. So, those discussions are ongoing.

Senator HATCH. Well, thank you.

Do you have anything further?

The CHAIRMAN. We thank you very much for your testimony. Oh. We have some more questions from Senator Baucus.

Senator BAUCUS. Well, both of you kind of sit back a little bit and just kind of give a little perspective here. We clearly all want this to work. So the real question is, what is your advice, on the positive side? What would the incentives be, and from where—here in Congress, or wherever—to help make this really work?

Second, or maybe the other side of the same coin, what are some of the pitfalls, some of the things we have to watch out for and help keep us on track? Just things to avoid.

Mr. KUHN. Yes. A couple, three things I would just share here. One, we just kind of finished talking about. One of the pitfalls would be if we made this thing excessively burdensome, and we just cannot do that because I think that would just create all kinds of problems.

Also, we need to make sure that we do not create a system that would create a situation where providers would not want to take riskier patients, because if they are paid for performance and they have a patient who is either non-compliant, does not want to follow their rules, or because they are higher risk, we want to make sure that we risk-adjust and we do that right so they will take riskier patients.

Then, finally, we really need to make sure that the measures are evidence-based. They have to be credible. So, I think those would be three things that I would just share with you in response to your question.

Dr. MILLER. I really do not have a lot to add. I was writing as you were speaking, but I think, in addition to what Herb said, to be sure that the process is consultative.

Pull people together and get consultation from the providers, from payors, from quality organizations, so that, when measures are rolled out and used in this system, there is widespread agreement in the validity of things, like whether they have been risk-adjusted, whether they capture the care, are they within the control of the provider, those types of things. You have a critical mass

of people, experts, saying this is the right way to go, and it includes the provider group themselves.

From the Congress, I think it is very important that if the Congress feels that this is the change to make, it is important that, legislatively, Medicare be allowed to pay providers differentially.

To the administrative actions, there are definitely things that Herb has already cranked through in this conversation on demonstrations that can be helpful to the process, and we have also made a recommendation on reviewing physician resource use and confidentially feeding back to physicians.

The point I am trying to make is, there are legislative changes that we will push and there are administrative changes which will also work in behind this. But the pitfalls that Herb went through were my list as well.

Senator BAUCUS. What are some of the carrots that kind of help physicians and hospitals really want to do this so they are not just pushed into it, but they are sort of incented to really want to do it?

Mr. KUHN. I would say, if a provider thinks a measure is a good idea, putting some money behind it is certainly going to speed the quality improvement that is out there.

Dr. MILLER. Yes.

Mr. KUHN. I think the evidence is there if you look at what has happened with the hospitals. This whole effort of the reporting by the hospitals was doing pretty well voluntarily. You were getting a pretty good number of hospitals. But as soon as you all passed the MMA and you put 40 basis points behind that, you had nearly 100 percent of reporting.

Senator BAUCUS. Right. Ninety-eight percent, I think.

Mr. KUHN. Yes. So I think what that shows us is that incentives do work. But you do not have to have a very big incentive. I think that is one thing on the MedPAC recommendations. The incentives do not have to be great, but they can change behavior rather quickly, and for the good, as we have seen here.

Senator BAUCUS. All right. Good. Thanks.

Dr. MILLER. The money was where I was going. I thought it was a trick question. [Laughter.]

Senator BAUCUS. No, it was legitimate. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Besides saying thank you, Senator Baucus and I will be calling on you in the next 3 months as we work on our legislation. We expect that to be part of our final package this fall.

Mr. KUHN. Very good.

The CHAIRMAN. Thank you both very much.

Mr. KUHN. Thank you.

Dr. MILLER. Thank you.

Senator BAUCUS. Thank you very much.

The CHAIRMAN. Our next panel is Dr. Byron Thames, board member of the AARP; Dr. Nancy Nielsen, Speaker of the House of Delegates of the American Medical Association; Mr. Leo Brideau, president and CEO of Columbia St. Mary's, Milwaukee; and Dr. James Mongan, president and CEO of Partners HealthCare in Boston.

We thank you for your testimony. If I mispronounced anybody's name, please correct me.

We are going to start with you, Dr. Thames.

STATEMENT OF BYRON THAMES, M.D., BOARD MEMBER, AARP, WASHINGTON, DC

Dr. THAMES. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, my name is Byron Thames. I am a physician and a member of the board of directors.

The CHAIRMAN. Let me interrupt you. I asked my staff how to pronounce your name, and they were wrong.

Dr. THAMES. Well, Senator, when I was in England, with the courtesy of the U.S. Air Force, when they called me "Temz," I accepted it. It is not a problem, sir.

The CHAIRMAN. All right.

Dr. THAMES. I am a physician and I am a member of AARP's board of directors. We want to thank you for inviting us to testify on the need to link health care payments to quality performance.

Linking Medicare payment to the quality of care that beneficiaries receive is a critical step for our Nation's health care system. AARP, therefore, strongly supports the Medicare Value Purchasing Act sponsored by Chairman Grassley and Senator Baucus.

This legislation lays out an appropriate and reasonable framework for achieving vitally needed quality improvement. Today, America spends more per capita on health care than any other nation in the world.

Health insurance premiums are rising much faster than general inflation. Last year alone, the Medicare Part B premium grew 17.5 percent, in large part due to reimbursement increases for providers. Steep increases are projected again for next year.

Despite these high and rising costs, quality is often lacking. We have a health care system in which hospital-based medical errors cause an estimated 98,000 preventable deaths each year.

At the same time, patients are receiving recommended health care services only about half the time. Clearly, we are not getting our money's worth. Medicare beneficiaries who live in higher-spending parts of the U.S. receive more care than those in lower-spending areas, but they do not have better health outcomes or greater satisfaction with care.

Medicare payment policies now do not promote better performance. Physicians and other providers are paid whether or not they provide good care. In fact, a hospital is paid more if it does not prevent a preventable, life-threatening infection because longer stays and more serious conditions automatically place patients in higher payment categories.

This situation is of particular concern to AARP members because, as we all age, we tend to use the health care system more. Older Americans are, thus, more vulnerable to preventable errors and other quality lapses.

Medicare program resources must be used to obtain real value for the dollars spent for care. We can no longer simply pay the bills for health care without using those payments as an incentive to improve the quality of care.

The time has come to improve our approach to paying doctors, hospitals, and other Medicare providers. Offering rewards for high quality, quality improvement, and the use of health information technology simply makes good sense. The Medicare Value of Purchasing Act will point us in the right direction to achieve this goal.

We want to thank you again for the opportunity to testify today, and I will be happy to answer any questions.

The CHAIRMAN. Thank you, Dr. Thames.

[The prepared statement of Dr. Thames appears in the appendix.]

The CHAIRMAN. Now, Dr. Nielsen?

STATEMENT OF NANCY H. NIELSEN, M.D., PhD, SPEAKER OF THE HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION, WASHINGTON, DC

Dr. NIELSEN. Thank you. The pronunciation is right.

The CHAIRMAN. Thank you. I come from Sioux Falls, Iowa. We have a lot of Danes around there.

Dr. NIELSEN. Chairman Grassley, Ranking Member Baucus, and members of the committee, thank you very much. I am Speaker of the American Medical Association's House of Delegates, and I am a practicing internist in Buffalo, NY.

We would like to commend you, Mr. Chairman and Senator Baucus, and your committee, for your efforts to improve quality by introducing S. 1356.

We also appreciate your repeated efforts in pressing CMS to make administrative changes to the physician payment formula, or the SGR, which would lower the cost of enacting a new payment system, especially your most recent communication to OMB Director Bolton, signed by 89 members of the Senate, including all members of this committee.

We urge CMS to use its administrative authority to remove drugs from the SGR retroactively and to include in the payment formula increased spending due to national coverage decisions and government health promotion policies.

We also commend Senators Kyl and Stabenow and their co-sponsors of S. 1081, which would set positive updates in 2006 and 2007.

Today we are here to discuss value-based purchasing. The AMA and its member physicians are staunchly committed to quality improvement. Over the past 5 years, we have dedicated over $5 million in convening the Physician Consortium for Performance Improvement for the development of performance measures.

As a result of the Consortium efforts, CMS is now using these measures in demonstration projects on pay-for-performance, authorized by the Medicare Modernization Act.

In June, our House of Delegates adopted principles and guidelines for pay-for-performance programs, and they are attached to our written testimony.

We are pleased that several key elements for quality measures under S. 1356 are consistent with those principles and guidelines. For example, your bill would require quality measures to be evidence-based, reliable, and valid, as well as feasible to collect and report. They also would be developed by the medical specialty societies.

We want to work further with the committee to address some areas of concern. First, value-based purchasing and the SGR are on a collision course. While S. 1356 recognizes the need to address the SGR, it must go a step further and replace it.

Value-based purchasing may save dollars for the program as a whole by reducing hospitalizations, but the majority of measures, such as those focused on prevention and chronic disease management, ask physicians to deliver more care.

The SGR penalizes volume increases that exceed a target. If the SGR is retained, the so-called reward for physicians will be additional pay cuts, on top of the projected 26 percent in cuts over the next 6 years, beginning in January. This is antithetical to the desired outcome of value-based purchasing and would only compound an ongoing, serious problem.

A recent AMA survey shows that if significant cuts occur, more than a third of physicians would decrease the number of new Medicare patients they accept; a third will discontinue rural outreach services; more than half would defer the purchase of information technology that is necessary to make the volume-based purchasing work; and a majority will be less likely to participate in Medicare Advantage. So, the SGR must be replaced.

Our second concern is about efficiency measures. There is not currently broad-based consensus regarding what constitutes appropriate levels of care. Measures of efficiency should not simply reward the lowest-cost provider.

On the other hand, physicians understand fully that over-use, under-use, or misuse of services is not in anybody's best interests. We are committed to developing efficiency measures that meet the same evidence-based standards as quality measures. They also must be vetted through a transparent, multi-stakeholder endorsement process.

Third, there needs to be a reliable method for risk adjustment. Without that, you do not get an adequate reflection of a physician's performance.

Fourth, we have some concerns about public reporting. Patients are served only if they are provided accurate and relevant information. Data collection must recognize that some factors are out of a physician's control. Sometimes patients are non-compliant for a variety of reasons.

Fifth, physicians should be fairly reimbursed for their administrative costs, particularly for information technology systems that will be necessary to collect and transmit accurate quality data.

Sixth, pilot testing is imperative prior to full implementation to flush out any unintended consequences.

Seventh, value-based purchasing programs must be phased in to allow all physician specialties the opportunity to participate.

Last, as opposed to a withhold pool, we urge that S. 1356 adopt a differential payment structure that provides a positive update for all physicians, with an additional payment for meeting quality goals.

Thank you very much for the opportunity to appear today.

The CHAIRMAN. Thank you, Dr. Nielsen.

[The prepared statement of Dr. Nielsen appears in the appendix.]

The CHAIRMAN. Now, Mr. Brideau?

STATEMENT OF LEO P. BRIDEAU, PRESIDENT AND CEO, COLUMBIA ST. MARY'S, MILWAUKEE, WI

Mr. BRIDEAU. Thank you, Mr. Chairman, Senator Baucus, and distinguished members of the committee. I am Leo Brideau, president and CEO of Columbia St. Mary's Health System in Milwaukee. On behalf of AHA's 4,800 hospital, health system, and other health care organization members and our 33,000 individual members, we appreciate the opportunity to appear before you today.

Columbia St. Mary's consists of four hospitals, a large employed physician group in 26 medical clinics, and a College of Nursing that serves southeastern Wisconsin with 155 years of history serving our community. In fact, we have the oldest hospital ever founded in the State of Wisconsin.

We are also part of Ascension Health, the largest faith-based and the largest not-for-profit health system in America. We are deeply involved in work to improve quality, both locally and nationally. I chaired a special committee of the AHA's board of trustees that explored future forms of payment for hospitals, physicians, and other providers.

The committee concluded that the payment system must more fully promote quality initiatives like pay-for-performance, and America's hospitals support the notion that payment incentives should be among the efforts to encourage improvement in health care quality.

In 2003, the AHA supported the provision in the Medicare Modernization Act that made part of the hospital inpatient update contingent on the reporting of 10 quality measures.

At that time, more than 2,000 hospitals were already reporting the data as part of the Hospital Quality Alliance. In addition to the AHA, the successful public/private collaboration includes CMS, AHRQ, the National Quality Forum, and a number of other organizations representing health care and consumers.

The AHA took the lead on this because every hospital we represent shares a mission that can be summed up in two words: patients first. Part of putting patients first is getting them the information they need to make important decisions about their care, and the centerpiece in our collaboration is Hospital Compare, a new website that resides at the DHHS web address.

Seventeen measures are reported on treatments for three conditions: heart attack, heart failure, and pneumonia. These measures are attached to my statement. They have gone through extensive testing for validity and reliability.

Patient information will also be gathered through the HCAPS survey, which will give the public information on aspects of quality that are best captured by asking patients themselves questions like, did the doctor or nurse speak to you in ways you could understand, did you get all the information you needed, was the call button answered in a timely fashion, and so on.

We also plan to add information on whether hospitals have taken steps that have proved effective in preventing serious complications of major surgery, and we are incorporating measures around preventing surgical wound infection. By 2007, we will augment that

with information on the prevention of serious blood clots, peri-operative heart attack, and post-operative pneumonia.

Senator Grassley, Senator Baucus, we congratulate you for your legislation that can impact Medicare payment through pay-for-performance. It is a concept we support very strongly. This bill is an important first step in moving our payment system forward to embrace the concept of pay-for-performance.

We would like to make a couple of suggestions that we think could strengthen the bill. First, we urge you to amend the hospital-related provisions to specify that it is the Hospital Quality Alliance measures that are to be used.

While quality measurement is not in place for other sectors of health care addressed in the bill, hospital quality measurement is under way and should be the foundation of pay-for-performance legislation.

We are also concerned that the bill ties payment to issues like efficiency. Pay-for-performance should focus solely on quality improvement. There is no common definition of efficiency of care for hospitals, and more work must be done to define what should be encouraged in terms of efficient care before it is incorporated into legislation that will dramatically affect the care patients receive.

Finally, Mr. Chairman, two thoughts on funding. We are proud that more than 99 percent of hospitals are reporting quality indicators based on the current incentive of market basket minus 0.4 percentage points.

With this participation rate, we see no reason to increase the penalty to 2 percentage points for those not participating. This likely would hit hospitals that are the most strapped for resources.

Also, we worry about ultimately imposing a 2 percentage point reduction in the standardized amount to fund this first broad Medicare experiment in rewarding excellence. We support a smaller pool of funding, and we would like to work with you to explore other funding sources.

In closing, we believe that an effective pay-for-performance program must focus solely on quality measurements, adhere to the best science, and have as a foundation the successful work being done by the Hospital Quality Alliance. We look forward to working with you toward our shared goal of improving care for all Americans.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Brideau.

[The prepared statement of Mr. Brideau appears in the appendix.]

The CHAIRMAN. Now, Dr. Mongan?

STATEMENT OF JAMES J. MONGAN, M.D., PRESIDENT AND CEO, PARTNERS HEALTHCARE, BOSTON, MA

Dr. MONGAN. Mr. Chairman and Senator Baucus, I am Dr. Jim Mongan, president of Partners HealthCare in Boston, a health system founded by the Brigham and Women's Hospital and Massachusetts General Hospital.

I always appreciate the opportunity to come before the Senate Finance Committee, where I began my career 35 years ago as com-

mittee staff for 7 years, working both for Senator Russell Long and Senator Wallace Bennett.

These leaders and their colleagues then were grappling, just as you are 35 years later, with the difficult task of balancing the enormous benefits Medicare and Medicaid bring to our elderly and poor against the significant cost of these programs to the Federal budget in our society.

The initiatives you are considering today fall squarely within this tradition, as pay-for-performance reimbursement, especially when coupled with the development of information technology, will maximize the value we receive as a Nation in health care.

Let me start with a word about our aspirations at Partners regarding quality and cost, and then make three key points about the legislation.

At Partners, we have a set of five initiatives, which we call our Signature Initiatives, to improve quality, efficiency, and value across our system. The first is to build out an electronic medical record with embedded decision support across our system to support evidence-based medicine.

The second is to ensure safety in drug delivery through computerized order entry, which was pioneered at the Brigham and Women's Hospital.

The third is to use our electronic data to measure quality and reliability across our system.

The fourth is to use our data to identify our sickest patients and construct disease management programs to assist in their care.

The fifth is to use electronic prescribing and test ordering to assure the selection of only high-quality and cost-effective drugs and imaging procedures.

Now, we were among the first providers in the country to begin pay-for-performance contracting 5 years ago, with over 500,000 patients. We have $88 million, or about 10 percent of our reimbursement at risk, based upon our ability to improve efficiency and quality.

With the benefit of 5 years' of experience, there are three points that I would make relevant to the proposed legislation. First, we agree that the thoughtful use of financial incentives can help drive improvement in health care.

During the past 5 years, we have seen steady and measurable improvement in the quality of care that we provide to our diabetics, asthmatics, and our patients with heart attacks and heart failure. We attribute at least some of this improvement to our initiatives supported by our pay-for-performance contracts.

Second, we strongly support the principles of Medicare value purchasing in the proposed legislation. The phased-in approach, in particular, will be helpful, both in the development of quality measures and the development of provider understanding.

The devil will be in the details, and the committee should understand that a Consumer Reports for health care will likely never be fully realized.

Anyone who has been a doctor or a patient knows that health care is not a product like a car or a television set. It is a series of interactions between at least two people, often many more.

Measuring the quality of health care is more like evaluating a marriage than evaluating an automobile. We all know that there are good husbands and bad husbands, and that some doctors are better than others. But coming up with measures that use administrative data to distinguish between them is quite difficult.

Pay-for-performance at this stage of development works best in measuring large groups or large hospitals and less well on the individual physician level, so we should embark on this era of transparency with appropriate humility.

Third, and finally, I wholly agree with the legislation's emphasis on health information technology. Currently, about 90 percent of our academic physicians have these systems, while only 20 percent of our community network physicians are connected.

Unfortunately, the Stark and anti-kickback laws prevent us from providing these tools to our network physicians. That is why a broad exception from these laws for this purpose needs to be an essential part of any legislation. I have provided more specific views to the committee in a separate statement.

In conclusion, I would urge your support for spreading information technology more broadly and for appropriately designed pay-for-performance systems. Both would be consistent with the Senate Finance Committee's 40-year record of support for, and responsible stewardship of, our critical health financing programs for the poor and the elderly.

Thank you for the opportunity to testify.

[The prepared statement of Dr. Mongan appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Mongan.

I am going to start with you for the first question, Dr. Thames.

AARP has a lot of experience in educating seniors about health care and a lot of other things.

Now, we have a problem of quality, of getting out information on quality. But we also have the challenge of providing beneficiaries with information that is easily understandable. So, given your experience, could you offer some suggestions that might be helpful in this area?

Dr. THAMES. Thank you, Mr. Chairman. I think maybe we can. Our experience in educating our members about things like Social Security and other issues certainly lets us start with making the beneficiary knowledgeable that quality is important and that it is a real problem.

Here in DC, these last 3 days of articles are certainly going to make the public in general, in this area, know that quality is an important issue. But I am not sure that the beneficiaries throughout the Nation are aware that, both in hospital care and physician care, medical errors and poor quality of care are important to them. They need the information you are asking.

Now, specifically, we believe that you have to identify the quality measures that are going to be most meaningful to the lay person. You have to identify what it is you want to tell them.

Second, you have to put it in language that they can understand. It cannot be medicalese, where they cannot understand what the problem is.

Third, you are going to have to translate it, sometimes, into more than the English language.

There is a large proportion of people who are Hispanic in this country. You are going to need to at least be bilingual as far as providing that material, and in some areas of the country you may have to have other languages to produce that material.

You need to use, wherever possible, magazines, bulletins, and the web. On the other hand, among our members, a lot of older seniors are web savvy, but a good many of them are not.

So, you are going to have to look at a toll-free telephone number or some way that they can ask the question, particularly those who have vision and hearing problems so they have difficulty in writing the letters and getting an answer back that they can read and understand.

And, last, you are going to have to target groups. Now, we have been most effective by using our membership and our board of directors. As you know, we speak on issues, with invitations throughout the country, to different groups.

But we also organize our own group events in which we educate volunteers to talk knowledgeably about the issues, and we use our Area Agency on Aging contacts, and others, to get large groups of our members and seniors who are interested in issues to come to those where they can ask questions of live people. I suggest that all of those would be necessary for you to get the best information out to beneficiaries.

The CHAIRMAN. Thank you very much.

Now, Dr. Nielsen, Senator Baucus and I, in writing our bill, feel that it is time to move forward very quickly, moving towards permanency in payment for performance.

We have had ample testimony in the first panel, particularly from Mr. Kuhn, stating that we have had plenty of demonstration projects, both in the public sector and the private sector.

You have made an argument to us about continuing pilot programs. So, I think I need to have you, with all this other testimony we have, justify why AMA feels that we still need to continue pilots or demonstrations.

Dr. NIELSEN. Yes, sir. Thank you, Mr. Chairman. I think the answer to that is that anybody who is worried about not doing harm wants to make sure that any unintended consequences are flushed out. So where there are pilot projects that have shown a result, go forward.

Where there are areas that have not yet developed performance measures, for example, develop them, study them, and then implement them. That is really the only reason. It is not to be a laggard. It is absolutely to be sure that we have, in fact, done our homework with all parts of the sector.

The CHAIRMAN. Would that be partly because, within medicine, there are so many specialties, some have been working on this and others have not? Is that where you are coming from?

Dr. NIELSEN. Yes, sir. That is correct. That is partly correct. For example, in the Consortium which we convened, we have a variety of specialties—over 65—that participate in that initiative.

But most of the performance measures that have been developed by us, and also by NCQA, deal with chronic conditions that are

mostly seen by primary care physicians and the specialists to whom they refer. There are some, for surgical specialties; for example, in my home State of New York, the Cardiac Surgery Outcomes Measures have been around for years.

But in a variety of other specialties, performance measures have not yet been developed. They need to be developed. We hope that, through the Consortium and other venues, we can assist those specialties to get there pretty quickly.

The CHAIRMAN. All right.

Senator Baucus and I do not preclude the necessity of helping and understanding the development of these standards and working with various subspecialties that might not have them. We know we have to have that foundation, I guess is the way to put it.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

The CHAIRMAN. When he gets done, I have three more questions.

Senator BAUCUS. Thank you, Mr. Chairman.

First, Dr. Mongan, welcome back.

Dr. MONGAN. Thank you.

Senator BAUCUS. Please give our best to your nephew, Mike.

Dr. MONGAN. Will do.

Senator BAUCUS. Is he here? Oh, there he is. There is Mike. Great. I will say, we really valued your work, Mike, a lot. You were just aces on this committee, as you know.

You are kind of a pioneer, Doctor, in all of this. You mentioned you have been working at this for 5 years. Sometimes providers will say, gosh, we want to provide care, but we are kind of worried about the bottom line here, too.

As we move and implement many more quality measures, that might reduce our readmissions rate, which is good for the patients and so forth, but financially it might put us in a little bit of a bind.

Now, my understanding is that you have focused on this very point and have done pretty well with providers, namely, your readmission rate is down in certain areas, and your testimony mentioned how you focused on the sickest patients. Yet it has not, as I understand it, adversely affected your financial condition.

Could you just talk to us a little bit about what you have done, as you are working to address quality and pay-for-performance in a way that has also not put you out of business?

Dr. MONGAN. Sure. I would love to say a word about that. I guess I should begin with a qualifier, that our institutions have been running pretty full, so we are not in any need of readmissions in order to meet our financial budgets, if you will. Consequently, we have not been in quite the exquisite bind that some might be.

Having said that, I believe that when a fuller analysis is done, that concern is over-stated. The percent of avoidable readmissions are not that high as a total percent of admissions, number one. And number two, they do not tend to be the DRGs that hospitals are making substantial margin on.

Senator BAUCUS. Could you expand on that a bit, please?

Dr. MONGAN. Yes.

Senator BAUCUS. Which DRGs are there that hospitals are not making a substantial margin on?

Dr. MONGAN. I would say—and again, this varies hospital by hospital—the most common readmissions tend to be the chronic medical conditions, like heart failure being one of the most classic of them.

I think, as you look at the data across the country, it is not those chronic medical DRGs where you do best financially, it is the surgical DRGs where you do a little better.

So I think, if the full analysis were done in the round, there is not as much of a financial issue as people might be concerned about. But, importantly, to just go one step beyond that, all of us need a margin to support our mission.

Our mission is not just to make a margin. Basically, we should all size ourselves to provide the amount of care that the population we serve needs. If there is a reduction in readmissions, fine. We can close a few beds and continue to operate in an appropriate fashion.

Senator BAUCUS. But you say that is somewhat a function of size. Is that the number of beds that are occupied or is that the size of the institution? I do not quite understand. Or does it matter?

Dr. MONGAN. Well, no, it does not matter. Basically, that algorithm would apply at either a large hospital or a smaller hospital. I mean, you should be sized, staffed and budgeted not to take care of unnecessary business or readmissions that you could have avoided, but care for the patients who have real need of that care, provided on a quality basis.

Senator BAUCUS. And why did you set up this separate operation focusing on the sickest patients? What is all that about?

Dr. MONGAN. We are believers that there are three important things to getting a handle on costs consistent with quality. We are talking about two of them here today: information technology and pay-for-performance reimbursement.

We also believe that disease management, even though it earned a bad name in the past decade, usually meaning we are not going to pay the bill, if done properly, we believe that there is power to disease management.

You just look at the simple numbers, that 10 percent of the people account for 70 percent of costs, 3 percent account for 50 percent, we believe if we focus in on those sickest patients and provide them extra supportive services, it will be better quality and enhanced efficiency.

We are demonstrating that in the case of heart failure, where we have, as I have said, reduced our readmissions and increased our quality. So, we think that is a sentinel example of what can be done.

We are doing an experiment with our thousand sickest Medicaid patients, working with the State, having special call centers to support their care. It is too early to give you data on that, but we believe that disease management, done appropriately, is a third leg of an important stool, and you are addressing two of the other ones.

Senator BAUCUS. I appreciate that. Yes. So what legitimate concerns do hospitals have as to whether paying for performance might reduce their bottom line? If you talk about what you are doing with providers, you have thought a lot about the subject, as well as other subjects, what legitimate concerns do you think other

hospitals or providers might have, and what would you say to them, or what would you say to us?

Dr. MONGAN. To be candid, Senator, as I have talked to hospital and physician people in our State, I think the bigger concern is not the damage to the bottom line from no more readmissions.

I really do not find much of that. I think the biggest concern, frankly, is a concern about whether this can be implemented in a fashion that is fair and accurate and not misleading. I go back to the old bromide, and the exquisite balance you all have to work with, that we should not let the perfect be the enemy of the good.

And we should not. Lots of my colleagues will say, we are not ready to measure, it is not perfect, we cannot do it. We should not let the perfect be the enemy of the good. We should move forward.

However, we should do everything we can to guarantee that the good is adequate, because if what we are going forward with really is not an adequate measurement, then you are going to mislead people about quality and you are going to be unfair to some providers.

So, I think the real concern is, are we ready? Where are we on that spectrum of perfect, to good, to adequate? Our belief is that we are in a place where we can go forward cautiously, with more focus on the larger institutions. But I think, as I said in my testimony, we should be humble as we go forward and be constantly looking at where we are.

Senator BAUCUS. Can you be a little bit more precise on where a hospital administrator or a physician might be legitimately concerned?

Dr. MONGAN. Sure, Senator. I can give you some examples where the statisticians talk about face validity. I will just rank a few. These anecdotes circle in the field. Up in our own State, for Massachusetts General, my own hospital and a very nearby community hospital I will not name, rankings came out in the paper.

It said that the nearby community hospital was the best place to go for a heart attack. Now, people looked at that and thought, that does not seem quite consistent with what we understand.

Well, when you look into it, that community hospital has a signed contract with Massachusetts General to send all of the sickest patients to Massachusetts General. It was not appropriately risk-adjusted. One anecdote like that does a lot of damage, if you will.

Senator BAUCUS. Yes.

Dr. MONGAN. I could go on with two or three others, but those are the things we have to be careful about.

Senator BAUCUS. I really appreciate that. Thank you very much, all of you, in your pioneering efforts here. I really appreciate it. Thank you.

The CHAIRMAN. Thank you, Senator Baucus.

Mr. Brideau, Senator Baucus's and my bill would set aside 1 percent of the Medicare payments into quality payment pools. For hospitals, these funds would come from a reduction to the inpatient base rate or standardized amount.

While our bill directs the Secretary to determine how the funds would be redistributed within certain guidelines, we could see this program working in a number of ways.

For example, that 1 percent of money taken from all hospitals could be redistributed so that one-third of the hospitals do not get any of the money back, one-third would get about 1 percent they contributed, and one-third would get back about 2 percent because they are high-quality facilities.

In your statement, you indicated that your association would like to work with the committee to explore other sources of funding for pay-for-performance. What other options would you consider, and what would be some of the advantages or disadvantages of these options?

Mr. BRIDEAU. Thank you, Senator. The concern that we would have, is really two-fold. One is, any method that basically creates a system of winners and losers, that is, a third would get no money, a third would get the same, and a third would get more, we believe we would be better served to basically set the bar, and set the bar high, and say, if you meet these process and these outcome targets, everybody who meets them then gets incentive payments above it, and if you do not meet it, you do not get the incentive payments, as opposed to creating this dichotomy of winners and losers within the health care system.

In terms of other sources for funding, I mean, effectively, earlier, there was a question of, should hospitals be paid more for doing the right thing? In fact, this does not propose to pay hospitals more, it proposes to pay us less unless we do the right thing, in which case it proposes to pay us the same, or perhaps in your exmaple, more.

We think a couple of sources of additional funding for this might be, one, the changes that are being proposed to the outlier payment system may produce some dollars that could be fed back into incentive pools for this.

The other is, we believe that it is pretty clear, to the extent we are able, through this kind of pay-for-performance mechanism, to drive quality improvement further than we have so far, that ultimately the cost of care should go down. I think all of us who have worked a lot in quality improvement understand that, as you drive quality up, you tend to drive costs down.

Our hope would be that a portion of the dollars that are saved, in terms of saving dollars, could funnel back in as incentive payments to hospitals so that it continues to feed this.

Certainly, the incentive to improve quality is not solely driven by money. That is pretty clear. In fact, my view is that public reporting drives the incentive even more than the kinds of dollars we are talking about here.

But, nonetheless, rather than penalizing hospitals, we believe there are ways—creative ways—to both save taxpayer dollars on the one hand, improve quality on the other, and provide incentives to the provider community to do just that.

The CHAIRMAN. All right.

Dr. Mongan, Senator Baucus and I have vetted the language of our bill with various stakeholders to better understand their concerns. One of the primary concerns that we heard from groups is on the financing part of our value-based purchasing programs.

In our bill, we take 1 percent out of the total payments and increase that to 2 percent of total payments over 5 years. This money

is then given back to providers that improve quality or reached certain targets of quality.

Now, in your testimony you mention that $88 million, about 10 percent of your reimbursement, is risk-based upon the ability to improve efficiency and quality. This is much higher than the 1 to 2 percent that we are proposing.

What has been your experience in working with provider groups when so much of the money is put at risk under your model? From what I know, I generally feel it is working right, but I want to hear you talk about it.

Dr. MONGAN. Ten percent is a significant number, Senator. We had substantial dialogue with the providers within our organization. There is, of course, a trade-off between where the standards are set and how much is at risk. If the bar were really, really, really high, we would have a lot of push-back at 10 percent.

This bar was set reasonably high. It was not, as some cynical providers said, tying your shoelaces. It was a significantly set bar. In fact, we are to meet the 90th percentile of standards for the treatment of heart conditions, asthma, and diabetes.

We felt confident enough that we were close enough to meeting those standards, and we had systems in place, predominantly with the electronic medical record that was well-distributed through our system, that we felt confident at going at risk at that level for the conditions that are cited in our contracts.

The CHAIRMAN. All right.

Back to you, Mr. Brideau. It is not our intent to create legislation that would reinvent the wheel. I want to make that very clear, and I did in my opening statement.

Now, you mentioned, the Hospital Quality Alliance has brought together individuals, consumers, purchasers, providers, and the government to provide information about hospital quality to the public. Obviously that is an effort that we applaud. We want to make sure that this type of collaboration continues.

The bill takes great steps to do just that. It specifically calls for a separate process to ensure proper implementation of the measurement system. Specifically, it calls upon the Secretary to consult with entities that have joined together to develop strategies for quality measuring, and then reporting.

So the question is, could the current Hospital Quality Alliance be this entity and help implement the measurements of the bill we have proposed?

Mr. BRIDEAU. Yes, Mr. Chairman. We would support the Hospital Quality Alliance being that entity. We think it has the right members to it. We might want to look to see if it needs to be broadened any, but we think it is a very broad-based organization, and we would support that because it would reduce the kind of duplication we are beginning to see.

If I might, Mr. Chairman, just add a comment on the question of how much is enough to put at risk? Certainly, Dr. Mongan leads one of the most prestigious institutions in the country and has very sophisticated systems to manage the kind of work he described.

In our case, we are implementing a complete electronic health record across our entire system, including all of our physician clin-

ics. We are in the middle of that now, and it is going to take another 2 years or so.

The point I would make is, even for a modest-sized health system such as ours, four hospitals and 26 clinics, our investment over the next 3 years in that is $75 million in capital, plus an additional $12 million per year, ongoing forever, in operating expenses in order to do this.

But we believe this is the price of admission for any size health care system. We are able to do that, and we are fortunate to be able to make that investment, and we believe our patients will benefit from it.

We are also concerned, however, about some of the smaller hospitals, rural hospitals, who really just have great difficulty in making that kind of investment, as well as the complexity of tying in with our independent physicians who are not employed by us, because there are laws that really prevent us doing what we think would be in the best interests of quality and tying them into our information system as well, sir.

The CHAIRMAN. All right.

That is the last of my questioning. Obviously, I associate myself with the remarks of Senator Baucus complimenting you and your willingness to continue to work with us.

In this kind of crunch time now, we have August off here. But when we come back in September and October, things like this will move very quickly. So, anything you want to input, make sure our respective staffs know that. Thank you all very much.

[Whereupon, at 12:10 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

"Improving Quality in Medicare: The Role of Value-Based Purchasing"
Senate Finance Committee Hearing
Statement of Senator Max Baucus
July 27, 2005

Thank you, Chairman Grassley, for holding this important hearing.

Today the Finance Committee is discussing value-based purchasing, or pay-for-performance, in Medicare. This is an idea that represents a sea change in Medicare policy. It is a significant departure from business as usual.

It is also a rather simple concept. The idea is to reward better health care quality with better payment. The idea is to get the most out of taxpayer dollars.

Unfortunately, value-based purchasing is a concept that has been hardly used in Medicare, which spends over $300 billion a year. In fact, the opposite is true. Too often, Medicare rewards poor-quality care.

Consider what the Sunday *Washington Post* had to say about Palm Beach Gardens Hospital in Florida.

> In 2002, state inspectors found "massive post-operative infections" in the (hospital's) heart unit. In a four-year period, 106 heart patients at Palm Beach Gardens developed infections after surgery. More than two dozen were readmitted with fevers, pneumonia and serious blood infections. And how did Medicare respond? It paid Palm Beach Gardens more.

This seems counterintuitive, but it's true. Medicare doesn't generally pay according to what patients <u>need</u>. Medicare pays according to what patients <u>receive</u>.

And very often, what patients need and what they receive are two very different things.

According to Dartmouth's Dr. Jack Wennberg, more health care is not necessarily better health care. Often the amount of treatment that Medicare beneficiaries receive depends more on how many providers are in their area than on whether the treatment is appropriate or not.

So how do we move toward a system that rewards quality, rather than volume?

First, we can learn from the private sector. Many employers, hospital systems, and insurers have taken steps to implement payment-for-quality plans. And they have worked. We will hear about some of those today.

Second, we can learn from what Medicare has already done. CMS has conducted demonstration projects, including one involving a group practice located in Billings, Montana. The 2003 Medicare bill mandates another. This experiment showed that when payment is tied to quality, positive behavior is reinforced.

But most important, we must act. We have to move past the ideas, past the demonstrations, and on to concrete action.

A wise man once said, "We cannot do everything at once . . . but we can do something at once."

That something is the establishment of a pay-for-quality system under Medicare.

Last month the Chairman and I introduced a bill to enable Medicare to move forward with value-based purchasing, the Medicare Value Purchasing Act of 2005. Our bill starts with paying for the reporting of quality measures. It would then graduate to paying for quality. Our bill would change Medicare into a system that rewards quality over volume. If we do it right, we can reduce unnecessary spending and improve patient care. That's a win-win.

And if we construct this system right in Medicare, then there is a strong likelihood that other payers will follow suit. Medicare tends to influence other insurance plans.

I want to thank our witnesses for being here today. Many of you have been involved in health care delivery throughout your careers, and I thank you for that service. Doctors, nurses, and other care providers in this country work extraordinarily hard to provide the best care possible to their patients.

I look forward to hearing your thoughts about how we can improve quality and value in Medicare, because a value-based purchasing program will not work without input from the people who will be affected – including patients, providers, and taxpayers.

The status quo will not suffice anymore. We need a system that works. We need it soon. And I look forward to hearing your thoughts on how to get the job done.

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Testimony
of
Leo P. Brideau
before the
Committee on Finance
of the
United States Senate

"Improving Quality in Medicare: The Role of Value Based Purchasing"
July 27, 2005

Good morning, Mr. Chairman. I'm Leo Brideau, president and chief executive officer of Columbia St. Mary's in Milwaukee, Wisconsin. On behalf of the American Hospital Association's (AHA) 4,800 hospital, health system and other health care organization members, and our 33,000 individual members, we appreciate the opportunity to express our views on legislation that can enable Medicare to better reward excellent quality.

Columbia St. Mary's is an organization of four hospitals, 26 clinics, and a college of nursing. We have all joined together to serve southeastern Wisconsin – with more than 155 years of service to individuals and families in these communities. Over the years we have earned a reputation for providing excellent state-of-the art medical care in a family-centered, healing environment.

Columbia St. Mary's is deeply involved in quality improvement activities both locally and nationally. Locally, with other Wisconsin hospital, physician and payer groups; and nationally, through our affiliation with Ascension Health, which is one of a few prominent organizations working closely with the Institute for Healthcare Improvement, we are working to improve the quality of care delivered to our patients.

In addition, I've had the pleasure of chairing a special committee of the AHA's Board of Trustees exploring options for future forms of payment for hospitals, physicians and other health care providers. The committee concluded that the current payment system must more fully promote quality initiatives, including pay for performance.

America's hospitals support the notion that payment incentives should be among a cadre of efforts to support and encourage improvement in health care quality.

A well-crafted system to reward excellent performance would be an important stimulant to the work that hospitals and health care professionals already are doing to improve care. In 2003, the AHA supported a provision of the Medicare Modernization Act (MMA) that made part of the hospital inpatient update contingent upon the reporting of 10 quality measures. At that time, more than 2,000 hospitals were already reporting this information. Therefore, hospitals are already reporting quality data as part of the Medicare program, and we believe it is time to move to the next step and tie some portion of payments to the performance of these measures.

We congratulate Senators Grassley and Baucus for their vision and leadership in creating a specific legislative proposal from the concept of rewarding excellence in care.

The Hospital Quality Alliance

We would like to outline the steps that the hospital field has already taken to address quality measurement and reporting. Mr. Chairman, America's hospitals are diverse ... some large and urban, some small and rural, many in between. But each and every one of them shares a mission that can be summed up in two words: Patients First.

Part of putting patients first is helping them get the information they need to make decisions about their care. That is why the AHA helped lead the way toward the creation of a single national database of credible hospital quality information for patients. This effort – the Hospital Quality Alliance (HQA) – is a public-private collaboration to improve care by measuring and publicly reporting on that care.

In addition to the AHA, this collaboration includes the Centers for Medicare & Medicaid Services (CMS); Agency for Healthcare Research and Quality (AHRQ); National Quality Forum (NQF); AARP; Association of American Medical Colleges; Federation of American Hospitals; Joint Commission on Accreditation of Healthcare Organizations; American Medical Association; American Nurses Association; National Association of Children's Hospitals and Related Institutions; Consumer-Purchaser Disclosure Project, representing 52 leading employee, consumer and labor organizations; and AFL-CIO. The goal is to collect and report data on standardized and easy-to-understand hospital quality measures.

The HQA grew out of increasing requests to hospitals from insurers, businesses, accreditors, and government seeking reports on different measures of quality. While all of these parties shared the same goal – to provide information about hospital quality to the public – the burden, complexity and cost of complying with all of these requests was becoming overwhelming for hospitals. Confusion among consumers also was growing as they faced a potential avalanche of disparate information about hospital quality.

As a group, the HQA has committed to several things. Among them: using a common set of priorities to focus on national public reporting of hospital quality measures and patients' perceptions of care; working with NQF-endorsed measures where possible; and setting priorities that correspond to the six aims identified in the Institute of Medicine's

Crossing the Quality Chasm report. Working together, we are creating a more reliable, valuable, and broadly used set of information on hospital quality than any one of the organizations could create on its own.

The centerpiece of the collaboration is *Hospital Compare*, a new Web site developed to share with consumers information about the quality of care delivered in the nation's hospitals. Included on the Department of Health and Human Services' Web site, it debuted on April 1, 2005 at www.hospitalcompare.hhs.gov, and provides patients and their families a new tool that can help them make important health care decisions. In addition to measures of quality, the site provides patients with key questions to help them begin conversations about their care with physicians and other caregivers.

Seventeen measures currently are reported on *Hospital Compare* (see attached chart). The measures reflect recommended treatments for three conditions: heart attack, heart failure and pneumonia. These three were chosen because they are among the most serious and common medical conditions, and are measures that hospitals can collect in a consistent manner to submit for public reporting. The quality measures currently on *Hospital Compare* as well as those that will be added either have or will have gone through extensive testing for validity and reliability. They will be consistent with the best available scientific information and will be modified and updated as new scientific discovery dictates.

The hospital quality measures also are endorsed by NQF, a national standard-setting body, which means they have been deemed useful by representatives of consumers, purchasers, health care providers, and the research and quality improvement communities.

A Commitment to More – and More Useful – Public Information

The HQA is committed to expanding *Hospital Compare* to include more information on clinical quality, as well as information based on patients' perceptions of the care they receive. Patient information will be gathered through the HCAHPS survey, which is now in the federal approval process. HQA's goal is to ensure that hospitals use the survey to gather information on patient perception of care and share their data on the *Hospital Compare* Web site.

The HQA strongly believes that the public wants and deserves information on those aspects of quality that are best captured by asking patients for their thoughts. Did the doctor or nurse speak in ways you could understand? Did you get all the information you needed? Was the call button answered in a timely fashion? Was what you should be doing after leaving the hospital explained clearly to you? This is specifically the job for which HCAHPS was created.

Like the clinical quality measures that are already a part of the HQA, the HCAHPS tool, which is being developed by researchers working with AHRQ and CMS, has been developed, tested, refined, reviewed, and agreed to via the NQF consensus process. We

are eager to implement this survey and augment the data currently available on *Hospital Compare* with information that promises to be easier for consumers to understand and incorporate into their decision-making.

In addition to featuring data on patients' perceptions of care, the HQA plans to add information on whether hospitals have taken steps that have been proved effective in preventing serious and common complications of major surgery. We already are incorporating measures of preventing surgical wound infection, but by 2007 will augment that with information on the prevention of serious blood clots, peri-operative heart attack, and post-operative pneumonia.

Building on the HQA

The HQA is a very effective public-private partnership that is not only accomplishing its goal of making credible information available to the public, but also is reducing the measurement "babble" that had been generated by a large variety of separate organizations asking hospitals to produce quality information. All of these disparate data requests can impede rather than support quality improvement. The HQA has brought focus to hospitals' improvement efforts.

Significant resources already have been invested in the HQA effort and the *Hospital Compare* Web site by all of the participants. Nearly 4,200 hospitals – more than 99 percent of all eligible Medicare Prospective Payment System hospitals and nearly 400 Critical Access Hospitals – have committed to this process and have led the way by sharing data with their communities and the public. This is a solid foundation on which we must continue to build. And it should be the foundation for any pay-for-performance program included in legislation. To base the pay-for-performance initiative for hospitals on the work of a group other than the HQA would be a duplication of effort, and a loss of significant knowledge and expertise.

While the HQA is off to a solid and successful start, the group is already focused on improvements. One of the ways we need to build on the HQA is by allowing more hospitals to be able to participate. The HQA has determined that the current measures do not apply well when assessing care provided at certain types of hospitals. For example, they cannot effectively assess care in children's hospitals, psychiatric hospitals, rehabilitation hospitals, and hospitals that only treat patients with diagnoses other than heart attack, heart failure and pneumonia.

In addition, the current measures are not particularly effective for assessing care in hospitals with few heart attack, heart failure or pneumonia patients. This is particularly the case for small, rural hospitals. To remedy this, the HQA partners have brought together researchers with expertise in rural health care and quality measurement to help identify a set of rurally relevant measures of care.

However, the limited number of patients in small hospitals means that their performance rates can be volatile. In designing a system that rewards excellence, this type of volatility can lead to inappropriate conclusions about the quality of care at these hospitals, and affect whether they deserve a reward under an incentive program. At the same time, omitting small hospitals from the program may imply that they do not provide care quality that is comparable to that of larger organizations. The implications of this volatility in their data must be carefully considered so that hospitals with small sample sizes can participate and receive appropriate recognition for the excellence they achieve.

The HQA partners are working to determine what measures can accurately assess care for a wide variety of hospitals. It is critical that the group choosing these measures consider how to enable hospitals serving different types of patients to participate, as well as how to allow hospitals with small sample sizes to participate.

The Legislation

Again, we congratulate Senators Grassley and Baucus for introducing legislation that could impact Medicare payment through pay for performance, a concept we support. We believe this bill represents a good first step in moving our payment system forward to embrace the concept of pay for performance.

We would like to make several suggestions for improvement in the legislation. We urge you to amend the hospital-related provisions in the legislation that could create a parallel and duplicative quality measurement system, and to specify that the HQA measures and process are to be used. While quality measurement systems are not in place today for many of the other sectors of health care addressed in the bill, hospital quality measurement is well underway.

We also are concerned that the legislation seeks to tie payments to issues, such as cost-effectiveness, that could change incentives. We believe that pay-for-performance should focus solely on quality improvement. There is no common definition of the cost-effectiveness of care for hospitals. Cost-effective over what period of time? The course of a hospitalization ... or a stated period? Also, cost effective for whom? The hospital ... the patient ... the government ... other payers? Each answer would lead to different designs in cost-effectiveness measures and very different conclusions about whether care was cost-effective or not.

Measuring and rewarding performance based on a particular definition of "cost effective" also would have dramatic consequences for patients. Just a few years ago, for example, health maintenance organizations developed criteria for cost-effective care that their doctors and other providers were told to follow. But the ensuing headlines of denials of tests and treatments, and the accompanying public outcry, led to considerable changes.

Much more work needs to be done to define what should be encouraged in terms of cost-effective care before it is incorporated into legislation that could dramatically affect the care patients receive.

While quality reporting under the bill is voluntary, the legislation provides that hospitals that do not report quality indicators would be penalized with a 2-percentage point reduction in their annual market basket increase. This penalty is too great. A reduction of market basket minus 0.4 percentage points was included in the MMA for hospitals choosing not to report quality measures. It was sufficient to encourage virtually every eligible hospital to participate (more than 99 percent of eligible hospitals are reporting quality indicators based on this incentive). With such an outstanding response rate, we see no reason to increase the amount. The sizeable penalty proposed in the current bill is likely to hit those hospitals most strapped for the resources – financial and human – that are needed to collect data and report quality measures.

Further, to finance the payment rewards, the legislation would ultimately reduce all hospital Medicare inpatient payments by 2 percentage points from their standardized amount. This amount is too large for the first widespread Medicare experiment in rewarding quality excellence. We believe pay-for-performance is important and should be implemented, but we support a smaller pool of funds from which to test the concept. In addition, we would like to explore with the committee other sources of funding for this initiative.

Conclusion

Mr. Chairman, the mission of every hospital in every community in America is to provide the best care possible to people in need. To achieve that mission, hospital leaders, trustees, physicians, nurses and others in the hospital family constantly strive not just to keep up with the demands of delivering health care in their communities, but also to improve the way they deliver that care.

We believe that pay-for-performance initiatives can greatly facilitate their efforts. We also believe that an effective pay-for-performance program that truly improves care must be focused on care measurements, must encourage adherence to the best available scientific information, and must have as its foundation the successful collaboration we have achieved with the Hospital Quality Alliance.

We look forward to working with this committee and staff to forge ahead toward our shared goal of improving the quality of care for all Americans.

Measures for The Quality Initiative

	Starter Set, beginning with patients admitted 3rdQ '02; Data first displayed 10/03;	Beginning with patients admitted 2ndQ '04; Data first displayed 1stQ '05	Beginning with patients admitted 3rdQ '04; Data first displayed September '05	Beginning early '06; Data first displayed early fall/winter, '07	Beginning 2nd Q '06. Data first displayed 1st Q '07
Heart Attack	o Aspirin at arrival* o Aspirin at discharge* o Beta blocker at arrival* o Beta blocker at discharge* o ACE Inhibitor for LVSD*	o Percutaneous coronary intervention within 120 minutes of arrival o Thrombolytic agent received within 30 minutes of arrival o Smoking cessation			
Heart Failure	o Assessment of LV function* o ACE for LVSD*	o Smoking cessation o Discharge instructions			
Pneumonia	o Antibiotic timing* o Oxygenation assessment* o Pneumonia vaccination*	o Smoking cessation o Blood culture before antibiotic	o Initial selection of antibiotic o Influenza vaccination		
Surgical Infections			o Timing of prophylaxis antibiotic o Duration of prophylaxis *Selection of antibiotic (Note: display suspended for technical issues)*		
HCAHPS				o Survey of patients' perceptions of care	
Surgical Care Improvement Project Measures					o Measures to provide data on prevention of perioperative heart attack, blood clots and post-operative pneumonia. Details to be worked out.

Responses to Questions From Leo P. Brideau
Senate Finance Committee Hearing of July 27, 2005

1) *Legal Barriers to Health IT Adoption:* **I have heard from hospitals in Montana and around the country that the existing Stark and anti-kickback laws are a legal barrier to helping the physicians and other providers in your community acquire and use health IT systems to build an interoperable network. The bill I introduced last month includes a statutory exemption to these laws for health IT. Can you explain, for my benefit and that of others in the room, why the current laws are such a barrier? Could you also explain how you would use the type of exemption I have proposed to improve quality of care for your patients? Could you accomplish this without this kind of exemption?**

Physician adoption of electronic health records (EHRs) is a goal of both Congress and the Administration. However, many physicians are wary of investing in information technology (IT) because of the costs and risks of these investments, and because their staffs lack experience in using IT. Some hospitals have more advanced IT systems than the physicians practicing in their community, as well as greater access to capital for financing the considerable costs – recent estimates put the price tag at $156 billion – of health IT. They also tend to have larger IT staff, and could lend that expertise to help physician offices adopt EHRs.

While the use of EHRs within hospitals and physician offices promises to improve quality of care, even greater benefits can be obtained by sharing information across health care providers so that, for example, emergency department staff can see medical histories, and primary care physicians can know what medications were given during an inpatient stay. To facilitate this sharing of clinical information, hospitals may want to provide community physicians with hardware, software, or other assistance that would allow the physicians to maintain electronic health records for their patients and thus improve the continuity and quality of care. However, hospitals in this situation must be careful of the Stark and anti-kickback laws.

Both the Stark and anti-kickback laws impose severe penalties on hospitals and physicians that violate them, and the fear of violating these laws is inhibiting progress in IT adoption. The federal Physician Self Referral (or Stark) law prevents physicians from referring Medicare and Medicaid patients to organizations in which they have a financial interest; this includes inpatient and outpatient hospital care. The anti-kickback law prohibits any remuneration in exchange for referring a patient covered by a federal health program. In both cases, remuneration includes both cash and in-kind payments. The Stark law is a "strict liability" statute and no element of intent is required for prosecution. Violators also are subject to significant civil money penalties if they knew or should have known that their referrals were prohibited. The Centers for Medicare & Medicaid Services (CMS) also has made clear that Stark law violations may be pursued as violations of the federal False Claims Act.

The federal anti-kickback law is a criminal statute that provides penalties for knowing and willful violations. The penalties are stiff. Violations of the anti-kickback law are punishable by up to five years in prison and criminal fines up to $25,000 for each offense, or both. In addition, administrative civil money penalties of up to $50,000 may be imposed for each violation and violations may be subject to damages of up to three times the amount involved in the violation. Violators also may be excluded from participation in federal health care programs, including Medicare and Medicaid.

The Stark law has limited exceptions and the anti-kickback statute has a number of safe harbors, but the exceptions are not specifically applicable to health information technology ventures and offer limited – if any – assistance to hospitals wishing to work with their physicians. The one IT-related exception to Stark would allow hospitals to provide IT to physicians for community-wide information exchange. However, the exception requires that the information exchange network be "available" to all providers and residents of the community. "Community" is not well defined in the exception, but is considered too broad a definition to allow hospitals to comply.

In a 2004 study, the Government Accountability Office concluded that various laws, "particularly the Physician Self-Referral Law, known as 'Stark,' . . . present barriers by impeding the establishment of arrangements between providers – such as the provision of IT resources – that would otherwise promote the adoption of health IT" (General Accounting Office. *HHS' Efforts to Promote Health Information Technology and Legal Barriers to its Adoption.* August 2004*)*.

Providing an exception to the Stark and anti-kickback laws would allow hospitals and physicians to collaborate on building their IT infrastructures, facilitating the information exchange needed to improve care. Internal hospital IT systems contain only part of a patient's medical record, and will have no health records for patients that a given hospital had not treated previously. Being able to exchange information with physicians and access patient information from ambulatory care records will improve hospitals' ability to provide the best-quality care. Given the ambiguity of the existing community-wide exception and the significant penalties for violations of the Stark law, hospitals cannot help physicians develop their own IT systems without an exception allowing this to happen.

We thank you for including exceptions to the Stark and anti-kickback laws in the bill you introduced last month (S. 1356). These exceptions can help increase sharing of health information and accelerate adoption of health IT. However, the bill conditions these protections on conformance with interoperability standards, without any transition time, which will limit the effectiveness of the exception.

Hospitals have been calling for increased standardization of health IT for many years. Most currently available IT products can only share information – even within the hospital – after implementing expensive interfaces and patches. However, the vision we share with you – IT systems that are compatible with interoperability standards – will not be realized for some time. Many standards exist, but the health care community has not yet agreed on which

should be adopted. Once standards are adopted, implementation will take time. The standards must have detailed implementation guidance, including how the standards will affect business rules and processes. All parties, including vendors, payers, and providers, will need time to transition to the new standards-based systems. Internally, hospitals will need to analyze how standards will impact their current systems, plan for implementation (including staffing, training, etc.), set aside resources, solicit and manage contracts with vendors, install and test new systems while maintaining backup systems, and finally roll them out across all departments. Experience implementing the transactions standards set forth in HIPAA – which after many years are still in a contingent implementation mode – demonstrates the need for a considerable transition period.

If exceptions to the Stark and anti-kickback rules are conditioned on conforming to standards without adequate transition time, few hospitals will be able to comply and the benefits of the exceptions – increased information sharing and greater physician use of EHRs – will not be realized in the short term.

In closing, not all hospitals are in a position to extend their IT resources to physicians in the community. However, those who are find that the lack of EHRs in physician offices limits the ability to exchange information that can improve patient care. Exceptions to the Stark and anti-kickback regulations would allow them to remedy that situation and accelerate the adoption of health IT among physicians.

2) ***Developing a Quality Measurement System:*** **What do you think the process to develop a quality measurement system should look like? How would this process resemble what happens now with selecting quality measures, and in what ways would it be different? What role do you think Medicare should play in this process, and why is this role important?**

Having an effective and efficient system to collect, verify, analyze and use quality data to reward excellence is the keystone to rewarding excellence in health care. While it is not yet true for all of health care, for hospitals an effective and efficient mechanism already exists and it should be put to use for any pay for performance program utilized by Medicare, Medicaid or other government programs. That mechanism is the Hospital Quality Alliance (HQA).

The HQA is a public-private collaboration to improve care by measuring and publicly reporting the hospital performance measures. Its founding organizations include the American Hospital Association (AHA), Centers for Medicare & Medicaid Services (CMS), Agency for Healthcare Research and Quality (AHRQ); National Quality Forum (NQF); AARP, Association of American Medical Colleges; Federation of American Hospitals, Joint Commission on Accreditation of Healthcare Organizations; American Medical Association; American Nurses Association; National Association of Children's Hospitals and Related Institutions; Consumer-Purchaser Disclosure Project, representing 52 leading employee, consumer and labor organizations; and AFL-CIO. The HQA's goal is to collect and publicly report data on standardized and easy-to-understand hospital quality measures and, in doing

so, provide the public with insight into hospital performance and stimulate improved performance.

S.1356 anticipates that the Secretary would make the decision as to which measures should be used. While it is critical that the Department be part of the decision-making process, it is equally critical that consumers, providers and other purchasers have a voice in which measures are to be used. Without such input, it is difficult to imagine that consumers will feel the information used is actually helping us address their concerns. Without active participation in the decision making, it is likely providers could come to view this as a new wrinkle in the reimbursement game rather than a reward system that should actually be used to affect the quality of care they deliver. One of the reasons we believe the HQA has been so effective is that the decision making is based on the best thinking, expertise, and perspectives of all of the interested parties, not just the government.

To ensure that we are selecting salient and important measures, the HQA relies in part on the perspectives of the various stakeholders, but also has engaged in a number of open discussions around the country, focus group discussions with a range of consumers and on other input to identify what aspects of care ought to be included. This has given our efforts credibility and has meant that hospital leaders and clinicians work to improve performance as assessed by these measures rather than simply assailing the validity of the measurement activity.

We strongly urge you to consider language that enables the Secretary to create a pay for performance program for hospitals that is based solely on the measures that have been chosen for the HQA and that appear on the Hospital Compare Web site. Such language could also give the Secretary discretion to determine that some of the measures that are being reported publicly on Hospital Compare are not appropriate for inclusion in a pay for performance activity.

Further, we urge you to specify that the data collection process would be the same as the one used to collect the data that are publicly reported on Hospital Compare, so that the reporting burden is not increased.

We strongly believe that it would be duplicative, confusing, and make health care more expensive without additional benefit if Medicare's system of rewarding excellence were built off a different set of measures or used a different system for collecting quality data. We need one system for identifying the key aspects of quality on which hospital performance should be measured, for collecting data, and for sharing critical quality information with the public. That system should be the one on which Medicare builds its rewards program for hospitals. The HQA has already proven itself to be an effective and efficient collaborative for this work, and Congress should specify that the work of the HQA is the platform from which Medicare should move into a program of rewarding excellence.

TESTIMONY OF

HERB KUHN

DIRECTOR

CENTER FOR MEDICARE MANAGEMENT

IN THE

CENTERS FOR MEDICARE & MEDICAID SERVICES

BEFORE THE

SENATE COMMITTEE ON FINANCE

ON

IMPROVING QUALITY IN MEDICARE: THE ROLE OF VALUE-BASED PURCHASING

July 27, 2005

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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 heath 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 to76 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 (NICCQ), 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.

Finance Committee Hearing
"Improving Quality in Medicare: The Role of Value-Based Purchasing"
Questions Submitted for the Record
Mr. Herb Kuhn
August 2, 2005
Senator Baucus

Question 1: Developing a Quality Measurement System:

CMS has explored quality improvement and pay-for-performance through demonstrations and the hospital quality reporting program. Based on these programs and your knowledge of the issue, what do you think the process to develop a quality measurement system for purposes of reporting and value-based payments should look like? Who should participate? What role do you think Medicare should play in driving quality measurement throughout the health care industry?

Answer:

CMS is committed to working with Congress, the provider community, and other stakeholders to develop reporting and payment systems that will help reshape the way we deliver health care in this country, and to provide better support for greater quality, fewer unnecessary costs and improved health. Linking a portion of Medicare payments to valid measures of quality and effective use of resources would give providers more direct incentives and financial support to implement the innovative ideas and approaches that actually result in improvements in the value of care that our beneficiaries receive.

The foundation of effective pay-for-performance initiatives is collaboration with providers and other stakeholders, to ensure that valid quality measures are used, that providers are not being pulled in conflicting directions, and that providers have support for achieving actual improvement. Consequently, to develop and implement these initiatives, CMS is collaborating with a wide range of health care providers, other public agencies, and private organizations who share our goal of improving quality and avoiding unnecessary health care costs.

The healthcare community has already exhibited leadership and interest in quality measurement, public reporting, and paying for performance. We have heard repeatedly from individual providers and provider organizations around the country about their desire to support the development and implementation of appropriate measures and payment methods and to participate in well-designed initiatives in this area. A number of specialty societies, including the American College of Physicians, American Academy of Family Physicians, and the Society of Thoracic Surgeons, are in the vanguard of leading change. In addition, like many private-sector health care payers and plans, CMS is conducting a number of demonstrations and piloting various payment reforms to reward providers for better quality, better patient satisfaction, and lower overall health care costs in the Medicare fee-for-service program. We will continue to work with health care providers and Medicare beneficiaries to make further progress on these efforts.

Question 2: Legal Barriers to Health IT Adoption:

We need to move forward with health IT and interoperability – health IT will improve care and allow providers to report data on quality. To reduce legal barriers to IT adoption, the bill I introduced last month included a statutory exemption to the Stark and anti-kickback laws for health IT systems. It requires that the Department publish rules establishing these exemptions within 180 days of enactment. If this provision is enacted, will your agency be able to meet the deadline?

Answer:

We are aware of, and share your concern about, legal barriers that may discourage the adoption of health IT, including the need for a targeted exception to self-referral restrictions and safe harbor guidance under the federal anti-kickback law. CMS and the HHS Office of Inspector General expect to issue Notices of Proposed Rulemaking on these issues in the next few weeks.

If further rulemaking were required, a 180 day deadline would be difficult to meet. The self-referral rules are complex and highly technical, and any new exception must be carefully researched and precisely defined. We are concerned that a 180 day deadline could result in a hurriedly drafted rule that would not be optimally useful to the health care community.

Question 3: Legal Barriers to Adoption of E-prescribing technology:

We have been waiting for several months for the publication of regulations outlining an exemption to Stark & Anti-kickback laws for e-prescribing technologies, as was instructed in the Medicare Modernization Act. In response to questions submitted following his nomination hearing in February, Inspector General Levinson said that these regulations were imminent. But we still have not seen them. Could you please give me a sense for when we might expect these important regulations?

Answer:

Proposed regulations establishing new self-referral exceptions and anti-kickback safe harbors are in the final stages of Department clearance. We expect to issue these rules in the next few weeks.

Question 4: Medicare Hospital Accreditation and Quality:

The Joint Commission, as it is known, has unique status under the law to deem hospitals compliant with the Medicare conditions of participation. This means that CMS has little ability to work with the Joint Commission to structure its accreditation standards or processes. Would you agree that removing the Joint Commission's unique deeming status, as I proposed in legislation last year, would increase CMS' oversight of the hospital accreditation program, which could improve quality overall? Do you think that

CMS should update the Conditions of Participation in an effort to improve quality and affect the accreditation process as well?

Answer:

In response to last year's report from the Government Accountability Office and the results from our own internal analysis of the hospital validation program and CMS oversight of the JCAHO accreditation process, CMS has undertaken further action to enhance its oversight of JCAHO activities in the hospital accreditation process.

CMS is undertaking a regulatory initiative to refine and improve the current method of measuring and calculating any differences between JCAHO findings and CMS-sponsored validation surveys, and to explore additional and alternative performance measurement methods. The regulatory initiative will examine methods that may be used by CMS to gain additional and more substantial information on the JCAHO processes. Additionally, CMS will explore regulatory changes to implement the statutory requirement to deny deemed status where CMS requirements are higher than requirements prescribed for accreditation by JCAHO.

CMS is investigating cost-effective approaches to enhance hospital survey activities, including integration of the results of approximately 4,000 complaint investigations conducted in JCAHO accredited hospitals by CMS and the states. CMS has secured the services of an independent contractor to analyze the hospital complaint data to determine the extent to which this information can be used as an additional tool to assess JCAHO performance.

CMS and the JCAHO are currently undertaking a joint effort to examine the JCAHO standards and elements of performance for hospitals as they relate to the Medicare hospital requirements and interpretive guidelines to move towards more consistent requirements in areas critical to providing safe, quality patient care.

Question 5: Quality Improvement Program:

An article in the Washington Post, published on Tuesday, July 26th, talked about the QIOs and the evolution of that program towards partnership with providers and away from their oversight function. Medicare spends almost $300 million a year on QIOs, and since this hearing is about getting the most bang for Medicare's buck, I am interested in what those dollars get us. What kinds of quality improvements have the QIOs shown? How does CMS make sure that the QIOs are actually helping to improve quality of care?

Answer:

The QIO program as a whole is the only major public quality improvement effort. Our funding is an important investment for Medicare. CMS spends this money on the QIOs because the agency places a very high priority on quality healthcare. The QIOs are the only organization solely dedicated to ensuring high quality healthcare is provided to

Medicare beneficiaries in the country, including beneficiaries who are of different ethnic backgrounds, race or may live in areas where healthcare is not as easy to receive – like some rural communities.

Because of the QIO program, Medicare beneficiaries, in fact every patient in America, has safer, more effective care and information available to them about that care. QIO work has shown hospitals how to successfully reduce the rate of surgical infections. QIOs have worked with providers to publicly report their quality measures so that consumers can make more informed decisions. QIOs have helped nursing home patients be physically restrained less often and experience less chronic pain. The QIO program is doing important work.

QIOs are making care safer and more effective. More and more providers are using clinical practices proven to get the best results.

For example:

QIOs boost public reporting on quality of hospital care:
Since 2002, QIOs have provided expertise on quality measurement and public reporting to almost 4000 hospitals nationwide. Almost all hospitals are now reporting some quality of care information on the Medicare website. Over the next three years, QIOs will assist 1,000 hospitals to publicly report quality performance on an expanded set of 22 quality measures for heart attack, heart failure, pneumonia and surgical infection prevention.

QIOs organize and drive patient safety initiatives:
QIOs are in the forefront of developing and supporting statewide patient safety efforts. In 17 states, QIOs have played a central role in statewide initiatives. In other states, they are leading local initiatives.

QIOs make hospitals safer:
Since 2002, QIOs have been working intensively with hospitals to reduce surgical infection rates. National results for 2002-2005 are not yet available, but preliminary reporting from 32 states shows significant impact preventing surgical infections which complicate more than 750,000 operations annually. A recent article in the American Journal of Surgery found that a QIO pilot project affecting 35,000 patients reduced the surgical infection rate in 2003 by 27%.

Over the next 3 years, QIOs will be working intensively with 15-30% of all hospitals on improving surgical care and inpatient care for heart attacks, heart failure, and pneumonia. These efforts will involve preventing post-operative pneumonia and surgery-related adverse cardiac events, as well as cutting the rate of surgical infections. The goal is to reduce surgical complications in these hospitals by 25%.

During 2002-2005, QIOs will help 450 hospitals cut their errors rates in care for heart attack, pneumonia and heart failure by 50%.

QIOs are helping wire America for better care:
Over the next three years, QIOs will help 10,000 -15,000 primary care physicians install and use electronic information systems to improve chronic and preventive care and reduce quality disparities in racial and ethnic populations.

QIOs are improving nursing home and home health care:
QIOs have worked with more than 2700 nursing homes since 2002 as part of the Medicare-sponsored Nursing Home Quality Initiative. In December 2004, CMS announced 2-year results showing that nursing homes that worked intensively with QIOs showed far greater improvement on a number of quality measures than those homes that did not.

CMS data showed that since the initiative began nursing homes reduced the prevalence of pain in long-term residents by 38%. Homes that worked intensively with QIOs on any clinical improvement project showed an overall 49% decrease in chronic pain. The average home reduced post-acute pain for short stay residents by about 11%. Those working intensively with QIOs reduced post acute pain by 18%.

Nursing homes in almost all states also reported a decrease in the use of physical restraints, with the average home showing a 23% decrease since the beginning of the quality initiative. Nursing homes that worked intensively with QIOs showed a 33% reduction in use of restraints.

Across the nation, the average home did not make progress reducing pressure ulcers among residents, while those that worked intensively with QIOs showed some improvement.

Since 2002, QIOs have provided highly structured training in quality improvement techniques to over 75% of all home health agencies. Over the next three years, QIOs aim to cut in half the number of preventable hospitalizations of home health patients in at least 1,400 home health agencies.

Finance Committee Hearing
"Improving Quality in Medicare: The Role of Value-Based Purchasing"
Questions Submitted for the Record
Mr. Herb Kuhn
August 2, 2005
Senator Snowe

Question 1: Resources for Payment for Performance

Mr. Kuhn, Secretary Leavitt has stated that he wants to implement payment-for-performance. In order to fairly reward performance we must do at least two things: First, we must measure performance and outcomes to build a sound basis for fair payment and, second, we must ensure that clinicians have the technology and tools that will give them access to the information they need to best treat their patients.

Payment methods must be fair. For example, if a provider is serving patients with higher risks, with greater comorbidities, then if the payment methodology does not recognize this, payments cannot be fair. As a result, providers could be encouraged to "cherry pick" low risk patients and many beneficiaries could suffer. So we clearly need to gather extensive data to develop fair means of performance payments.

In addition, as you have noted previously, it will be critical for clinicians to have ready access to the information needed to treat their patients. This is often missing at the point of care.

Wide adoption of health IT systems is necessary to achieve both objectives. At a time when providers are struggling to serve beneficiaries, we must look for methods to encourage adoption of health IT. Since most benefits accrue to the patient and payer, not the provider, it simply makes sense that we help providers adopt IT. The federal government should provide financial incentives by giving providers access to grants and tax incentives to help offset the initial costs, and sustained Medicare reimbursement incentives so that clinicians who use IT systems to improve quality see a return on investment. These will create powerful incentives for clinicians to rapidly get IT systems in place, and we can begin the move to a pay for performance reimbursement system.

How can we reasonably expect to move to a pay for performance system without taking these steps first?

Answer:

In order to pay providers on the basis of their performance, we have to be able to measure that performance adequately. We have considered several different types of measures -- measures of provider structure, measures of the processes of care providers use, and measures of the outcomes of their activities -- each of which have advantages and drawbacks. While our plans are still evolving in this area, we are considering initiatives in which we would first pay providers for providing appropriate information about their

activities, and then in subsequent periods provide incentive payments to those with better outcomes.

Based on the experience of the Hospital Quality Alliance, reporting quality measures has been demonstrated to improve the quality of hospital care. The hospitals participating in this program have not relied on electronic health records (EHRs) to collect data or report the measures, yet they have still achieved improvements in quality. The structure of pay-for-performance initiatives for providers in ambulatory care settings could include the utilization of claims data to obtain data for quality measures that have been agreed upon by a broad group of stakeholders, including physicians and payers. This would enable reporting of quality measures without imposing an undue burden on physician offices. As this initiative matures and EHRs become interoperable (i.e., can share data and report measures), physician offices will be in a better position to adopt health information technology (HIT) and EHRs to automate the reporting of quality measures. CMS is evaluating options to incent physician adoption of EHRs and has an ongoing initiative to support adoption and effective use of HIT through the Medicare Quality Improvement Organizations. As with other private sector initiatives (i.e., Bridges to Excellence), pay-for-performance can be successfully implemented in parallel with ongoing adoption and use of HIT. As the Secretary has indicated, it is important to achieve interoperability and certification of EHRs prior to realizing widespread adoption of EHRs. But given the existing infrastructure and the availability of claims data, pay for reporting can begin in the short term in ambulatory care.

Question 2: Implementation of Health IT

Mr. Kuhn, Secretary Leavitt has stated that "HHS is taking advantage of the current low adoption rate for EHRs, and putting the goal of interoperability first. When interoperability is in place, EHR adoption will follow."

We are faced with several compelling facts: Up to a third of health care spending, or more than half a trillion dollars, is wasted because of poor or redundant care, and up to 98,000 avoidable deaths occur each year due to medical errors. Given these numbers, and the fact that we have the technology available today to lower drastically both our costs and the present level of medical errors, it is critical that we act now to accelerate the adoption of health information technology.

The CITL (Center for Information Technology Leadership) estimates savings of $44 billion annually from the use of health IT in independent settings, and significantly more from an interconnected system. And, according to CITL, we could reduce medication errors by 50% through the use of stand-alone electronic prescribing systems.

The best way to accelerate the adoption of health information technology and start saving money and lives now is for the federal government to provide financial incentives. And it simply makes sense for us to do this. Much of the financial return is to the payers of health care – the Medicare trust funds and other federal health programs will reap

significant benefits from the use of health IT by providers serving the beneficiaries of these programs.

Why shouldn't we start saving lives, and our businesses and taxpayers' money, by implementing financial incentives now?

Answer:

There are some financial savings and clinical improvements from the use of health IT in independent settings, but these benefits are limited. Our healthcare system today is fragmented, and most people get their care from multiple settings – different physicians, hospitals, long-term care facilities, labs, pharmacies, and many others. When health IT draws upon information that is limited to any single setting, the benefits are limited. If decision support – which includes such functions as clinical alerts, reminders, drug-drug interaction checks, allergy interaction checks, etc. – is supported only by the patient information in any single setting, critical information from other settings may be missing. This means, for example, that the best ePrescribing system, with state-of-the-art drug-drug interaction checking, can only check a prescription against the drugs that a provider knows the patient takes, and not against all of the other medications given by other physicians. Real transformation occurs when health IT is applied to the longitudinal medical record that incorporates clinical information from a patient's many different providers.

Not only is interoperability required to derive truly transformational benefits; interoperability will help drive adoption of electronic health records (EHRs) more quickly. With the advent of certified, interoperable EHRs and an interoperable Nationwide Health Information Network (NHIN), EHR adoption will be stimulated without subsidies by lowering the cost of technology and reducing risk to buyers. Clinicians will have greater price transparency, and health IT products will be more plug-and-play (i.e., requiring much less customization and integration work to get these systems up and running).

HHS is placing its primary efforts on interoperability in order to ensure that health information can seamlessly follow patients as they desire. Interoperability was a nearly unanimous recommendation from the recent Request for Information on the NHIN architecture that had more than 500 respondents. Right now, we have a one-time chance before large-scale health IT adoption occurs to overcome fragmentation of health care. With interoperability, the benefits will be greater, and the adoption rate for EHRs will rise much more quickly.

Finance Committee Hearing
"Improving Quality in Medicare: The Role of Value-Based Purchasing"
Questions Submitted for the Record
Mr. Herb Kuhn
August 2, 2005
Senator Kyl

Question 1:

Do you think we can implement a P4P system absent new funding for end-stage renal facilities which face systemic problems with their market basket update or with a flawed SGR system for physicians?

Answer:

In addition to providing adequate payments, Medicare's payment system for physicians and other providers should encourage and support them to provide quality care and prevent avoidable health care costs. After all, physicians are in the best position to know what can work best to improve their practices, and physician expertise coupled with their strong professional commitment to quality means that any solution to the problems of health care quality and affordability must involve physician leadership.

Because it is critical for CMS payment systems to support better outcomes for our beneficiaries at a lower cost, CMS is working closely and collaboratively with medical professionals and the Congress to consider changes to increase the effectiveness of how Medicare compensates physicians for providing services to Medicare beneficiaries. We are engaging physicians on issues of quality and performance with the goal of supporting the most effective clinical and financial approaches to achieve better health outcomes for people with Medicare.

At the same time, however, we are concerned and are closely monitoring the current volume-based payment system for physicians' services, which projects seven years of negative updates in physician payments. Simply adding larger updates into the current payment system would be extremely expensive from a financing standpoint, and would not promote better quality care. Under this system, there are significant variations in resources and in spending growth for the same medical condition in different practices and in different parts of the country, without apparent difference in quality and outcomes. CMS is committed to working with Congress and the medical community to remedy this situation by developing reporting and payment systems that enable us to support and reward quality.

Medicare needs to move away from a system that pays simply for more services, regardless of their quality or impact on patient health, and consequently contributes to reductions in the physician update under the current payment formulas, to a system that instead encourages and rewards efficiency and high quality care for the Medicare program and its beneficiaries. CMS' physician payment system should support,

encourage, and provide an incentive for physicians to achieve Medicare savings by avoiding unnecessary services such as duplicate tests and to use those savings in developing improvements to the physician payment system.

Question 2:

Should individual physician quality measures be publicly reported in a similar manner as hospital facilities (available on a website)? Should a beneficiary be able to see how an individual physician ranks on quality measures?

Answer:

The President's FY 2006 Budget emphasized that "the Administration has promoted accountability for quality, creating incentives to collect data from Medicare providers on quality measures and making them publicly available."

Public reporting efforts build upon the success of our other quality reporting initiatives (Nursing Home Compare, Home Health Compare, Dialysis Compare, and Hospital Compare) which provide quality information to consumers and others to help guide choices and drive improvements in the quality of care delivered in these settings.

Question 3:

If a provider (hospital, nursing home, physician) continues to perform in the lower tier or decline in quality, do you think the provider should eventually be removed from the system? How do private health organizations handle their consistently low performers?

Answer:

With respect to private health organizations that participate in the Medicare Advantage (MA) program, the Medicare law requires MA plans to conduct quality improvement activities, such as chronic care improvement programs and performance reporting. Some of these activities have the potential to provide plans with information on individual providers, but CMS does not require plans to collect information on individual providers. We understand from health plan representatives and health care quality organizations that some plans track physician performance on key quality indicators, share that information with providers, and work with them to improve performance. Sometimes poor performers are excluded from a plan's network, but our impression, based on limited input from health plan representatives and other organizations, is that plans are more likely to place them in a less favorable coinsurance tier. When enrollees have to pay higher coinsurance to see certain providers, the providers may lose patients and this gives them an incentive to improve their performance in order to move to a more favorable coinsurance tier.

Question 4:

Should we have categories within any of the providers groups? Should cardiologists, internists, urologists, etc. be considered on quality measures among their specialties or as physicians as a whole? Should academic, for profit, non-profit, critical access and rural hospitals all be considered the same for quality measures? Should publicly traded, private or non-profit health plans all be judged and rewarded for performance in the same manner?

Answer:

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. The goal of the Surgical Care Improvement Program is to prevent or decrease surgical complications, in an effort to improve outcomes, and decrease hospital days and unnecessary 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. For example, we are 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. McClellan 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, we 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 the Medicare beneficiaries.

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 also has been enhancing its activities to give such providers technical assistance with proven systems improvements 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 improve performance. 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.

Question 5:

In order to "pay for performance in a way that will accurately and fairly reflect performance we will need to do at least 2 things:

1) measure performance and outcomes, and
2) ensure that clinicians have the technology and tools that will give them access to the information they need to best treat their patients.

Physicians are sometimes slow to adopt technology, in part because of their reluctance to new technology, but often because of the costs of new technology which can become outdated and replaced by new systems very quickly.

If clinicians don't have health IT systems in place, we will neither be able to accurately measure their performance or outcomes and thus pay them fairly so they are not unjustly rewarded or penalized, nor will they be able to provide the best possible care. MedPAC suggested we reward physicians on their use of technology first and then move into rewarding for quality measures.

Should it be the federal government's responsibility to assist physicians in upgrading their offices with health information technology systems? If not, what is the most appropriate balance to encourage physicians to incorporate technology into their practices?

Answer:

The adoption of EHRs by large physciain groups and hospitals is already occurring, outside of any specific policies to promote this behavior. HHS is pursuing an "interoperability forward" strategy, in which adoption policies will be linked to interoperability. Through the Requests for Proposals which were issued in June 2005, HHS plans to issue a contract to develop and evaluate a certification process for health IT. This will quickly move to develop a first generation of criteria for the minimum requirements for functionality and interoperability. These will be tested in the market and will evolve through real-life use and evaluation. HHS will focus first on criteria for ambulatory EHRs. This means that by Spring, 2006, physicians and hospitals will be able to purchase EHRs that, if certified, will be able to interoperate with forthcoming network infrastructure in the future.

Certification will have a significant impact on the adoption rate, but certification alone may not be enough. HHS will consider appropriate incentives that focus on putting the right technologies into the hands of clinicians at the point of care. This may include

value-based purchasing, Stark exceptions, Anti-Kickback Statute safe harbors, etc. But, the HHS strategy will link these incentives to the capacity to interoperate and securely share health information.

Opening Statement
Finance Committee Hearing:
Improving Quality in Medicare: The Role of Value-Based Purchasing
July 27, 2005

Senator Jon Kyl

Thank you, Mr. Chairman, for holding this hearing today. I am appreciative of your focus on two areas of great concern – quality and payment.

I often say that if health care is the most important thing, if we would leave whatever we were doing should a phone call inform us that a loved one had a medical emergency, we must pay appropriately for that service.

Far too often, Medicare payments do not inadequately cover services. This is for a number of reasons: limited resources, increases in the volume of services provided as compared to targets, and, to a certain extent, the ability of providers to drive up the volume of services. I believe the examination of quality will shed some light on these problems, especially unnecessary tests and procedures, and excessive or induced demand used to compensate for decreased payments. By examining quality, we will not only look at best practices, we will also find waste in the system.

I applaud the groups, both public and private, that have been actively engaged in the quality discussions. It is important that this emphasis on quality be supported by the providers and practioners because in the end, we all want the same thing: healthier patients. I hope that the discussion of pay-for-performance will continue to involve those most knowledgeable and experienced in both the provision of services and the attainment of quality.

I must express a bit of concern that the discussion of pay-for-performance deviates from the standard practice of health plans and even CMS pilot programs that provide additional funds in reward for stellar performance. Most health plans have committed extra funds to rewarding their providers for quality, and have given providers a positive incentive to participate and achieve higher goals. Other systems use tiered co-payments for beneficiaries who choose hospitals or physicians ranked in the top tier, allowing those who truly value quality to obtain it by paying for it.

Jon Kingsdale with Tufts Health Plan in Massachusetts is quoted as saying, "We believe the preferred way to address the issues of improving quality and controlling cost trends is to provide members with more choice, not less. If we can engage and involve consumers in making choices between higher value and lower value providers at the appropriate decision-making points, we can reward members and providers for moving toward value." I would like to have the article from the AHIP Coverage magazine included in the record. ("Using Tiered Provider Networks to Create Incentives for Quality Care," by Jay Greene, AHIP Coverage, Jan / Feb 2005, pages 22–30)

What is most troubling for me is that we would proceed with a pay-for-performance system for physicians without addressing (and by that I mean fixing) the flawed physician payment system. I recognize and appreciate the Sense of the Senate language included in the bill you have introduced; but, frankly, we need action – both from Congress and the administration – to correct the flaws in our payment system.

To superimpose a "withhold" on physicians who already face a stream of cuts does not make sense. It only digs a deeper hole for us to climb out of and will probably lead to a host of

unintended consequences. I predict we will see the exit of physicians from the practice, the reluctance of high quality physicians to participate in the Medicare program, and an increase in the volume of services that will harm the sustainable growth rate – a vicious cycle that ultimately hurts patient access and outcomes.

I am interested in how Arizona physicians – especially in rural areas of my state such as Springerville, Prescott, Globe, Show Low, Nogales – will fare under a system where up to two percent of reimbursement is withheld. For physicians in these areas, that may make a big difference in their ability to practice at all. Especially when we have not addressed medical liability, the nursing shortage and other issues plaguing the system, we need to be very careful in imposing a "top down" pay-for-performance system.

We need to continue to consider quality. But we must be realistic and acknowledge that we often get what we pay for; and in this case, if we are trying to force quality without paying for it, we will probably not achieve our intended results. Nor will outcomes always be good with even the best of care.

I urge caution, Mr. Chairman, and a commitment to fix the reimbursement system, which means at a minimum, not reducing physician reimbursement while simultaneously trying to improve quality.

Thank you.

Using Tiered Provider Networks to Create Incentives for Quality Care

BY JAY GREENE

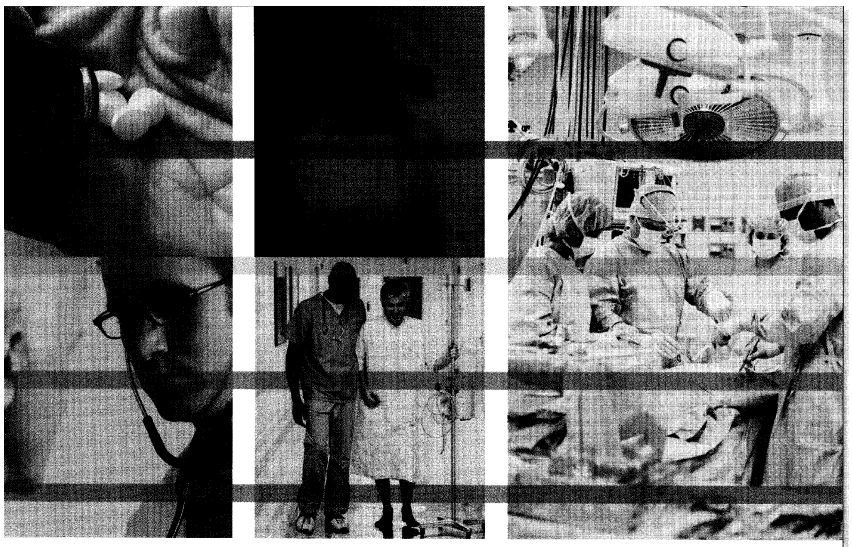
HOW DO YOU OFFER HEALTH PLAN MEMBERS MORE CHOICE in selecting a physician or hospital while at the same time create incentives for providers to lower costs and increase quality?

One way is to offer members a product that groups hospitals and physicians into "tiered provider networks" and charges different co-payment amounts based on the rankings.

Under tiered networks, hospitals or physicians ranked in the top tier—based on a health plan-specific formula that combines measurements that demonstrate high quality and low cost—charge members lower co-payments for visits or hospital stays. Providers ranked in a lower tier charge members a higher co-payment at the point of service.

A growing number of health plans are creating HMO and PPO products based on this kind of tiered provider network concept, says Jon Kingsdale, senior vice president with Tufts Health Plan, Waltham, Mass.

"We believe the preferred way to address the issues of improving quality and controlling cost trends is to provide members with more choice, not less," says Kingsdale. "If we can engage and involve consumers in making choices between higher value and lower value providers at the appropriate decision-making points, we can reward members and providers for moving toward value."



Instead of offering lower co-payments at the point of service, another method is to offer a more restricted network with a lower premium to provide incentives for members to select the higher value provider. For those members wishing a broader choice of providers, the plan would be priced at a higher premium level, notes Kingsdale.

"The movement right now is consumer engagement," says Scott Aebischer, senior vice president for product innovation and customer service at HealthPartners, St. Paul, Minn. "We have seen this progression from indemnity, to managed care, to PPO, and now going back to indemnity with a twist. The tiered approach is just one option for consumer engagement. It's a natural because health plans have so much data on providers."

In an attempt to slow premium increases that have averaged more than 10 percent annually the past four years, health plans have been working with employers to develop various products that seek to replace utilization management as the chief cost containment tool.

"We are seeing health care cost trends skyrocketing and we are trying to get consumers to pay attention to costs," Aebischer says.

In one of the largest hospital tiering programs in the country, Blue Shield of California, San Francisco, launched Network Choice in April 2002. Now with more than 1.2 million members participating, David Joyner, senior vice president for network management, says Network Choice has been successful in encouraging hospitals to adopt additional quality improvement programs.

Under Network Choice PPO, hospitals are classified into two categories. The top tier, named Choice, has no additional co-pays other than the normal 20 percent deductible; the second tier, Affiliate, has an additional 10 percent co-pay. For the HMO Network Choice product, members who choose a hospital in the Affiliate tier pay a higher co-payment for the top-tier Choice hospital.

"In provider negotiations, the tiering introduces a new dialogue on the relative costs between hospitals," Joyner says. "They are concerned because if they increase rates it could put them in the Affiliate category, and we have seen some movement in members to the Choice facilities."

Since 2002, Blue Shield has estimated $19.3 million sav-

ings in health care costs from tiered services. Some 81 percent of services are now performed at Choice facilities, which represent about 83 percent of hospitals in the network.

"Because of the value (tiered provider networks) can add, I am optimistic in the long term that the solution to ills in the system is aligning incentives between us, employers and consumers," says Joyner.

"In the short term, I feel a lot of resistance from providers in this structure," Joyner says. "It will be difficult in the near term to achieve results, but we hope consumers will make choices that will drive providers to lower prices and increase quality."

Provider opposition to tiered networks depends on the market, provider experiences with public reporting of quality and cost data, and the historical working relationships between health plans and providers.

Donald Fisher, president of the American Medical Group Association, Alexandria, Va., supports tiered networks if physicians are involved in choosing the measurements. "As long as the measurements are on the group or team level and physicians are at the table, we have no problem with tiering," Fisher says. "We are seeing medical groups coming together to share data with the public even without the health plans asking for it."

Fisher says the key is that the quality standards are measures of outcomes and not processes. "When we look at the data, particularly with chronic illness patients, a coordinated approach gets better outcomes and efficiency," he says.

Joyner says Blue Shield is evaluating how to tier physician groups. "It is more challenging to measure quality performance on individual physicians," he says. "There are so many variations."

In Minnesota, HealthPartners had a good experience with

Cost and Quality Measures

Hospital Quality Alliance: Improving Care Through Information

Formerly known as the National Hospital Quality Initiative, the alliance is administered by the U.S. Department of Health and Human Services and Medicare's quality improvement organizations. The alliance's goal is to construct a single, prioritized and standard quality measure set for hospitals. As of late 2004, a total of 3,704 hospitals nationwide participate in the voluntary reporting program.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Specification Manual for National Quality Measures (2005)

The aligned manual represents the result of efforts by the Centers for Medicare & Medicaid Services and the Joint Commission on Accreditation of Healthcare Organizations to achieve identity among common national hospital performance measures and to share a single set of common documentation.

Quality measures are available for the following conditions: acute myocardial infarction, heart failure, pneumonia, surgical infection prevention, and pregnancy.

A copy of the manual can be downloaded from the JCAHO Web site: **http://www.jcaho.org/pms/core+measures/aligned_manual.htm**.

Leapfrog Group

An initiative launched by a small group of large employer health care purchasers working to improve the safety, quality, and affordability of health care for Americans. The Leapfrog Group identified four hospital quality and safety practices that are the focus of its health care provider performance comparisons and hospital recognition and reward. The four quality practices are: computer physician order entry, evidence-based hospital referral, intensive care unit physician staffing, and a quality index of 27 safe practices.

For more information: **www.leapfroggroup.org/about_us/leapfrog-factsheet**.

California Hospital Experience Survey

Formerly known as the PEP-C Patient Satisfaction Measurement, the survey allows consumers to learn how hospital patients rated their care at 200 hospitals throughout California. The information, organized by city, county, geographic area, and ZIP code, is the result of a recent survey open to all general acute care hospitals in California. The survey now is based primarily on the federal standard hospital survey, Hospital-CAHPS, and was developed in partnership with the California Institute for Health Systems Performance and The NRC+Picker Group.

For more information: **www.calhospitals.org**.

California Perinatal Quality Care Collaborative

The California Perinatal Quality Care Collaborative (CPQCC) is an outgrowth of a 1997 initiative first proposed by the California Association of Neonatologists and now includes more than 60 hospitals. The Collaborative focuses on the development of perinatal and neonatal outcomes and information, which allows for data driven performance improvement and benchmarking throughout California. Member hospitals submit data to the CPQCC Data Center which is managed locally.

For more information, visit the CPQCC Web site: **www.cpqcc.org**.

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providers when it rolled out its tiered network product in 2003, Aebischer says.

"It is very well accepted by providers," Aebischer says. "We spent lots of time talking with them about the measurements and distinguishing folks in the market."

Used often in conjunction with tiered networks are hospital and physician "report cards," which give consumers information on provider costs and quality. Members, in turn, make more informed health care choices and visit a chosen provider, and as a result, pay lower co-pays.

HealthPartners uses report cards with its "Distinctions" tiered provider network product. The PPO plan offers two tiers for primary care physicians, specialists and hospitals. For example, the co-pay for a tier one primary care physician is $15 and tier two is $25. Tier one hospitals per admission is $100 and for tier two is $250.

"The next step we will move into in 2005 is to explore co-pay differentials for types of services (for example, cardiology)," Aebischer says.

One reason providers more readily accepted the HealthPartners tiered network approach is the history of using quality report cards in Minnesota. For more than 15 years, a coalition of public and private employers called the Buyers Health Care Action Group in Bloomington has been publicly reporting quality data, Aebischer says. One of its missions is to educate providers and consumers about quality and health care value.

"We introduced quality metrics six years ago and the providers are well-versed in pay-for-performance (quality incentives) and the use of report cards," Aebischer says.

On the other hand, Tufts Health Plan initially experienced opposition to the tiered network after presenting the quality measurements to the hospitals, Kingsdale says. Tufts Health Plan measures costs and efficiency based on its cost per admission, which is case- and risk-adjusted per inpatient stay.

"We initially picked four or five measures of quality in three services and then took it to the hospitals," Kingsdale says. "The hospitals thought it was the right product, but they objected to the methodology and the fact that (we) didn't consult with them."

Kingsdale says Tufts Health Plan then formed an 11-member committee of experts selected by the health plan and the state hospital association, and also worked with a larger committee of the state's 68 hospitals, to review the metrics.

"We met over a 75-day period and significantly changed the metrics for quality," he says. "We have different metrics for each service."

Introduced in July, Tufts Health Plan Navigator PPO product includes about 30 percent of hospitals statewide in tier one. In 2005, Kingsdale says the health plan will add a third tier that will include about 25 percent of hospitals.

Under the three-year phase in of the tiered program, Tufts Health Plan is considering how to evaluate primary care physicians in 2006 and a plan is under consideration to add specialists in 2007. The Navigator product has enrolled about 68,000 members so far from the state of Massachusetts employees and dependents plan, known as the Group Insurance Commission. Overall, Tufts Health Plan has about 125,000 members in various tiered PPO, HMO and point of service products, or about 18 percent of its commercial membership, Kingsdale says.

Tufts Health Plan assigns a level one or level two co-payment for each of three service categories: pediatrics, maternity care, and adult medical-surgical. The health plan excludes mental health, substance abuse and organ transplantation, which have centers of excellence designations, from the tiered program.

Health plans vary somewhat as to the types of cost and quality measures they use. For example, Tufts Health Plan uses four

quality measures from the Joint Commission on Accreditation of Healthcare Organizations, and several from the Leapfrog Group (computerized physician order entry and intensive care unit physician staffing) for hospitals. (For information on the resources, see the sidebar, p. 24).

"One thing to do is work with the provider community in developing the best metrics," Kingsdale says. "This is an evolving, state of the art, very controversial system among providers. If the point is to educate consumers, make sure you involve the providers."

Kingsdale also suggests that tiered networks should be ranked based on a combination of cost and quality data. "Just using cost data is inadequate," he says.

A spokeswoman for the American Hospital Association, Washington, D.C., says the AHA favors providing consumers with quality information. "We don't have a position on tiered networks," says Caroline Steinberg, vice president for trends and analysis. She adds: "We are opposed to tiering hospitals solely based on cost.... Our concerns relate to the quality of the information provided to consumers so they can make good decisions."

Quality Can Make a Difference

In response to Blue Shield's Network Choice program, Joyner says several hospitals in California initially opposed the tiered program. At least two hospitals refused to participate in the program and newspaper advertisements were placed against it.

"In the spirit of transparency, we put out detailed cost and quality information. We are getting a lot of medical quality directors seeking information from us. This is positive. The end point is whether the members demand high value and the providers deliver."

"Most hospitals took steps to improve quality and hold down costs so they could be ranked in the top tier," Joyner says.

Joyner says Blue Shield compares the relative costs of hospitals in each category based on service mix and severity of illness adjustments. "We give high-quality hospitals a credit to adjust their cost scores," he says. Blue Shield uses the RBRVS (Resource Based Relative Value Scale) for hospital system developed by Milliman USA.

Joyner says there is a "huge disparity in costs between hospitals in the same marketplace." Quality differences, however, are much less. "If a hospital is priced 20 percent to 30 percent off the threshold, quality can make a difference. But if a hospital is double the price threshold, quality makes little difference."

Blue Shield uses a variety of quality indicators from Leapfrog, JCAHO, California Hospital Experience Survey, the California Perinatal Quality Care Collaborative (CPQCC) and the Hospital Quality Alliance. "We decided not to create our own quality metrics because we didn't want to increase the administrative workload of hospitals," Joyner says. (For more information on quality indicators, see the sidebar, p. 24.)

But one rather large question remains unanswered: Does tiering stimulate price competition among hospitals and physicians? "That is the $64,000 question," Kingsdale says. "In theory, we are beginning to reinforce competition between providers in cost and quality. Hospitals asked us if they lowered their prices would they move into tier one."

Kingsdale says if members shift utilization by using tier one providers "that could make a difference on price. In the absence of patients shifting, the high-cost hospitals will be perfectly fine with their prices and it will not have any impact on pricing."

However, Kingsdale says hospitals are asking Tufts Health Plan for their individual raw data on quality and prices. "In the spirit of transparency, we put out detailed cost and quality information. We are getting a lot of medical quality directors seeking information from us. This is positive. The end point is whether the members demand high value and the providers deliver."

Joyner says price competition depends on consumer purchasing behavior. "There are certain price points where people's behavior will change. In buying gasoline, for example, as prices go up people will start to pay attention to prices at different gas stations and select the one with the greater value for them," he says. "I think some of this is happening in health care. The rise in health care costs is so rapid and significant that purchasers are starting to contemplate things now they wouldn't choose at a lower price point."

Offering tiered networks based on cost and quality with a financial incentive to choose the higher value provider allows the market to work effectively, Joyner says.

"This is not the same managed care deal (as in the 1990s)," Joyner says. "Before it was to eliminate the high-cost providers. You may choose hospital A or B, but you cannot choose C. Tiering gives you all the choices. It depends on your personal balance

"Most hospitals took steps to improve quality and hold down costs so they could be ranked in the top tier."

of cost vs. choice. Some members will say, 'I will only go to the inexpensive option. I will only pick A or B,' but others will pick higher cost, which may be C. To me, we are avoiding the pitfalls of the previous structures of saying 'no' to people."

Aebischer says HealthPartners has not yet seen lower hospital prices, but only about 150,000 out of the health plan's 650,000 members are in tiered networks. "We will see tiering evolve. I have seen a much bigger interest in the provider community in what they can do to improve their overall service experience. They are very interested in doing what they can do to be the best."

HealthPartners uses total cost of care (combined price, quality and utilization) and 32 quality measures to tier physician groups and hospitals. Measurements for primary and specialty care include overall patient satisfaction surveys, patient-centered and best practices, and participation in the "pay for performance" quality incentive program. For hospitals, Health Partners also uses Leapfrog participation and JCAHO accreditation.

Some health plans have a variation in quality and price for physicians, but HealthPartners has noticed very little.

"There is not much disparity in the market here for quality," Aebischer says. "There are some primary care physicians in the lower quadrant, but most are in the middle." He adds that there also is more variation in costs between hospitals and specialty physicians.

"It is no surprise that we are starting to see members driving utilization to the higher value hospital," Kingsdale says. "That is positive because it rewards the high value hospital and rewards the member with a lower co-payment."

One of the challenges facing health plans is educating mem-

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bers in how to use the tiered network. "We went through a massive education initiative to explain this system to our members," Kingsdale says. "We talked to 20,000 employees at fairs and booths, in direct mailing to homes, and we had TV and radio advertising."

Health plans also are providing educational information to physicians on how members make quality and cost decisions.

"We hope by educating physicians they will be better informed on the tiering concept and they can help teach their patients about value," Joyner says.

Aebischer says HealthPartners has seen an increase in the volume of phone calls from members seeking more information on the tiered product.

"We have a whole generation of people who didn't have to pay anything and now they are being asked to pay different co-pays," he says. "They want to ask more questions about why their provider is in the lower tier."

But some members are clearly confused about what it means when a provider is ranked in a lower tier. Some mistakenly believe that a lower co-payment means that the provider delivers lower quality. "Patients equate less expensive providers with lower quality care," Joyner says. "It is a real problem to get them to understand the meaning of 'value.' Every study we have done shows there is no relationship between cost and quality."

Kingsdale agrees. "We have a significant number of providers with high quality and low cost," he says. "We find it is high value to do more quality early on and have fewer medical errors later on."

It is this generally agreed principle that is driving health plans like Tufts Health Plan, Blue Shield of California and HealthPartners to further refine their tiered provider network programs.

"I see increased interest in the development of this kind of product," Aebischer says. "We are the only plan in Minnesota offering this product. Our competitors are planning this model. Interest in consumer-driven products is very lively. It is an open question, however, whether it will lead to lower prices and higher quality. We believe so."

Jay Greene is a health care writer based in St. Paul, Minn.

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Pay for performance in Medicare

July 27, 2005

Statement of
Mark E. Miller, Ph.D.

Executive Director
Medicare Payment Advisory Commission

Before the
Committee on Finance
U.S. Senate

Chairman Grassley, Ranking Member Baucus, distinguished Committee members, I am Mark Miller, Executive Director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you today to discuss the Commission's recommendations to link payments to the quality of care in Medicare. I commend your leadership in this important new direction.

The Commission has concluded that change to Medicare's payment systems is urgently needed. The payment systems are neutral or negative to quality; for example, a hospital is paid more when a patient is readmitted to the hospital with an infection he acquired there. Other costs of poor quality include unnecessary illness, injury, disability, and death. It is time for the Medicare program to start to differentiate among providers when making payments. In our March 2004 and 2005 reports to the Congress, MedPAC discusses several important policy changes that differentiate among providers. Taken together, these changes will improve the quality of care for beneficiaries and lay the groundwork for obtaining better value in Medicare. While some providers have raised concerns about aspects of a pay-for-performance program, these concerns must be weighed against the costs of not moving forward: allowing the program to reward poor care and not recognize quality care.

Over the course of the last two years, the Commission has recommended that Medicare create incentives to improve quality through its payment systems. This approach builds upon the experience of private purchasers in designing and running pay-for-performance programs that refocus and reward health care providers for improving the quality of care. The Institute of Medicine and others have pointed to the quality gaps in the American health care system. While Medicare already has some programs in place to improve quality, these are not enough to orient the whole system towards improving quality; nor is it equitable for Medicare to pay a high quality provider the same as one that furnishes poor care. Because Medicare is such an important part of the American health care system, it can be very influential in transforming the incentives in the broad health care system—by making the business case for providers to improve quality of care.

CMS, along with accreditation and provider organizations, has played a critical role in building the infrastructure to move to pay for performance. The agency has identified and developed quality measures, collected standard data on quality, and published information on the performance of some providers. The agency also has developed demonstration programs to test various aspects of pay for performance.

MedPAC has concluded that Medicare is ready to implement pay for performance as a national program and that differentiating among providers based on quality is an important first step towards purchasing the best care for beneficiaries and assuring the future of the program. The Commission has also recommended that Medicare measure resource use of physicians and feed this information back confidentially to them. The Commission's agenda is to explore measurement of resource use and evaluate its use in pay-for-performance program. This testimony first provides a summary of our analysis of five settings—hospital, physician, home health, Medicare Advantage, and end-stage

renal disease—where the Commission has concluded that pay for performance is ready to move forward and then discusses the role of information technology (IT) in improving quality and the next steps for the program's evolution.

Criteria for deciding whether to move forward

The Commission studied dozens of private sector pay-for-performance initiatives to develop a framework to evaluate which settings were ready to move toward pay for performance. In each setting, we reviewed the types of measures available—outcomes, process, structural, and patient experience. Outcome measures report the results of care—whether the patient recovered, died, or improved function. Process measures capture the actions that providers take that are known, through clinical research, to improve outcomes. Structural measures tell whether the provider has the capacity to provide high quality care. And patient experience measures indicate dimensions such as satisfaction and understanding of the care process. Our framework uses the following four criteria to evaluate each setting:

- Measures must be based on clinical evidence, accepted by independent experts, and familiar to providers. While few individual measures can capture all dimensions of quality, they should identify meaningful differences in the quality of care that individual providers furnish.

- Collecting and analyzing data should not be unduly burdensome for either the provider or CMS. Many providers already report data to CMS; data that are already collected should be used when possible. The Commission has also identified additional measures that would improve quality measurement and make each setting ready for pay for performance, taking into account both the burden and the value of the additional information needed. Providers' capability to provide information should become better over time as clinical information technology improves.

- When outcome measures are used, they should be risk adjusted. Providers should not be financially penalized for the poorer outcomes of high-risk patients. However, even when risk adjustment is not adequate for outcome measures, Medicare can use process, structural, and patient experience measures, which generally do not need to be risk adjusted.

- Most providers should be able to improve on the available measures. The measures should identify aspects of quality where there is room for improvement because the goal of the program is to improve performance and differentiate among providers. The measures should capture an aspect of care that providers believe they can control. The number of measures should be sufficient to give a good picture of providers' overall quality. For example, only measuring whether a hospital gives aspirin after a heart attack probably does not capture enough of the quality of care to reflect the experience of many patients or many dimensions of their care.

As it used these criteria to analyze whether each of the settings was ready to move forward, the Commission also considered broad, cross-cutting questions on how a pay-for-performance program would work best for Medicare. These design principles are intended to create a program that would improve quality of care for the most beneficiaries possible, minimize adverse consequences, and be fiscally prudent.

- The pay-for-performance program should reward providers based on both improving care and exceeding certain benchmarks. This achieves two goals: rewarding those who have already achieved high quality and encouraging improvement from providers with low initial scores. Only rewarding those providers who already provide the best quality might discourage lower-quality providers from making the effort to improve care. This approach—rewarding attainment and improvement—would improve the care for the most patients.

- Medicare should fund the program by setting aside a small share of payments in a budget neutral approach. The Commission concluded that a small share—starting with 1 to 2 percent of current provider payments—would be the least disruptive for beneficiaries and providers. The percentage set aside should increase as Medicare and providers gain more experience with pay for performance. The Commission intends for all of the money in the pay-for-performance fund to be paid out.

  Some have suggested that this amount is not enough to encourage providers to change; others say this budget neutral approach will financially harm providers who do not perform well, and so discourage their participation in Medicare. Medicare is a large purchaser of care, making up a considerable share of some providers' revenues. Redistributing 1 to 2 percent of these revenues can represent a significant amount of funds to those providers with high performance. The percentage set aside to fund the pay-for-performance pool from each provider is small enough, however, that it should not disrupt access to care. The Commission undertakes an annual assessment of the adequacy of providers' payment amounts. This process would determine if payments are adequate for a provider setting (e.g., hospitals) as a whole. Pay for performance is an approach that, within that total payment pool, changes the distribution of funds to reward providers with the best performance.

- Establish a process for continual evolution of measures. Evolution involves considering new measures, dropping measures, and ensuring research is underway to create or validate others. We describe the process we envision in more detail later in this statement. It is important for such a consensus process to develop common measure sets among private and public purchasers to reduce provider burden.

What settings are ready to move forward to pay for performance?
Using the criteria listed above developed from discussions with private purchasers—available measures, reasonable burden, risk adjustment if necessary, and ability for providers to improve—the Commission recommended in its March 2004 and March 2005 reports that Medicare adopt pay-for-performance programs for:

- hospitals,
- physicians,
- home health agencies,
- Medicare Advantage plans, and
- dialysis facilities and physicians who treat dialysis patients.

CMS already has quality information for most of these settings that could be used as a "starter set" of measures. However, to ensure that measures capture a broader spectrum of quality for patients and types of providers, additional information would be needed, particularly for physicians. These measures with examples of each set are provided in the summary table (Table 1) at the end of the document.

Hospitals
A variety of quality measures are available for a hospital pay-for-performance program. More than 20 process measures, including the ten measures that hospitals already report to CMS, are one measure set (Table 2). Patient safety measures, for example pressure ulcer prevention programs, can be captured through a survey that is already being used by some purchasers. Two outcomes measures are also ready. Patient experience can be captured through another survey that will be ready soon. MedPAC recommended changes to the coding of diagnoses on the hospital claims to further expand the measures of hospital quality by allowing us to know whether complications or co-morbid conditions developed in the hospital or were present in the patient before he arrived.

Process measures are based on evidence showing that the type of care delivered increases the chances of positive patient outcomes. Examples of process measures include whether a patient was prescribed a beta blocker after being hospitalized for a heart attack or whether they received an antibiotic to prevent surgical infection. Providers also like these types of measures because they provide clear guidance on what processes need to be changed to improve quality.

Almost all hospitals report to CMS on one set of 10 measures (referred to as the annual payment update measures). In addition to these 10, hospitals participating in the Hospital Quality Alliance—a voluntary reporting initiative whose members include hospital organizations, CMS, the Joint Commission on Accreditation of Healthcare Organizations and AARP—are now reporting to CMS on an additional 12 measures, including several on preventing surgical infections.

We have fewer outcome measures for hospitals, but some information on mortality and rates of adverse events is available on claims or from other administrative data. Two widely endorsed mortality measures—those for acute myocardial infarction and coronary artery bypass graft—could be part of an initial set. Safety, as measured by the rate of adverse events, is a critical component of quality in hospitals, but we need more detailed

information on the billing claim that is used to calculate these measures to be able to hold hospitals accountable for adverse events (for example, pressure ulcers or complications) that occurred in the hospital, rather than for conditions that were present in the patient before he arrived. To allow for this distinction, the Commission recommended that CMS require hospitals to identify which secondary diagnoses were present on admission and submit this information to CMS on its billing claims forms.

Other measures that could be added in the near future include safe practices and patient experience of care. Safe practices, which include pharmacist participation in medication use and pressure ulcer prevention programs, can be assessed through a survey already used by the Leapfrog Group based on National Quality Forum-endorsed practices. Patient experience of care can be assessed through a hospital version of the Consumer Assessment of Health Plan Survey, known as H-CAHPS. It assesses patients' experiences, for example with nursing care and understanding of side effects of their medications.

Physicians

Because physicians are central to the delivery of all types of health care, their participation in a pay-for-performance program is essential. Measures are available for many types of physician specialties. However, measuring physician quality is more complex than measuring quality in other settings because of the lack of data, the wide variety of specialized services, and the number of physicians. These complexities led the Commission to recommend a two-step implementation strategy for physicians.

The first step would have physicians report on whether they have certain IT functionality, that is how their information systems track and follow-up with their patients. Examples of these types of measures include: whether physicians had patient registries to identify and track patients with coronary artery disease, or whether physicians treating patients in hospitals took responsibility for ensuring that patients received their recommended follow-up. These measures would apply across all types of physicians. The measures may best be achieved through using advanced clinical information technology, so they would also encourage providers to adopt IT. Doing so would also help move to the second step by building the infrastructure necessary to measure and improve processes of care.

These IT functionality measures would reward the quality outcomes of using IT, rather than simply the purchase of a system. Physicians would not have to purchase fully operational electronic health records; less sophisticated technology could be used to create patient registries. Although physicians' assessment of their ability to track their patients would be a new task for most physicians, there are precedents. An NCQA recognition program requires physician offices to report on their IT functionality through a Web-based data collection tool. CMS is also emphasizing these practices though the Quality Improvement Organizations and the Medicare Care Management Performance Demonstration.

The second step, two to three years later, would move to measuring physicians' clinical processes of care for different health conditions. While many of these measures are

available and are already being used in private purchasers' pay-for-performance programs, they are not yet available for every type of patient or physician. To encourage specialty societies and others to speed development of these types of measures, Medicare should establish a date certain when all physicians will be measured on their performance on processes of care relevant to their patients.

The Commission suggests that, at least initially, the source of data for these process measures be claims, as these are the least burdensome to physicians. While claims-based process measures are not available for every type of condition or specialty, researchers at RAND are finding that they are available for many conditions of importance to Medicare beneficiaries and physicians. Claims data would be an even better source for quality measures if they were linked to prescription (from the Part D program when available) and laboratory value data (obtained through laboratories). The Commission recommended that these data be collected and linked with physician claims to improve quality measurement. Additional process of care measures can be derived from medical record abstraction, flow sheets, or electronic health records.

Home health care

Home health care has a ready set of outcomes measures that are already collected and have good risk adjustment. Outcome measures from CMS's Outcome-Based Quality Indicators set could form the starter set of pay-for-performance measures. The National Quality Forum, Agency for Healthcare Research and Quality (AHRQ), and an expert panel convened by CMS concur that a set of these measures are reliable and adequately risk adjusted. They pose no additional data collection burden because they have been collected and computed by home health agencies and CMS since 1999. Risk adjustment is supported by data on patient prognosis, functional status at the start and completion of care, multiple diagnoses, and behavioral and cognitive status.

The evolution of home health care quality measurement should include the addition of valid, reliable, and adequately risk-adjusted functional stabilization scores and adverse event measures. Though the goal of care for many home health patients is improvement, some home health care is intended to prevent decline in patients who could not be expected to improve. Stabilization measures could be indicators of how well agencies are meeting the needs of such patients in addition to the needs of patients who are improving.

More work is needed to develop measures related to adverse events such as falls in the home or potentially dangerous dehydration, which are rare but can be very dangerous to patients. The rarity of adverse events in the home health setting, compared to functional improvement or stabilization, makes adverse events more difficult to risk adjust. Adding improved adverse event measurement to the set of indicators used for pay for performance would be a good next step because they reflect patient safety, an important indicator of the quality of care. Measures of processes related to patient safety could also be added.

Medicare Advantage
Medicare Advantage (MA) plans are ready for pay for performance because measures are developed and already collected. CMS has been providing the public with information regarding the quality of MA plans for several years and plans have shown that they are able to improve on the measures. However, some plans perform far better than others on the reported measures. In fact, room for improvement exists on all of them, making stronger incentives for improvement important for MA plans.

CMS has information on all plan scores through the Consumer Assessment of Health Plans Survey (CAHPS). CAHPS measures member satisfaction with the plans' provision of services. They also report on the Health Outcomes Survey. In addition, although all plans do not report on all Health Plan Employer Data and Information Set (HEDIS) outcome and process measures, all plans report on some of them. These measures include such services as immunization and screening rates.

Because they are process measures, the HEDIS set does not require risk adjustment. Adjustment is available for the CAHPS measures of patient experience, based on the correlation between certain demographic factors and patient satisfaction. Plans have developed a variety of strategies to improve their scores on these measures; but improvement is still possible as performance varies from plan to plan.

End-stage renal disease (ESRD): dialysis facilities and physicians who treat dialysis patients
Dialysis facilities and physicians who treat ESRD patients are ready for pay for performance because well-accepted measures are already collected. Among the publicly reported measures, those for dialysis adequacy and anemia have improved. However, current quality improvement activities have not uniformly improved these outcomes for all patients. Furthermore, other aspects of care, such as mortality and hospitalization rates have shown little improvement.

MedPAC found that the physicians who treat dialysis patients and for whom Medicare makes a monthly capitation payment should also be paid in part based on their performance on managing their dialysis patients. This will focus both the facilities and the physicians who treat dialysis patients on improving patient care on the same set of measures.

Pay for performance could include measures of dialysis adequacy and anemia management. CMS has collected data on these measures from dialysis facilities since 1999. These measures do require risk adjustment, but information on patient characteristics that affect outcomes is available and would provide adequate risk adjustment.

Additional measures for pay for performance for the future could include those for nutritional management, vascular access care, bone disease management, and use of home dialysis.

The role of information technology

In all settings, better use of IT would decrease the burden of reporting quality information and facilitate improvement efforts. Recommending that Medicare include functions of IT systems in physicians' offices is a first step; this notion should be expanded to other settings where IT can both improve quality reporting and quality outcomes. Including IT use in pay-for-performance programs will improve the return on investment for purchasing IT and will make an ongoing business case to providers to continue to use the IT as a part of the care process.

The Commission has focused on promoting IT through pay for performance based on a review and analysis of the barriers and current extent of adoption of IT. The acquisition of IT alone does not necessarily lead to its use. Even more importantly, acquisition alone does not lead providers to use it to change care delivery to improve quality, which is the desired outcome. By contrast, the Commission's recommendation to differentiate payment based on quality performance focuses on the objective of improved quality, not simply the purchase of an IT system. In addition to improving the return on investment for IT, focusing on the objective—better quality—provides guidance to physicians and vendors about how the IT systems should be designed and used.

The Federal government also is involved in important activities to standardize products and the language used in IT to enhance interoperability. These activities address other barriers to adoption and are an important complement to providing financial incentives through pay for performance.

Moving towards the future

The Commission sees several important additional future directions for pay for performance. These include developing a process for continually improving measure sets, developing measures for additional settings, developing and potentially integrating measures of resource use into pay for performance, and developing measures to capture coordination of care.

After Medicare chooses an initial measure set to start the pay-for-performance program in each setting, it will need to improve and adapt measure sets over time. Improving measure sets involves considering criteria for new measures, dropping measures, and ensuring that research is under way to create or validate others. Medicare would also need to evaluate the adequacy of risk adjustment in new and existing measures. A single entity could bring together government agencies (e.g., AHRQ), purchasers (e.g., the Leapfrog Group), providers (e.g., physician specialty societies), health services researchers, and performance measure development groups (e.g., the Hospital Quality Alliance) to inform the evolution of measures and make recommendations to CMS. One goal of this process should be to ensure coordination among private and public purchasers to agree on common measures and thereby reduce the burden on providers to report them.

The Commission recommended a pay-for-performance program focused on improving quality. However, in the private sector many pay-for-performance incentives are also

aimed at improving efficiency—the interaction between the resources used to deliver care and the quality of the product. MedPAC is evaluating the potential to include measures of both quality and resource use in a Medicare pay-for-performance program. Private sector initiatives also are looking at measures of longitudinal efficiency, that is, the extent to which providers provide high quality and lower resource use over longer periods of time. Ultimately, we want to be able to reward efficiency and quality for more meaningful periods of time than individual admissions or visits; examples of these periods are an acute episode of care or six months of chronic care. Measures of longitudinal efficiency would reward providers for providing care right the first time and those who assure effective handoffs among different providers and settings.

Pay-for-performance programs should also evolve to reward providers in other settings, particularly where there are concerns about quality and where many patients use the setting. The Commission concluded that more measures are needed to capture the quality of skilled nursing facilities; we will look at what is needed for this setting to move to pay for performance in the coming year.

Linking payment to quality within a setting does not necessarily enhance coordination across settings. Many quality problems happen as patients move from setting to setting. For example, when a hospital discharges a patient home without the necessary clinical information, she could receive the wrong medication. Measures of care coordination that would align provider incentives across settings are another priority for development.

MedPAC plans to look at the last three issues as part of its agenda and expects to report out to the Congress in these areas in the future.

Conclusion

In conclusion, the Commission has recommended linking payment to quality through pay-for-performance programs in Medicare. We recognize that doing this requires the program and providers to change and raises some issues. On net, however, the Commission's judgement is that the benefits of moving forward outweigh the costs of remaining at the status quo. Medicare's role in this area is critical to move the health care system forward to provide better quality of care. Pay for performance will also address an inequity in the current payment system: paying the provider who gives his patients better care the same as the provider who does not.

TABLE 1 **Summary of potential pay-for-performance measure sets, by setting**

Setting	Type of measure	Example	Data source
Hospitals	Process	Heart attack patients discharged with prescription for beta blockers	Medical records
	Structure	Safe practices: Existence of pressure ulcer prevention programs	Web-based survey
	Outcomes	Mortality (CABG, AMI), adverse events	Claims
	Patient experience	H-CAHPS: Whether patient understood the risk of their medication	Survey
Physicians	Structure	IT functionality: Whether the office has in place systems (e.g. patient registries) for tracking and following up on patients	Web-based survey
	Process	Diabetic patients who receive certain diagnostic services (e.g. HbA1c tests)	Claims
	Outcomes	Diabetic patients with good blood sugar control	Claims (with laboratory and prescription claims)
Home health agencies	Outcomes	OBQIs: Patients who improved their ability to walk	OASIS assessment tool
Medicare Advantage plans	Process	HEDIS: Breast cancer screening	Medical records and claims
	Patient experience	CAHPS: Difficulty in obtaining care when needed	Survey
	Outcomes	HOS: Patients whose health status improved	Survey
Dialysis facilities and physicians	Outcomes	Patients with adequate dialysis	Medical records or claims
	Process	Patients with fistula	Medical records or claims

Note: CABG (coronary artery bypass graft), AMI (acute myocardial infarction), H–CAHPS (Hospital–Consumer Assessment of Health Plans Survey), IT (information technology), HbA1c (hemoglobin A1c), OBQI (Outcome-Based Quality Indicators), OASIS (Outcomes Assessment Information Set), HEDIS (Health Plan Employer Data and Information Set), CAHPS (Consumer Assessment of Health Plans Survey), HOS (Health Outcomes Survey).

Source: Analysis from MedPAC's 2004 and 2005 Report to the Congress: Medicare Payment Policy.

TABLE 2

Many hospital process measures are endorsed or collected for multiple purposes

Hospital quality measures	APU	HQA	JCAHO	Premier Demonstration	NQF	QIO
Acute myocardial infarction (AMI)						
Aspirin at arrival	✓	✓	✓	✓	✓	✓
Aspirin prescribed at discharge	✓	✓	✓	✓	✓	✓
ACE inhibitor for LVSD	✓	✓	✓	✓	✓	✓
Adult smoking cessation advice/counsel		✓	✓	✓	✓	✓
Beta blocker at arrival	✓	✓	✓	✓	✓	✓
Beta blocker at discharge	✓	✓	✓	✓	✓	✓
Mean time to thrombolysis			✓			✓
PCI received within 120 minutes of arrival		✓	✓			✓
Thrombolytic agent received within 30 minutes of arrival		✓	✓	✓	✓	✓
Inpatient mortality			✓	✓	✓	
CABG mortality				✓	✓	
AMI test measures only						
LDL cholesterol assessment						✓
LDL cholesterol testing within 24 hours after arrival						✓
Lipid-lowering therapy at discharge						✓
Heart failure						
Discharge instructions		✓	✓	✓	✓	✓
Left ventricular function assessment	✓	✓	✓	✓	✓	✓
ACE inhibitor for LVSD	✓	✓	✓	✓	✓	✓
Adult smoking cessation advice/counseling		✓	✓	✓	✓	✓
Pneumonia						
Oxygenation assessment	✓	✓	✓	✓	✓	✓
Pneumococcal vaccination	✓	✓	✓	✓	✓	✓
Blood cultures performed within 24 hours before or after arrival						✓
Blood cultures performed before first antibiotic		✓	✓	✓	✓	✓
Adult smoking cessation advice/counseling		✓	✓	✓	✓	✓
Antibiotic timing (mean)			✓			
Initial antibiotic received within 4 hours of arrival	✓	✓	✓	✓	✓	✓
Initial antibiotic selection for community-acquired pneumonia		✓	✓	✓		✓
Influenza vaccination		✓	✓	✓	✓	✓
Surgical infection prevention						
Prophylactic antibiotic received within 1 hour prior to surgery		✓	✓		✓	✓
Prophylactic antibiotic selection for surgical patients		✓	✓		✓	✓
Prophylactic antibiotics discontinued within 24 hours after surgery end time		✓	✓		✓	✓

Note: APU (annual payment update), HQA (Hospital Quality Alliance), JCAHO (Joint Commission on Accreditation of Healthcare Organizations), NQF (National Quality Forum), QIO (Quality Improvement Organization), LVSD (left ventricular systolic dysfunction), PCI (percutaneous coronary intervention), CABG (coronary artery bypass graft), LDL (low-density lipoprotein), ACE (angiotensin-converting enzyme). QIO measures are from the 7th scope of work.

Source: MedPAC analysis, based on material prepared by the Iowa Foundation for Medical Care, from MedPAC's 2005 Report to the Congress: Medicare Payment Policy.

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August 26, 2005

The Honorable Charles E. Grassley
Chairman, Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Questions for the record from the Finance Committee Hearing "Improving Quality in Medicare: The Role of Value-Based Purchasing"

Dear Senator Grassley:

This letter is in response to the questions you sent us on August 2, 2005. Answers to the questions from Senator Baucus and Senator Kyl are as follows:

Replies to questions from Senator Baucus

1. ***Timeline for Value-based purchasing:*** **There has also been a lot of debate about what providers and plans are or are not ready to move forward with value-based purchasing. Can you explain in more depth the MedPAC recommendations on pay-for-performance for hospitals, physicians, plans, dialysis facilities, and home health agencies? How did you decide that these providers were ready to move forward? Lay out a timeline for me – based upon your research and the Commission's views. When can we expect each group to report data on quality to CMS, and when is it feasible to begin tying their payments to quality?**

MedPAC staff spent about a year talking with private purchasers, coalitions, and large insurers who had implemented pay-for-performance systems. From these discussions, we distilled four criteria for determining whether a sector was ready for pay for performance, based on the measures that were available. The criteria require that measures are:

- Well-accepted, evidence-based, valid and reliable,
- Pose no undue burden on providers or CMS,
- Adequately risk-adjusted, and
- Indicative of quality issues that providers can improve.

When the Commission applied these criteria to sectors of the Medicare program, we found that four sectors are ready for the implementation of pay-for-performance programs now. In home health, Medicare Advantage, and dialysis, CMS already has measures and data collection systems in place and requires the participation of all providers in those sectors. For inpatient

hospitals, condition-specific process measures and a data collection system are in place; participation is voluntary. Additional safe practice measures have also been developed and used by over 1000 hospitals.

For physicians, there are two steps necessary over the next three years to begin a pay-for-performance program. The first step would have physicians report on whether they have certain IT functionality; that is, how their information systems track and follow-up with their patients. Examples of these types of measures include: whether physicians had patient registries to identify and track patients with certain conditions, like coronary artery disease, or whether physicians treating patients in hospitals took responsibility for ensuring that patients received their recommended follow-up. These measures would apply across all types of physicians. The second step, two to three years later, would move to measuring physicians' clinical processes of care for different health conditions. While many of these measures are available and are already being used in private purchasers' pay-for-performance programs, they are not yet available for every type of patient or physician. To encourage specialty societies to put measure development on a fast track, Medicare should establish a date certain when all physicians will be measured on their performance on processes of care relevant to their patients. The Commission also suggests that, at least initially, the source of data for these process measures be claims, as these are the least burdensome to physicians.

2. ***Developing a Quality Measurement System*: MedPAC has looked at quality improvement programs and thought a great deal about pay-for-performance. Based on that work, what do you think the process to develop a quality measurement system should look like? Who should participate? And what role do you think Medicare should play?**

The Commission has recommended that Medicare should lead efforts to begin payments for performance and establish a process for continual evolution of measures. Evolution involves considering new measures, dropping measures, and ensuring research is underway to create or validate others. The entity that leads the process should be independent, open, and have a secure stream of funding. It should make recommendations to CMS based on rigorous analysis by clinical and quality measurement experts. Its membership should include health researchers, quality measurement experts, government agencies, purchasers, and providers. It is important for such a consensus process to develop common measure sets among private and public purchasers to reduce provider burden.

3. ***The role of health IT in Value-based purchasing:* There has been a lot of discussion about health IT during the last year, and the need to facilitate health IT adoption. Many of my colleagues are concerned – and I agree – that we can't just "pay for IT for IT's sake". But IT relates to quality improvement in many ways. Based upon your work and the Commission's discussions, what do you think is the role of health IT in a value-based purchasing program? Specifically, how can Medicare facilitate health IT adoption, and how important is this role to building a national, interoperable health IT network?**

The Commission has focused on promoting IT through pay for performance based on a review and analysis of the barriers that have limited the adoption of IT. The Commission recommended that Medicare differentiate payment based on measuring functions that improve quality, not simply the purchase of an IT system, because the purchase of IT does not necessarily lead providers to use it to change care delivery to improve quality, which is the desired outcome. In fact, the implementation of IT without successful, accompanying changes in the delivery of care can lead to expensive failures.

We recommend including IT functionality in a pay-for-performance program in order to improve the return on investment for IT, focus on the objective of changing the delivery of care, and build the capacity for physician offices to be able to measure, report on, and improve care on other measures over time. An example of a measure of physician office IT functionality is whether the office has a patient registry for tracking those with chronic conditions.

As more providers begin to use and demand information electronically, the need and ability to develop a national, interoperable, health IT network will increase. To assist in the development of this network, the government should also continue to press forward on work to create standard terminology and messaging standards for the smooth movement of information among providers.

4. ***The cost of failing to pay for quality in Medicare:*** **We have heard how value-based purchasing will improve the quality of care delivered to Medicare beneficiaries. But aren't there other compelling reasons to go down this road? The Washington Post published a series of articles July 24-26 on Medicare's quality. One article described in detail how bad practices actually net providers more money in Medicare. What you see are the major cost implications of continuing to separate quality from Medicare payment?**

The greatest implication of continuing to separate quality from Medicare payment is the financial and personal cost to the beneficiary of lower quality care. Many patients are at risk for complications and infections in hospitals. In addition, a significant proportion of Medicare beneficiaries in hospitals do not receive care known to be effective for their condition. Serious shortcomings exist throughout the health care system.

A system that is neutral or negative towards quality can create equity issues for those providers who improve quality. For example, a hospital that reduces readmission rates through improved patient safety would forgo the revenue from those additional admissions, perhaps even losing market share to a competitor with higher readmission rates.

As to whether linking payment to quality will reduce spending or not, the evidence is inconclusive. If better quality allows patients to avoid hospitalization, complications, or readmissions, then spending may be reduced. However, to the extent that P4P encourages increased use of appropriate care, spending for some services may increase. The potential of pay-for-performance programs to improve quality and decrease the human cost of lower quality

led the Commission to conclude that Medicare must lead this important change to the health care payment system.

Replies to questions from Senator Kyl

1. **Do you think we can implement a P4P system absent new funding for end-stage renal facilities which face systemic problems with their market basket update or with a flawed SGR system for physicians?**

Every year, MedPAC reviews the adequacy of Medicare payment. This year's analysis of the payment adequacy factors led the Commission to recommend that physicians and dialysis facilities receive an update payment, even though increases are not currently scheduled.

The factors we consider in every sector of the program are the quality of care, beneficiary access to care, changes in volume of service, the supply of providers, providers' access to capital, the adequacy of current payments, and changes in payments and costs over the coming year. Our analysis of these indicators finds that current Medicare payments for physician services are adequate; however, in consideration of next year's expected costs and our payment adequacy analysis, the Commission recommends that payments for physician services be updated by the projected change in input prices, less an adjustment for productivity growth.

Most of our indicators of payment adequacy for dialysis services are positive. Beneficiaries are not facing systematic problems in accessing care, providers have sufficient capacity to meet demand, quality is improving for some measures, and providers' access to capital is good. Nevertheless, the Medicare margin for composite rate services and injectable drugs declined from 1999 to 2003. Because we are concerned about the trend in the Medicare margin and the uncertainty in payments due to recent changes in law and regulation, the Congress should update the composite rate by the projected rate of increase in the ESRD market basket index less 0.4 percent for 2006.

For pay for performance, MedPAC recommended beginning programs in both sectors with a small portion of payments. MedPAC will continue to annually assess, in every Medicare sector, whether payments are adequate to ensure access to quality care for Medicare beneficiaries.

2. **Should individual physician quality measures be publicly reported in a similar manner as hospital facilities (available on a website)? Should a beneficiary be able to see how an individual physician ranks on quality measures?**

The Commission does not have a position on this issue.

3. **If a provider (hospital, nursing home, physician) continues to perform in the lower tier or decline in quality, do you think the provider should eventually be removed from the system? How do private health organizations handle their consistently low performers?**

The Commission does not have a position on this issue. We note that Medicare currently has conditions of participation, audit functions, and the authority to de-certify providers that do not meet program standards. We also note that some private systems have used individual physicians' scores to exclude certain physicians from their networks or to create tiers of physicians.

4. **Should we have categories within any of the providers groups? Should cardiologists, internists, urologists, etc. be considered on quality measures among their specialties or as physicians as a whole? Should academic, for profit, non-profit, critical access and rural hospitals all be considered the same for quality measures? Should publicly traded, private or non-profit health plans all be judged and rewarded for performance in the same manner?**

We support the use of quality measures that are crosscutting when they are available. That is, they apply to all types of providers. For hospitals, this could include measures of whether the hospital (large, small, academic or rural) has a pressure ulcer prevention program or a surgical infection prevention program. For physicians, measures of IT functionality, such as the ability to track and follow-up with patients, are applicable to all.

However, some measures are specific to care for a particular condition. Hospitals admit a wide variety of patients and so a set of measures, such as those collected through the hospital-supported Hospital Quality Alliance are very useful. Some hospitals, such as critical access hospitals, perform a somewhat different function than the typical inpatient acute care hospital. Additional measures of how well critical access hospitals stabilize and transfer patients may be useful for the sub-group of critical access hospitals.

Physicians are often very specialized as well. On the measures specific to certain conditions, sub-groups of physicians should be compared with others who see similar patients. Health plans are responsible for a wide variety of patients and should be measured on a variety of measures that apply to all types of plans.

5. **In order to "pay for performance in a way that will accurately and fairly reflect performance we will need to do at least 2 things:**

    1. **measure performance and outcomes, and**
    2. **ensure that clinicians have the technology and tools that will give them access to the information they need to best treat their patients.**

Physicians are sometimes slow to adopt technology, in part because of their reluctance to new technology, but often because of the costs of new technology which can become outdated and replaced by new systems very quickly.

If clinicians don't have health IT systems in place, we will neither be able to accurately measure their performance or outcomes and thus pay them fairly so they are not unjustly rewarded or penalized, nor will they be able to provide the best possible care. MedPAC suggested we reward physicians on their use of technology first and then move into rewarding for quality measures.

Should it be the federal government's responsibility to assist physicians in upgrading their offices with health information technology systems? If not, what is the most appropriate balance to encourage physicians to incorporate technology into their practices?

MedPAC recommended that the primary federal government role should be to become a more responsible and prudent purchaser. Including IT in a pay-for-performance program can shift the physician's return on investment in information technology. By including measures of IT functionality in the payment distributed in a pay-for-performance program, Medicare is sending a strong signal that using IT to improve the quality of beneficiary care will be rewarded. In addition to improving the return on investment for IT, focusing on the objective—better quality—provides guidance to physicians and vendors about how the IT systems should be designed and used. Rewarding IT functionality is also an incentive to build the capacity for physician offices to be able to measure, report on, and improve care on other measures over time.

The Federal government should also be involved in important activities to standardize products and language used in IT to enhance interoperability. These activities address other barriers to adoption and are an important complement to providing financial incentives through pay for performance.

Please feel free to follow up with me on any of these issues. Again, we appreciate the opportunity to testify on this topic and commend the Committee's leadership in this area.

Sincerely,

Mark E. Miller
Executive Director

MM:am:j

Senate Finance Committee Testimony
James J. Mongan, MD
President & CEO
Partners HealthCare System
Boston, MA
July 27, 2005

Mr. Chairman, I am Dr. Jim Mongan, president of Partners HealthCare in Boston, an integrated health care delivery system founded by the Brigham and Women's Hospital and Massachusetts General Hospital. I always appreciate the opportunity to come before the Senate Finance Committee where I began my career 35 years ago working as committee staff for 7 years for both Senator Russell Long and Senator Wallace Bennett.

These leaders and their colleagues were grappling then, just as you are 35 years later, with the difficult task of balancing the enormous benefits Medicare and Medicaid bring to our elderly and poor, with the significant cost of these programs to the Federal Budget and our society.

The initiatives you are considering today fall within this tradition – as I believe that pay for performance reimbursement, especially when coupled with the development of information technology has the potential to maximize the value we receive both as patients and as a nation in health care.

I'll start with a word about our aspirations at Partners HealthCare regarding quality and costs, and then make three key points about your proposed legislation.

At Partners we have a set of five initiatives, which we call our "signature initiatives" to improve quality, efficiency and value across our system:

- The first is to build out an electronic medical record, with embedded decision support, across our system to support evidence based medicine.
- The second is to ensure safety in drug delivery through computerized order entry pioneered at the Brigham and Women's Hospital.
- The third is to use our electronic data to measure quality across our system.

- The fourth is to use our data to identify our sickest patients, and construct disease management programs to assist in their care.
- And the fifth is to use electronic prescribing and test ordering to assure the selection of high quality and cost effective drugs and imaging procedures.

We were among the first health care providers in the country to plunge into pay for performance contracting back in 2000 and we have more than 500,000 patients under pay for performance contracts. This year we have $88 million or 10% of our reimbursement at risk based upon our ability to improve efficiency and quality.

With the benefits of five years of experience there are three main points that I would make relevant to the proposed legislation.

- First, we agree that the thoughtful use of financial incentives can help drive improvement in health care. During the past five years we have seen steady improvement in the quality of care that we provide to our diabetics, our asthmatics and our patients with heart attacks and heart failure. We attribute at least some of this improvement to our initiatives, supported by our pay for performance contracts.

- Second, I can express my strong support for the principles of Medicare value purchasing that are reflected in the proposed legislation. The phased-in approach in particular will be helpful in the development of measures, and the development of providers' understanding. These "report cards" will never be perfectly accurate or completely fair, but we recognize that they serve two important purposes – first, to help health care providers recognize opportunities to improve and second, to provide reassurance that physicians and hospitals are focused on efficiency and quality.

  The devil will be in the details, and it is important that the committee understand that the goal of a "consumer reports" for health care will likely never be fully realized. Anyone who has been a doctor or a patient knows that health care is not

a product like a car or television set – it is a series of interactions between at least two people, often many more. Measuring the quality of health care is more like evaluating a marriage than evaluating an automobile. Now we all know that there are good husbands and bad husbands and that some doctors are better than others. But coming up with measures that can use administrative data to distinguish between them is, in the opinion of many experts, quite difficult. Pay for performance at this stage of development works best in measuring large groups or large hospitals, and less well on the individual physician level. So we should embark on this era of transparency with appropriate humility.

- Third, I agree wholeheartedly with the legislation's emphasis on health information technology. In our system we often say that we need two revolutions to improve health care, an industrial revolution in which physicians start using the electronic tools that can reduce errors; and a cultural revolution in which we reorient ourselves into teams that care for populations of patients. These revolutions are next to impossible without ready availability of information systems like.

Currently about 90% of our academic physicians have these systems while only about 20% or our community network physicians are connected. Unfortunately, the Stark and anti-kickback laws prevent us from providing these necessary tools to our network physicians. That is why a broad exception from these laws, for this purpose, needs to be an essential part of the proposed legislation. I have provided more specific views on this issue to the committee in a separate statement.

To conclude I would urge your support for spreading information technology more broadly, and for appropriately designed pay for performance systems. Both would be consistent with the Senate Finance Committee's 40 year record of support for, and responsible stewardship of our critical health financing programs for our most vulnerable citizens – the elderly and the poor.

Supplemental Statement
of
James Mongan, M.D.
President and Chief Executive Officer, Partners HealthCare System

Promoting Expansion of Health Information Technology:
Necessity of Relief from Stark/Anti-Kickback Provisions

Background

- Legislation to promote the use of health information technology must address the significant restriction to expanded use of health information technology (IT) posed by federal Stark physician referral and anti-kickback statutes.

- Health care providers that assist their physician networks with improving their IT capability could inadvertently violate the Stark/anti-kickback laws.

- The Partners HealthCare System ("Partners")* has made a significant investment in health information technology: Today, the vast majority of our academic medical center physicians are using electronic medical records that allow doctors anywhere in our system to access patients' medical records and make fully informed decisions about their care. Computerized provider order entry systems, which have been shown to reduce medication errors, and decision support systems aimed at more cost effective diagnosis, are now being used at Brigham and Women's Hospital, Massachusetts General Hospital and Faulkner Hospital and will become standard throughout the system in the next few years.

- The next step toward achieving system-wide improvement is to upgrade the IT systems of the affiliated physicians in the Partners' network. Partners is prepared to make another very significant investment to achieve that goal.

- Partners cannot risk that step, however, until Congress provides clear direction that such expansion of health IT is permissible and will not violate Stark or anti-kickback laws.

Request

- Partners requests that Senate health information technology legislation create an exception to the Stark and anti-kickback statues for the provision of information technology limited to support that is not tied to business considerations, but rather designed to improve quality and promote the electronic exchange of information.

- A legislative exception, effective upon enactment, will allow providers like Partners to implement their quality initiatives quickly through their IT investment plans, and not await further administrative direction from the Secretary of HHS.

- Stark and anti-kickback statute relief not be tied to the adoption of federal standards for health information technology:

- It has been suggested that federal standards are necessary to insure interoperability among systems. However, the reality is that technologies that provide the highest degree of interoperability will be the ones most widely embraced by the marketplace. Health systems will not invest in technology that is limited in its ability to communicate across several systems or platforms. Making providers wait until the government issues standards will delay the implementation of technology significantly and is unlikely to produce a higher degree of interoperability than that which will naturally evolve as a result of developments in the IT marketplace.

July 27, 2005

*(Partners is a system founded by Brigham and Women's Hospital and Massachusetts General Hospital, and includes Faulkner Hospital, McLean Hospital, Newton-Wellesley Hospital, North Shore Medical Center, Partners Community HealthCare Inc., Partners Home Care, Rehabilitation Hospital of the Cape and Islands, and the Spaulding Rehabilitation Hospital Network.)

Dr. James J. Mongan
Responses to further inquiries from Senate Finance Committee

Questions from Senator Baucus: What have you found to be the key elements for implementing successful quality improvement initiatives? How do you get physicians involved in these initiatives? How can the lessons learned by translated to making quality improvement work in all hospitals, including smaller hospitals? What role can the Federal government play in driving such improvement?

Dr. Mongan's response: These are hugely important issues, and challenges that dominate the professional lives of many people in our organization and others. The four major points I would make in response are:

1. We believe that integration of providers creates the opportunity to create and pursue targets that seem beyond the control of any individual component of the health care system. For example, hospitals tend to feel that they have a limited prevent admissions or improve quality because decision-making is in the hands of physicians. Physicians tend to believe that they have limited ability to effect change because they have few systems at their disposal. However, if physicians and hospitals are integrated into a single entity that takes responsibility for improvement, more ambitious goals can be discussed.

2. Systems adoption should be the focus of pay for performance incentives at this stage of development of the health care system. Adoption of computerized and "human-ware" systems is more likely to lead to long-term improvement than providing an incentive for a short-term "push" to meet some arbitrary performance goal (e.g., percentage of diabetics who get their LDL cholesterol level checked). In addition, system adoption can be less expensive and less controversial to measure than "outcomes" measures the require analysis of claims.

3. Systems adoption can be promoted for providers not integrated into delivery systems through existing programs. A major challenge is how to create effective incentives for adoption of systems that are not based upon contracts with groups of providers. One approach for engaging physicians is Bridges to Excellence, a program led by General Electric and other major employers such as UPS, Raytheon, Ford Motor Company. Bridges to Excellence is a program through which employers provide incentives to physician practices that adopt systems likely to reduce errors of all three types (over-use, mis-use, and under-use). Leapfrog is moving in a similar direction to provide a rewards structure for hospitals (as opposed to just serving as a public accountability system that reports on hospital systems and performance).

4. Minimize duplication of accountability programs in health care systems. We would encourage you to try to work through existing programs (e.g., Bridges to

Excellence, Leapfrog, JCAHO) in developing and implementing new incentive systems. The goal of this recommendation is to minimize provider reporting burden, so that their resources can be focused on actual improvement and system adoption. In addition, working with existing programs can reduce costs for CMS. For example, if CMS adopted Bridges to Excellence as a vehicle for driving physician adoption of electronic medical records and improvement of care, CMS would not have to develop or administer a system for determining which physicians met the criteria and therefore had earned the rewards.

Question from Senator Kyl: Has your plan used new money for your pay for performance program or employed the withhold system?

Dr. Mongan's response: The short answer is that we use a withhold system in which 10% or more of the payments are withheld, and received by our doctors and hospitals if and only if we achieve negotiated targets for improvement. Prospect Theory, which won the Nobel Prize for Economics in 2002, teaches that the threat of a loss is a more powerful motivating force than the promise of a bonus – even if the amounts of money at stake are similar. Since both we and the health plans are seeking to motivate our hospitals and doctors to adopt systems to improve care, we both want the most effective possible way of "framing" the incentive. We believe that withholds are more powerful incentives than bonuses.

However, the health plans would likely tell you that our incentive program is based upon "new money," because – if we are successful in achieving our targets – they pay us fees and rates that represent increases that often exceed the rate of inflation. The justification for such increases include:

1. Physicians and hospitals have expenses that are increasing faster than the general consumer inflation rate.
2. The improvements in efficiency and quality expected to result from performance improvement lead to savings and to increased value from health care.
3. Providers need the resources to adopt the systems required to improve care.

Statement

of the

American Medical Association

to the

Committee on Finance
United States Senate

RE: Improving Quality in Medicare: The Role of Value-Based Purchasing"

Presented by: Nancy H. Nielsen, MD, PhD

July 27, 2005

Chairman Grassley, Ranking Member Baucus and Members of the Committee, the American Medical Association (AMA) appreciates the opportunity to provide our views today regarding "Improving Quality in Medicare: The Role of Value-Based Purchasing."

The AMA would like to commend you Mr. Chairman and Ranking Member Baucus, and Members of the Committee, for all of your hard work and leadership in recognizing the fundamental problems inherent in the Medicare physician payment update formula and the need to replace the flawed formula. You have also enhanced patient access to care by reducing geographic payment disparities so that rural communities are better able to recruit and retain physicians.

We also extend our gratitude to Chairman Grassley and Ranking Member Baucus for your past and continued efforts in pressing the Centers for Medicare and Medicaid Services (CMS) to use its authority to make administrative changes to the physicians payment sustainable growth rate (SGR) formula that would reduce the cost of replacing the formula with one that reflects the costs of practicing medicine. Without it, we are in grave danger of a Medicare meltdown that would present serious access problems for our nation's senior and disabled patients.

We are also thankful to Senators Jon Kyl and Debbie Stabenow and the over 15 co-sponsors of S. 1081, the *Preserving Patient Access to Physicians Act of 2005*, for their efforts to resolve the Medicare physician payment crisis. In accordance with the recommendation of the Medicare Payment Advisory Commission (MedPAC), this bill would set the Medicare physician payment increase for 2006 at no less than 2.7 percent, instead of the 4.3 percent cut

projected by the current formula. It would also avert cuts in 2007 by providing a positive update based on CMS' measure of practice cost inflation.

We appreciate the opportunity to present our views today on value-base purchasing for physicians' services under Medicare.

AMA COMMITMENT TO THE DEVELOPMENT OF EFFECTIVE QUALITY IMPROVEMENT PROGRAMS

The AMA is committed to quality improvement, and we have undertaken a number of initiatives to achieve this goal. Over the last five years, the AMA has dedicated over $5 million in convening the Physician Consortium for Performance Improvement for the development of performance measurements and related quality activities. It has grown to become the leading physician-sponsored initiative in the country in developing physician-level performance measures. CMS is now using the measures developed by the Consortium in the demonstration projects on pay-for-performance authorized by the MMA. The activities of the Consortium, as well as other AMA initiatives in performance improvement are described in the attached document.

AMA PAY-FOR-PERFORMANCE PRINCIPLES AND GUIDELINES

As quality improvement efforts have evolved, so has the concept of value-based purchasing (or pay-for-performance). The AMA believes that physician pay-for-performance programs designed properly to improve effectiveness and safety of patient care may serve as a positive force in our healthcare system. If done improperly, however, they could be detrimental to the mission of improving care for vulnerable populations. In our ongoing efforts to advance the development and effective implementation of pay-for-performance programs, the AMA's House of Delegates adopted in June comprehensive pay-for-performance (PFP) principles and guidelines.

Overall, these principles address five broad aspects of pay-for-performance programs: (i) quality of care; (ii) the patient/physician relationship; (iii) voluntary participation; (iv) accurate data and fair reporting; and (v) fair and equitable program incentives. More specific guidelines are associated with each principle. These principles and guidelines are attached.

Similar to these AMA principles, which support the use of quality of care measures created by physicians across appropriate specialties, the code set used to capture quality of care measures also needs to be created by physicians working with the specialty societies. To date, the AMA/CPT Editorial Panel has developed over 30 Category II CPT performance measurement codes, and more will be needed and developed. These codes will help diminish the burden on physicians by allowing claims to capture accurate clinical data about the quality of care delivered by physicians. Health plans will also benefit from the development and use of these codes by not having to send record reviewers to obtain the data from the charts.

LEGISLATION TO ESTABLISH VALUE-BASED PURCHASING FOR PHYSICIANS UNDER MEDICARE

Value-Based Purchasing for Physicians and Current SGR Formula Cannot Co-Exist

S. 1356, the *Medicare Value-Based Purchasing Act of 2005*, introduced by Chairman Grassley and Ranking Member Baucus, would establish a value-based payment system for paying for physicians' services. It also contains a "Sense of the Senate" provision that expresses that further action is needed by Congress to address the negative physician payment updates to ensure: (i) long-term stability of the Medicare physician payment system, (ii) appropriate reimbursement for "high quality and efficient delivery" of Medicare services; and (iii) future access and affordability of Medicare services for beneficiaries.

The AMA appreciates the Chairman's and Ranking Member's efforts under S. 1356 to establish a new Medicare payment system for physicians' services, as well as your recognition that Congress must address the flaws of the current SGR physician payment update formula, which have led to ongoing Medicare physician pay cuts that are detrimental to Medicare beneficiary access to care.

We urge the Committee, however, to ensure that any value-based legislation replaces the current SGR physician payment formula with a stable, reliable payment system that preserves patient access and reflects increases in physician practice costs. This would treat physicians similarly to other Medicare providers, such as hospitals, home health agencies and skilled nursing facilities. The flawed SGR formula cannot co-exist with a value-based purchasing program for physicians. The SGR and value-based purchasing are incompatible.

Value-based purchasing may save dollars for the Medicare program as a whole by reducing medical complications and hospitalizations. The majority of measures, however, such as those focused on prevention and chronic disease management, ask physicians to deliver more care. During his May 11, 2004 testimony before the House Ways and Means Health Subcommittee, CMS Administrator, Dr. Mark McClellan, suggested that one of the agency's quality improvement projects, the Chronic Care Improvement Project, "may actually increase the amount of (patient-physician) contact through appropriate office visits with physicians."

The SGR is a spending target that penalizes volume increases exceeding the target. If the SGR is retained, the so-called reward for physicians will be additional pay cuts. This is antithetical to the desired outcome of value-based purchasing and would only compound an ongoing serious problem.

The flaws in the SGR formula led to a 5.4% payment cut in 2002, and additional cuts in 2003 through 2005 were averted only after Congress intervened. The Medicare Trustees project that physicians and other health professionals face steep pay cuts (about 26%) over the next six years (from 2006 through 2011). If these cuts begin, on January 1, 2006, average physician payment rates will be less in 2006 than they were in 2001, despite substantial practice cost inflation. These reductions are not cuts in the rate of increase, but are actual cuts

in the amount paid for each service. Physicians simply cannot absorb these draconian payment cuts and, unless Congress acts, physicians may be forced to avoid, discontinue or limit the provision of services to Medicare patients.

The AMA conducted a survey of physicians in February and March 2005 concerning significant Medicare pay cuts from 2006 through 2013 (as forecast in the 2004 Medicare Trustees report.) Results from the survey indicate that if the projected cuts in Medicare physician payment rates begin in 2006:

- More than a third of physicians (38%) plan to decrease the number of new Medicare patients they accept;
- More than half of physicians (54%) plan to defer the purchase of information technology, which is necessary to make value-based purchasing work;
- A majority of physicians (53%) will be less likely to participate in a Medicare Advantage plan;
- About a quarter of physicians plan to close satellite offices (24%) and/or discontinue rural outreach services (29%) if payments are cut in 2006. If the pay cuts continue through 2013, close to half of physicians plan to close satellite offices (42%) and/or discontinue rural outreach (44%); and
- One-third of physicians (34%) plan to discontinue nursing home visits if payments are cut in 2006. By the time the cuts end, half (50%) of physicians will have discontinued nursing home visits.

A physician access crisis is looming for Medicare patients. While the MMA brought beneficiaries important new benefits, these critical improvements must be supported by an adequate payment structure for physicians' services. There are already some signs that access is deteriorating. A MedPAC survey found that 22% of patients already have some problems finding a primary care physician and 27% report delays getting an appointment. **Physicians are the foundation of our nation's health care system. Continual cuts (or even the threat of repeated cuts) put Medicare patient access to physicians' services at risk. They also threaten to destabilize the Medicare program and create a ripple effect across other programs. Indeed, Medicare cuts jeopardize access to medical care for millions of our active duty military family members and military retirees because their TRICARE insurance ties its payment rates to Medicare.**

Factors that Need to be Addressed in Physician Value-Based Purchasing Legislation

We urge the Committee to ensure that any value-based purchasing legislation addresses certain key areas of concern for physicians, many of which are further enumerated in the AMA principles and guidelines.

Requirements for Quality Measurement

We appreciate that several of the requirements for quality measures under S. 1356 would be consistent with AMA principles and guidelines. For example, S. 1356 requires quality measures to be evidence-based, reliable and valid, as well as feasible to collect and report. The bill also requires them to be developed through consultation with provider-based groups and clinical specialty societies. Finally, the bill requires the measures to be relevant to rural areas, as well as the frail elderly over the age of 75 and those with complex chronic conditions. The AMA also urges that quality measures allow for variation when it is necessary to meet the individual patient's unique needs, such as in cases where patients have allergies or adverse reactions.

The AMA is aware that other legislation recently approved by the Senate Committee on Health, Education, Labor and Pensions (HELP) contains provisions that establish a quality measurement system that differs slightly from the provisions in S. 1356. We encourage the Senate Finance and Senate HELP Committees to work together to develop a quality measurement system. The AMA looks forward to the opportunity to work with both Committees in that endeavor.

Funding of Value-Based Purchasing Programs

Value-based purchasing programs must be structured carefully to promote program effectiveness and the safety of patient care, and not penalize physicians. All physicians should be able to participate in the program voluntarily and should receive a positive base payment update, with an additional value-based payment for achieving quality goals. Performance measurement should be scored against both absolute values and relative improvements in those values.

Value-based programs that are funded through an overall percentage reduction of the physician payment update are not consistent with AMA policy. Thus, we cannot support value-based programs that are funded by a withhold pool. This is in contrast to other types of value-based purchasing programs, such as those using a "differential" payment structure, under which a base payment is made for services provided, with an additional value-based payment for meeting reporting and/or quality goals. Further, to maintain broad access to physicians, any Medicare physician payment system must be annually increased to reflect increases in physician overhead costs.

Physicians must also receive payments under a value-based program on a timely basis. There should not be a substantial time lag in determining the amount of payment due to a physician. A physician practice, like any other enterprise must operate on a business plan based on predictable and reliable financial fundamentals. This is nearly impossible if a substantial amount of a practice's revenue stream is unknown and delayed for up to one to two years.

Pilot Testing

In addition, any pay-for-performance program needs to be pilot tested prior to full implementation. Since value-based purchasing is a completely new concept with regard to Medicare payment for physicians' services, pilot testing is critical for determining whether this type of payment system achieves its intended purpose. Pilot tests would also help identify program "glitches" and any needed modifications prior to full implementation of the program.

Measures of Efficiency

Measures of efficiency are another strong area of concern. Efficiency measures have the danger that the lowest-cost treatment will supersede the most appropriate care for an individual patient. We urge that S. 1356 require that efficiency measures meet the same high standards that apply to quality measures. Efficiency measures must be evidence-based, valid measures developed by the medical specialty societies in a transparent process. Efficiency cannot only relate to cost issues, as we have learned from the experience of UnitedHealthcare. Its United Performance insurance product was introduced this year. Although a settlement after intense negotiations has been reached, two large medical groups had informed United they would not participate in the performance program because performance reports for efficiency seemed to take into account primarily the lowest-cost care, and not quality. Most importantly, there must be broad-based consensus regarding what constitutes appropriate levels of care before measuring for efficiency.

Risk-Adjustment

Without an appropriate technique for risk-adjustment, an adequate reflection of a physicians' patient population will be lacking. This would skew the data and have grave consequences for purposes of determining a fair comparison of physician performance, payment and public reporting, as discussed further below.

Public Reporting

The AMA also is very concerned about potential, adverse affects of public reporting, Providing patients with flawed information would undermine the goals of value-based purchasing and violate the oath – first do no harm. Unintentional adverse consequences for patients, including, for example, patient de-selection in the case of those with certain ethnic, racial, socioeconomic or cultural characteristics that make them less compliant must be avoided. Further, patient health literacy issues could distort physician performance measures. Several critical issues must be resolved before public reporting provisions can be implemented. There needs to be a method for ensuring that any publicly reported information is: (i) attributable to those involved in the care; (ii) appropriately risk-adjusted; and (iii) accurate, as well as relevant and helpful to the consumer/patient.

We appreciate that S. 1356, in accordance with the AMA guidelines, would provide physicians the opportunity to review data prior to the data being made public. We urge,

however, that physicians also have the right to appeal with regard to any data that is part of the public review process. Further, physicians should also have the right to have their comments included with any publicly reported data. This is necessary to give an accurate and complete picture of what is otherwise only a snapshot, and possibly skewed, view of the patient care provided by a physician.

Implementation of Value-Based Purchasing Program and Performance Measures

In implementing performance measures, it is important to learn from private sector programs already in existence. We know from some private sector programs that application of measures is more effective if they are implemented on a graduated basis. It is best to begin by implementing only a limited number of measures to assess how well they work, and then build upon the program from that starting point. Thus, we recommend that pay-for-performance legislation include limits on the number of measures with which physicians must comply over certain time periods.

Administrative Costs

The AMA urges that any value-based purchasing program ensure that physicians are not burdened with additional administrative costs, especially for information technology systems that are needed to participate in the program. As discussed above, physicians cannot continue to absorb unfunded government mandates. To that end, we appreciate that S. 1356 would help alleviate some administrative costs for physicians. The bill would provide exceptions under the federal Medicare anti-kickback statute as well as the Stark II physician self-referral law for entities that offer information technology, products, systems and services to physicians for improving health care quality and promoting electronic exchange of health information.

Other Critical Considerations

The AMA wishes to raise overall factors to be considered as we move forward in developing value-based purchasing legislation for physicians: (i) the number of patients needed to achieve a statistically valid sample size; (ii) the desire to keep the data collection burden low, while at the same time maintaining accuracy of the data; (iii) level of scientific evidence needed in establishing appropriate measures; (iv) the ability to trace a performance measure back to one or many physicians involved in a patient's care; (v) the complexities of distributing payments when multiple physicians are involved in a patient's care, and without violating any fraud and abuse laws and regulations; and (vi) protection of patient privacy.

We look forward to working with the Chairman and the Committee to achieve a new payment system that truly benefits our patients.

NEED TO REPLACE THE FATALLY FLAWED SGR PAYMENT SYSTEM

As discussed above, the SGR system is fatally flawed and cannot co-exist with value-based purchasing for physicians. It must be replaced by a new formula that appropriately reflects

increases in the costs of practicing medicine. If Congress were to act alone to enact a new formula, the cost of doing so would be significant. Thus, the Administration must join efforts with Congress to achieve this goal. As discussed below, there are fundamental problems with the SGR, and CMS has the authority to make immediate administrative changes to the formula that would lower the cost for Congress to enact a new one.

Problems under the SGR Payment System

Medicare pays for services provided by physicians and numerous other health care professionals based a target rate of growth (the SGR). If Medicare spending on physicians' services exceeds allowed spending in a particular year, physician payments are cut in the subsequent year. Conversely, if allowed spending is less than actual spending, physician payments increase.

There are two fundamental problems with the SGR formula:

1. Payment updates under the SGR formula are tied to the gross domestic product, which bears little relationship to patients' health care needs or physicians' practice costs; and

2. Physicians are penalized with pay cuts when Medicare spending on physicians' services exceeds the SGR spending target, yet, the SGR is not adjusted to take into account many factors beyond physicians' control, including government policies, that although good for patients, promote Medicare spending on physicians' services. (These factors are discussed below under "Administrative Action Needed to Assist Congress in Replacing the SGR.")

Problems with the Payment Formula Due to GDP

GDP Does Not Accurately Measure Health Care Needs

The SGR permits utilization of physicians' services per beneficiary to increase by only as much as GDP. The problem with this "relationship" is that GDP growth does not track the health care needs of Medicare beneficiaries. For example, when a slowed economy results in a decreased GDP, the medical needs of Medicare patients remain constant, or even increase, despite the economic downturn. Yet, physicians and numerous other health professionals, whose Medicare payments are tied to the physician fee schedule and who are doing their best to provide needed services, are penalized with lower payments because of a slowly growing economy, resulting in the decreased GDP. Further, GDP does not take into account the aging of the Medicare population, technological innovations or changes in the practice of medicine.

Historically, health care costs have greatly exceeded GDP. Yet, the SGR is the only payment formula in Medicare tied to that index. In contrast, payments for hospitals, skilled nursing facilities and home health, for example, are all tied to their inflationary pressures.

Technological Innovations Are Not Reflected in the Formula

The Congressional Budget Office has said that Medicare volume increases are due to "increased enrollment, development and diffusion of new medical technology" and "legislative and administrative" program expansions. The SGR system's artificial cap on spending growth ignores such medical advances when it limits target utilization growth to GDP growth.

The United States' population is aging and new technologies are making it possible to perform more complicated procedures on patients who are older and more frail than in the past. Over the last decade, life expectancy has risen by a year for women and two years for men. Life-spans for both sexes rose by about a half year just between 1999 and 2002, and 65-year-olds of both sexes now can expect to become octogenarians. Improvements in the field of anesthesia and surgery make it possible to operate on older and older patients when complex surgery is required. People 80 and older now frequently undergo extensive surgery to prevent heart attacks and strokes.

Both Congress and the Administration have demonstrated their interest in fostering advances in medical technology and making these advances available to Medicare beneficiaries through FDA modernization, increases in the National Institutes of Health budget, and efforts to improve Medicare's coverage policy decision process.

The only way for technological innovations in medical care to really take root and improve care is for physicians to invest in those technologies and incorporate them into their regular clinical practice. The invention of a new medical device cannot, in and of itself, improve health care — physicians must take the time to learn about the equipment, practice using it, train their staff, integrate it into their diagnosis and treatment plans and invest significant capital in it. Although the Medicare hospital payment system allows an adjustment for technological innovations, the physician payment system does not do so. The physician payment system is the only fee structure of Medicare that is held to GDP, and no other Medicare payment system faces as stringent a growth standard.

Government efforts to foster technological innovations could be seriously undermined as physicians now face disincentives to invest in new medical technologies or to provide them to Medicare beneficiaries.

Site-of-Service Shifts Are Not Considered in the Formula

Another concern that is not taken into account in the SGR formula is the effect of the shift in care from hospital inpatient settings to outpatient sites for certain medical procedures. For example, when the 2005 Medicare Trustees report was released, CMS noted that expenditures for inpatient hospital services covered by Part A were lower than previous forecasts, but failed to mention that lower inpatient spending was a contributor to increased Part B spending for physicians' services.

It has been a goal by Congress and the Bush Administration to utilize more physician services through disease management and prevention initiatives in order to avoid expensive hospitalizations and nursing home admissions. Technological innovations have also made it possible to treat many services that once required hospitalization in physicians offices instead. Physicians are keeping seniors with chronic diseases out of hospitals by managing their care in the office. Hospital days per 1000 population between 1995 and 2002 declined by more than 15% among 65 to 74 year olds and by more than 10% for those 75 and older.

Where inpatient care is avoided, deductibles are reduced from about $900 to about $100; if ambulatory care is involved, co-payments are limited to 20% of Medicare's allowed charge in physician offices compared to up to 45% in a hospital outpatient department.

While these trends have led to the treatment of increasingly complex cases in physicians' offices, the increased use and intensity that results is not recognized in the SGR formula.

Beneficiary Characteristics Are Not Reflected in the Formula

A related factor that also is unrecognized in the SGR formula is changes over time in the characteristics of patients enrolling in the fee-for-service program. For example, increases in patients diagnosed with, or having complications due to such diseases as obesity, diabetes and end stage renal disease, require greater utilization of physicians' services. Yet, these types of changes in beneficiary characteristics are not reflected in the SGR.

Spending On Services Necessary to Meet Patient Need

As discussed above, payments to physicians are cut if actual Medicare spending on physicians' services exceeds allowed spending. On March 30, the CMS reported that Medicare spending on physician services grew by 15% in 2004. Other Medicare data, including the 2005 Medicare Trustees Report, suggests spending growth of 12% to 13%. About 7% represents an increase in services per patient. This follows utilization increases of about 5.5% in 2001, 6% in 2002 and 5% in 2003. What happened in 2004 is not some "unprecedented" spending spike. It is the continuation of a trend brought about by expanded life-spans, more chronic disease and better treatments.

Nevertheless, it is not surprising that Medicare spending on physician services continues to increase. First, Medicare's two public trustees have noted that much of the growth in physician services can be traced to technological advances. Revolutionary changes in the practice of medicine have made it possible to keep millions of Medicare's elderly and disabled beneficiaries alive and active well into their 80s. Second, the prevalence of expensive chronic conditions such as kidney failure, heart disease and diabetes has increased dramatically, despite these vast improvements in mortality and quality of life. More than three-fourths of Medicare beneficiaries now have at least one chronic illness, about two-thirds have a least two, and 20% have five or more. Thus, with the positive results of medical advances and the increase in widespread chronic conditions among the elderly, Medicare spending to meet these patients' needs is a good investment for their overall health and quality of life. Congress has recognized the value of this investment by twice intervening to avert sharp Medicare physician pay cuts.

Physician Pay Cuts Can Mean Higher Costs for Beneficiaries

CMS has noted that an increase in Medicare payments for physician and other health professionals would, in turn, increase the Medicare Part B premium for beneficiaries. Physician pay cuts, however, will ultimately cost beneficiaries more because these cuts will force physicians to discontinue providing certain services in the physician's office. Rather, patients will have to receive these services in higher-cost hospital settings.

ADMINISTRATIVE ACTION NEEDED TO ASSIST CONGRESS IN REPLACING THE SGR

As discussed above, CMS has the authority to take immediate administrative action to modify the current SGR physician payment formula. These administrative actions, discussed below, would significantly lower the cost for Congress in replacing the formula with one that reflects increases in physician practice costs.

1. CMS Must Remove Medicare-covered, physician-administered drugs and biologics from the physician payment formula, retroactive to 1996

CMS has the Authority to Remove Drugs from the SGR

The AMA urges CMS to remove spending on physician-administered drugs from calculations of the SGR, retroactive to 1996. When CMS calculates actual Medicare spending on "physicians' services," it includes the costs of Medicare-covered prescription drugs administered in physicians' offices. CMS has excluded drugs from "physicians' services" for purposes of administering other Medicare physician payment provisions. Thus, removing drugs from the definition of "physicians' services" for purposes of calculating the SGR is a consistent reading of the Medicare statute. Drugs are not paid under the Medicare physician fee schedule, and it is illogical to include them in calculating the SGR.

Further, CMS has the authority to revise its previous calculations of actual spending under the SGR by removing the costs of drugs back to the base period using this revised definition. Once CMS has revised calculations of actual spending back to the base period, it will have revised calculations of allowed spending, by definition, because the statute sets the base period allowed spending equal to the base period actual spending. This process would remove drugs entirely from both actual and allowed spending back to the SGR base period. CMS has demonstrated its authority to revise calculations of actual spending by actually revising spending to account for omitted codes and more complete claims data.

CMS' authority to remove drugs from the SGR retroactively was corroborated in a legal memorandum drafted by Terry S. Coleman, a former Acting General Counsel of the U.S. Department of Health and Human Services, as well as a former Chief Counsel and Deputy Administrator of the Health Care Financing Administration.

CMS Should Remove Drugs from the SGR

In the past, some CMS officials have argued that including drugs in the SGR was necessary to counter-balance incentives for over-utilization in the drug reimbursement system. The AMA does not accept this premise. Certainly physicians are not administering chemotherapy drugs to patients who do not have cancer. Even if such incentives existed, however, they were surely eliminated by the reductions in payment for these drugs under the MMA. Pharmaceutical companies, not physicians, control the cost of drugs. Further, pharmaceutical companies and United States policy, not physicians, control the introduction of new drugs into the market place.

Drug expenditures are continuing to grow at a very rapid pace. Over the past 5 to 10 years, drug companies have revolutionized the treatment of cancer and many autoimmune diseases through the development of a new family of biopharmaceuticals that mimic compounds found within the body. Such achievements do not come without a price. Drug costs of $1,000 to $2,000 per patient per month are common and annual per patient costs were found to average $71,600 a year in one study.

Further, between the SGR's 1996 base year and 2004, the number of drugs included in the SGR pool rose from 363 to 444. Spending on physician-administered drugs over the same time period rose from $1.8 billion to $8.7 billion, an increase of 365% per beneficiary compared to an increase of only 63% per beneficiary for actual physicians' services. As a result, drugs have consumed an ever-increasing share of SGR dollars and have gone from 3.7% of the total in 1996 to 10% in 2004.

This lopsided growth lowers the SGR target for real physicians' services, and, according to the Congressional Budget Office, annual growth in the real target for physicians' services will be almost a half percentage point lower than it would be if drugs and lab tests were not counted in the SGR. As 10-year average GDP growth is only about 2%, even a half percent increase makes a big difference. Thus, including the costs of drugs in the SGR pool significantly increases the odds that Medicare spending on "physicians' services" will exceed the SGR target. Ironically, however, Medicare physician pay cuts (resulting from application of the SGR spending target) apply only to actual physicians' services, and not to physician-administered drugs, which are significant drivers of the payment cuts.

Medicare actuaries predict that drug spending growth will continue to significantly outpace spending on physicians' services for years to come. In 2003, MedPAC reported that there are 650 new drugs in the pipeline and that a large number of these drugs are likely to require administration by physicians. In addition, an October 2003 report in the *American Journal of Managed Care* identified 102 unique biopharmaceuticals in late development and predicted that nearly 60% of these will be administered in ambulatory settings. While about a third of the total are cancer drugs, the majority are for other illnesses and some 22 medical specialties are likely to be involved in their prescribing and administration.

The development of these life-altering drugs has been encouraged by various federal policies including expanded funding for the National Institutes of Health and streamlining of the drug

approval process. The AMA shares and applauds these goals. However, it is not equitable or realistic to finance the cost of these drugs through cuts in payments to physicians.

2. Ensure that government-induced increases in spending on physicians' services are accurately reflected in the SGR target

As discussed above, the government encourages greater use of physician services through legislative actions, as well as a host of other regulatory decisions. These initiatives clearly are good for patients and, in theory, their impact on physician spending is recognized in the SGR target. In practice, however, many have either been ignored or undercounted in the target. Since the SGR is a cumulative system, erroneous estimates compound each year and create further deficits in Medicare spending on physicians' services.

Effective January 1, 2005, CMS implemented the following new or expanded Medicare benefits, some of which have been mandated by the MMA: (i) initial preventive physical examinations; (ii) diabetes screening tests, (iii) cardiovascular screening blood tests, including coverage of tests for cholesterol and other lipid or triglycerides levels, and other screening tests for other indications associated with cardiovascular disease or an elevated risk for that disease, (iv) coverage of routine costs of Category A clinical trials, and (v) additional ESRD codes on the list of telehealth services.

As a result of implementing a new Medicare benefit or expanding access to existing Medicare services, the above-mentioned provisions will increase Medicare spending on physicians' services. Such increased spending will occur due to the fact that new or increased benefits will trigger physician office visits, which, in turn, may trigger an array of other medically necessary services, including laboratory tests, to monitor or treat chronic conditions that might have otherwise gone undetected and untreated, including surgery for acute conditions.

CMS has not provided details of how these estimates were calculated, and certain questions remain. Further, CMS reportedly does consider multiple year impacts and cost of related services, but the agency has not provided any itemized descriptions of how the agency determined estimated costs. Without these details, it is impossible to judge the accuracy of CMS' law and regulation allowances. For example, in reviewing the 2004 utilization and spending data, we found that utilization per beneficiary of code G0101 for pelvic and breast exams to screen for breast or cervical cancer had increased 10% since 2003, yet this benefit was enacted in BBA 1997 nearly eight years ago. Likewise, per beneficiary utilization of code G0105, colorectal cancer screening of a high-risk patient, also enacted in the BBA, was up 13%. These impacts should be taken into account in revising the 2005 and 2006 SGR.

CMS should also seek to identify other spending increases attributable to quality improvement programs and ensure that they, too, are reflected in the SGR law and regulation factor. For example, Medicare's Quality Improvement Organizations (QIO) have encouraged physicians to determine the left ventricular function of all patients with congestive heart failure, measured using a nuclear medicine test or an echocardiogram. Further, CMS revised the codes for end-stage renal disease services in 2004 to encourage four physician visits per month. From 2003 to 2004, consistent with CMS' intent, Medicare spending for the new ESRD codes rose 17% above 2003 spending for the old codes.

Spending due to all of the foregoing government initiatives should be reflected in the SGR.

3. Ensure that the SGR fully reflects the impact on physician spending due to national coverage decisions

When establishing the SGR spending target for physicians' services, the law requires that impact on spending, due to changes in laws and regulations, be taken into account. The AMA believes that any changes in national Medicare coverage policy that are adopted by CMS pursuant to a formal or informal rulemaking, such as Program Memorandums or national coverage decisions, constitute a regulatory change as contemplated by the SGR law, and must also be taken into account for purposes of the spending target.

When the impact of regulatory changes for purposes of the SGR is not properly taken into account, physicians are forced to finance the cost of new benefits and other program changes through cuts in their payments. Not only is this precluded by the law, it is extremely inequitable and ultimately adversely impacts beneficiary access to important services.

CMS has expanded covered benefits through the adoption of more than 80 national coverage decisions (NCDs), including implantable cardioverter defibrillators, diagnostic tests and chemotherapy for cancer patients, carotid artery stents, cochlear implants, PET scans, and macular degeneration treatment. While every NCD does not significantly increase Medicare spending, taken together, even those with marginal impact contribute to rising utilization. CMS has stated its view that it would be very difficult to estimate any costs or savings associated with specific coverage decisions and that any adjustments would likely be small in magnitude and have little effect on future updates.

We disagree, and strongly believe that CMS should make these adjustments in its rulemaking for 2006. **CMS already adjusts Medicare Advantage payments to account for NCDs, so it clearly is able to estimate their costs.** With respect to the magnitude of impact, as one example, CMS reported in January that the recent expansion of coverage for implantable defibrillators would make the devices available to some 500,000 people. In addition, CMS has provided us with data showing that 2004 Medicare Part B spending on PET scans was $387 million, a 51% increase over 2003, and the agency has acknowledged that PET scans play an important role in diagnosing a number of diseases.

The AMA, along with 33 national medical organizations and state medical associations, contracted with the National Opinion Research Center (NORC) to estimate the costs of several NCDs to illustrate that it is possible to make such estimates and provide a sense of their magnitude. NORC's evaluation of the cost of the expanded coverage of photodynamic therapy to treat macular degeneration considered the cost of exams and flourescein angiography tests to determine the appropriateness of treatment as well as treatment costs. NORC was also able to separate the costs that Medicare would have incurred due to local carrier coverage decisions from the expected costs associated with the NCD for treatment of the occult form of macular degeneration, for which Medicare prohibited coverage prior to the NCD. NORC conservatively estimates that the new coverage is increasing expenditures by

more than $300 million a year and could boost spending by more than twice that amount if used by all the eligible Medicare patients.

While the AMA strongly supports Medicare beneficiary access to these important services, physicians and other practitioners should not have to finance the costs resulting from the attendant increased utilization. **Accordingly, CMS should ensure that the impact on utilization and spending resulting from all national coverage decisions is taken into account for purposes of the SGR spending target.**

The AMA will continue in our long-term commitment to improving the quality of care for our patients. We appreciate the opportunity to provide our views to the Committee on these important matters, and we look forward to working with the Committee and CMS to develop a physician payment system that truly benefits patients by offering the highest quality of care and ensuring access to that care.

AMA Principles for Pay-for-Performance Programs

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our healthcare system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. **Ensure quality of care** – Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.

2. **Foster the patient/physician relationship** – Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. **Offer voluntary physician participation** – Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. **Use accurate data and fair reporting** – Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. **Provide fair and equitable program incentives** – Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

AMA Guidelines for Pay-For-Performance Programs

Safe, effective, and affordable healthcare for all Americans is the American Medical Association's (AMA) goal for our healthcare delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the healthcare delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program.
    1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
    2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
    3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
    4. Performance measures should be scored against both absolute values and relative improvement in those values.
    5. Performance measures must be subject to the best-available risk-adjustment for patient demographics, severity of illness, and co-morbidities.
    6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
    7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the healthcare team.

- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.
    1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
    2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-compliance, and sponsors of PFP programs should attempt to minimize non-compliance through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice. Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
    1. Programs should provide physicians with tools to facilitate participation.
    2. Programs should be designed to minimize financial and technological barriers to physician participation.

- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
    1. Programs should use accurate administrative data *and* data abstracted from medical records.
    2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
    3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
    1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
    2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.
- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance

should be shared with physician program participants and widely promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

American Medical Association

Physicians dedicated to the health of America

AMA Convened Physician Consortium for Performance Improvement

Consortium Background

The American Medical Association (AMA) is a national leader in creating tools to help physicians provide the highest quality care to their patients. In recognition of physicians' professional responsibility to provide quality health care, the AMA began developing physician performance measures in 1998, and in 2000 started convening the Physician Consortium for Performance Improvement. The **AMA has spent approximately $5 million dollars over the past five years to staff and operate the Consortium.** It is the leading physician-led initiative in the country to develop physician level performance measures. Consortium membership includes:

- Experts in methodology;
- Clinical experts representing more than 65 national medical specialty and state medical societies;
- Agency for Healthcare Research and Quality (AHRQ);
- Centers for Medicare and Medicaid Services (CMS);
- Joint Commission on Accreditation of Healthcare Organizations - liaison member, and;
- National Committee for Quality Assurance (NCQA) - liaison member.
- National medical specialty societies continue to join the Consortium.

Studies have shown that the 30 percent of Medicare beneficiaries with four or more chronic conditions are responsible for almost 80 percent of program spending in any year. Much of the Consortium's focus has been on achieving improvement in physician care for these conditions. To date, the **Consortium and its partners have developed 90 performance measures for 15 clinical areas listed below:**

- Adult Diabetes
- Asthma
- Chronic Obstructive Pulmonary Disease
- Community-Acquired Bacterial Pneumonia
- Coronary Artery Disease
- Heart Failure
- Hypertension
- Major Depressive Disorder
- Osteoarthritis of the Knee
- Prenatal Testing

Preventive Care and Screening Measures:

- Colorectal Cancer Screening
- Influenza Immunization, Adult
- Screening Mammography
- Problem Drinking
- Tobacco Use Cessation

CMS Pilot Testing

All current CMS physician quality demonstration projects and pilots are utilizing and testing AMA Consortium measures. These include the following:

- Doctors' Office Quality (DOQ) Project;
- DOQ-Information Technology (DOQ-IT) Project;
- The Medicare Physician Group Practice Demonstration;
- Medicare Chronic Care Improvement Program / Sec. 721 MMA, and;
- Medicare Care Management Performance Demonstration Project / Sec. 649 MMA.

Integration of Consortium Measures in Electronic Health Records

The July 2004 Framework for Strategic Action from the HHS Office of the National Coordinator for Health Information Technology, Dr. David Brailer, cites the Consortium's work with CMS to develop the specifications required to integrate performance measures into electronic health records (EHRs). With AHRQ and AMA funding, AMA and its partners are testing Consortium performance measures with multiple EHR products.

2005 Consortium Pipeline

The Consortium plans to complete approximately 18 measures in the following categories by the end of 2005:

- Atrial Fibrillation
- Perioperative Care
- Child and Adolescent Major Depressive Disorder
- Pediatric Acute Gastroenteritis

National Quality Forum (NQF)

Consortium measure sets are currently undergoing expedited review by the NQF for national **endorsement expected in summer 2005**.

Ambulatory Quality Alliance (AQA)

On May 3, 2005 the AQA adopted a 26 measure "starter set" for implementation by public and private sector health plans. **20 of the measures are part of the AMA Physician Consortium-NCQA ambulatory care performance measurement set that was submitted to NQF for expedited review. The remaining six measures were developed by the National Diabetes Quality Improvement Alliance, of which AMA is a founding member.** Nancy Nielsen, MD, Speaker of AMA's House of Delegates, Chaired an AQA Subcommittee on Quality Data Reporting.

Future Steps with CMS

Senior CMS officials have publicly stated that **CMS is looking to the Consortium to be the primary measure development body for physician level performance measures used by CMS for quality improvement and accountability purposes (e.g. pay for performance).**

Response of the American Medical Association to Questions from the Senate Committee on Finance Re: "Improving Quality in Medicare: The Role of Value-Based Purchasing"

Nancy H. Nielsen, MD, PhD
Speaker, AMA Board of Trustees
August 24, 2005

The American Medical Association (AMA) is pleased to provide you with our views concerning the following questions:

Questions from Senator Baucus

Question: *Medicare's role in physician health IT adoption.* I am a strong proponent of health IT adoption, for purposes of improving quality and reporting quality data. And as you are well aware, health IT is a key component of making value-based purchasing work. Last week, Medicare announced free access to the Vista electronic medical record software that has been used at the VA. How do you think this will enhance health IT adoption? What can Congress do to help physicians gain access to health IT?

Answer: The AMA is firmly committed to maintaining and optimizing the delivery of high quality patient care. We are encouraged by the promise that health information technology (HIT) holds, if properly developed and carefully integrated into the existing health care delivery system. The AMA is also appreciative that Congress and the Administration recognize the need to assist physicians with the significant cost of investing in HIT, as demonstrated by the recent announcement that Medicare will provide access to the Vista electronic health record software system (used at the Veterans' Administration). In fact, the AMA has worked with CMS to facilitate the Vista Office Electronic Health Record project. We encouraged CMS to make installation of the software as simple as possible, and we have ensured that needed billing codes are available for download from the AMA's website in a format that will work with the new software. However, it remains to be seen how well this software will function in the physician office setting.

We urge Congress' and the Administration's continued assistance with HIT investment, and have several recommendations for Congress to help physicians gain access to HIT. The AMA adopted new HIT policy at its annual meeting earlier this year. AMA policy supports:

- The development, adoption and implementation of national health information technology standards through collaboration with public and private interests, and

consistent with current efforts to set health information technology standards for use by the federal government;
- Interoperability among all HIT systems;
- Protecting the privacy and security of electronic health records;
- Appropriate recognition of the scope of such an undertaking through the provision of adequate funds dedicated to the system's development; and
- Properly aligning incentives so that the predicted cost-savings associated with HIT is shared with physicians and others who will be expected to invest most heavily in these systems.

The AMA urges that these principles are paramount in any HIT legislation considered by Congress. Further, we urge Congress' continued attention to the following factors with regard to HIT legislation:

Maximizing Physician Investment in HIT

While health care consumers and payers, as well as developers of HIT systems, will play significant roles in the implementation of HIT, physicians and other health care providers will be asked to invest in HIT and fundamentally alter how they practice medicine and care for patients. **We, therefore, urge Congress to ensure that HIT legislation encourages the full integration of existing coding mechanisms, billing systems and HIPAA requirements, so that the significant expenditures that physicians have already made continue to have value. We also request that Congress ensure that physicians retain proportional representation on any working groups for purposes of HIT development and implementation.**

Incentives for HIT Implementation

Congress should provide adequate funding to physicians investing in HIT to ensure the success of an undertaking of this magnitude, with due consideration for the constraints already faced by solo physicians and those who practice in rural, inner-city, and medically underserved areas.

The integration of HIT systems into health care will be a lengthy and expensive undertaking, with the burden of technology investment and training falling heavily on already overburdened physician offices and their staffs. According to a study entitled, *The Costs of a National Health Information Framework*, published in the August 2005 issue of *The Annals of Internal Medicine*, the adoption of a national health information network is estimated to cost approximately $156 billion in capital investment over the next five years, with $48 billion in annual operating costs. Approximately two-thirds of the capital costs would be dedicated to acquiring functionalities and one-third to interoperability. Additionally, according to David Bates, director of clinical and quality analysis for Partners Healthcare, a Massachusetts nonprofit healthcare system, about 89% of the cost savings from electronic health records would go to insurers and employers, with only about 11% accruing to physicians and hospitals.

Since the financial benefits of HIT investment will accrue to participants across the health care system, and disproportionately less to physicians, we urge Congress to ensure that the financial burden of investing in HIT does not fall primarily on physicians and that appropriate assistance is provided to them.

Study of State Licensure Laws

There is currently variation among state laws related to the licensure, registration and certification of medical professionals, which could impact the secure electronic exchange of health information among the states and between the states and federal government. **While the AMA supports the concept of ensuring appropriate interstate transfers of health information, we urge Congress to ensure that any standardization effort in this regard does not undermine state sovereignty in licensure and regulatory oversight of health care professionals and organizations, or interfere with state medical practice laws.** We strongly urge Congress to ensure that any federal HIT legislation does not encroach on traditional states' rights.

Federal Anti-kickback and Stark Laws

Congress should remove legal impediments under the federal anti-kickback and Stark laws to allow private assistance for physician investment in HIT. This would help physicians absorb the potentially prohibitive cost of integrating this technology into their practices. Further, protections under these laws should allow adequate time for physicians to structure and fully implement such arrangements, especially in light of the likelihood that physicians will be required to make technology upgrades as standards change and the field evolves. These protections should be strong and comprehensive enough to overcome considerable physician trepidation about violating anti-kickback and Stark laws.

Question: *Measuring quality in multiple medical specialties.* Since the AMA represents a very diverse group of physicians I was hoping you might have some ideas of how best to measure quality of care among physicians of different specialties, and I am interested in your thoughts on the following questions: What do you think the process to develop a quality measurement system should look like, and where should the measures come from? What role should Medicare play? How should the different specialties be treated?

Answer: The AMA is committed to quality improvement, and we have undertaken a number of initiatives to achieve this goal. As quality improvement efforts have evolved, so has the concept of value-based purchasing (or pay-for-performance). The AMA believes that physician pay-for-performance programs designed properly to improve effectiveness and safety of patient care may serve as a positive force in our healthcare system. If done improperly, however, they could be detrimental to the mission of improving care for vulnerable populations.

In developing performance measures, it is critical that the medical specialty societies are integrally involved in that process and that there is collaboration between the federal and private sector in these efforts. Thus, over the last five years, the AMA has dedicated over $5 million through the Physician Consortium for Performance Improvement (which we convened in 2000) for the development of performance measures. Consortium membership includes: (i) clinical experts representing more than 65 national medical specialty and state medical societies, and additional medical specialty societies continue to join the Consortium; (ii) experts in methodology; (iii) the Agency for Healthcare Research and Quality (AHRQ); (iv) the Centers for Medicare and Medicaid Services (CMS); (v) the Joint Commission on Accreditation of Healthcare Organizations - liaison member, and; (vi) the National Committee for Quality Assurance (NCQA) - liaison member.

The Consortium has grown to become the leading physician-sponsored initiative in the country in developing physician-level performance measures, and senior CMS officials have publicly stated that CMS is looking to the Consortium to be the primary measure development body for physician level performance measures used by CMS for quality improvement and accountability purposes (*e.g.*, pay-for-performance). In fact, CMS is now using the measures developed by the Consortium in its large group practice demonstration project on pay-for-performance, and plans to use them in demonstration projects authorized by the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA). Once measures have been developed through the Consortium, they should be reviewed and endorsed in a transparent process by a multi-stakeholder organization, such as the National Quality Forum (NQF). In fact, the NQF recently endorsed 36 measures for outpatient care, 24 of which were developed by the Consortium.

Medicare can also play a strong role by collaborating with the medical community throughout the process of performance measurement development, as well as during implementation of any pay-for-performance program. Further, CMS can encourage participation in the program by providing financial assistance for the development of measures and investment in HIT. Currently, measurement development and HIT efforts are largely being funded by physicians, and federal funding would only be equitable since any cost savings resulting from pay-for-performance programs will be spread across the health care system. Thus, this burden should not fall squarely on physicians.

Pay-for-performance programs should also adhere to the comprehensive pay-for-performance principles and guidelines adopted by the AMA's House of Delegates in June 2005. We submitted those principles and guidelines as part of our written testimony presented at the Senate Finance Committee's July 27 hearing on value-based purchasing, where we provided certain recommendations for consideration in implementing a pay-for-performance program:

First, value-based purchasing and the SGR are on a collision course, and the SGR must be replaced. Value-based purchasing may save dollars for the program as a whole by reducing hospitalizations. But, the majority of measures – such as those focused on

prevention and chronic disease management – ask physicians to deliver more care. The SGR penalizes volume increases exceeding a target. If the SGR is retained when a value-based purchasing system is implemented, the so-called reward for physicians will be additional pay cuts, on top of the projected 26% in cuts over the next six years, beginning January 1, 2006. This is antithetical to the desired outcome of value-based purchasing and would only compound an ongoing serious problem.

A recent AMA survey shows that if significant cuts occur, more than a third of physicians would decrease the number of new Medicare patients they accept. A third would discontinue rural outreach services. More than half would defer the purchase of information technology that is necessary to make value-based purchasing work. And, a majority will be less likely to participate in Medicare Advantage. It is clear from the foregoing that the SGR must be replaced and cannot exist alongside pay-for-performance.

Our second recommendation concerns quality measures. They must be evidence-based, reliable and valid, as well as feasible to collect and report. As discussed above, they must also be developed by the medical specialty societies and vetted through a transparent, multi-stakeholder endorsement process.

Third, strong considerations must accompany the development of measures of efficiency. These measures have the danger that the lowest-cost treatment will supersede the most appropriate care for an individual patient. Therefore, efficiency measures must meet the same high standards that apply to quality measures. That is, efficiency measures must be evidence-based, valid measures developed by the medical specialty societies in a transparent process. Most importantly, there must be broad-based consensus regarding what constitutes appropriate levels of care before measuring for efficiency.

Fourth, there needs to be a reliable method for risk-adjustment. Without it, there will not be an adequate reflection of a physicians' performance.

Fifth, potential, adverse affects of public reporting must be avoided. Patients are served only if they are provided accurate and relevant information. Providing patients with flawed information would undermine the goals of value-based purchasing. Further, data collection must recognize that some factors are out of a physician's control, and that patients are sometimes non-compliant for a variety of reasons. There must also be a method for ensuring that any publicly reported information is attributable to those involved in the care and appropriately risk-adjusted. Moreover, physicians must have the opportunity for prior review and appeal with regard to any data that is part of the public review process, and physician comments should be included with any publicly reported data. This is necessary to give an accurate and complete picture of what is otherwise only a snapshot, and possibly skewed, view of the patient care provided by a physician.

Sixth, physicians should be fairly reimbursed for their administrative costs, especially for information technology systems necessary for the collection and transmission of accurate, quality data.

Seventh, pilot testing is important prior to full implementation, to flesh out any unintended consequences.

Eighth, value-based purchasing programs must be phased in to allow all physician specialties the opportunity to participate.

And lastly, as opposed to a withhold pool, we urge that pay-for-performance programs are based on a "differential" payment structure that provides a positive update for all physicians, with an additional payment for meeting quality goals.

Question: *Implementing value-based purchasing*: the drawbacks of a pilot program; I recognize that Value Based Purchasing is a new concept for some physicians, but CMS demonstrations and private-sector programs have shown success with value-based purchasing for physicians, and MedPAC has recommended moving in this direction. The bill I introduced with Chairman Grassley lays out a gradual timeline, starting with pay-for-reporting and moving to pay-for-performance. It also establishes a process in which physicians would have a say in what measures are used and how the program is developed. And it allows for different specialties to be evaluated according to different measures. In what way does this process I have outlined not provide the checks and balances necessary?

Answer: The AMA appreciates your genuine efforts to establish an appropriate process for development and implementation of a Medicare pay-for-performance program for physicians' services. To that end, we would like to share with you the attached framework for a phased-in approach to a Medicare pay-for-performance program, as jointly developed by the AMA and a number of medical specialty societies. We are committed to working with Congress and the Administration to help develop a fair, ethical, patient-centered, and evidence-based Medicare pay-for-performance program.

The attached framework is the result of extensive work by organizations representing a wide variety of physician specialties. It is our belief that the only way pay-for-performance will be successful in Medicare is if it recognizes the great diversity of physician practices in this country. Many medical specialty organizations have shared with Congress very detailed principles outlining the necessary elements for pay-for-performance to work effectively. This framework is not intended to supersede these important documents but rather highlight areas of consensus in medicine to provide you with our best sense of how Medicare might begin to implement pay-for-performance.

We also emphasize that fundamental to this framework is the recognition that Medicare today sits at a crossroads. As discussed earlier, modernizing the way that Medicare pays physicians to help support quality care will not work under the existing SGR formula. Thus, we believe that SGR must be repealed if pay-for-performance is to be successfully implemented in Medicare.

Further, in addition to the phased-in approach described in the attached framework, the AMA urges pilot testing of pay-for-performance programs prior to full implementation, to flesh out any unintended consequences. This is important because the pay-for-performance program (or "value-based purchasing" program) that would be established under S. 1356 is a completely new program in Medicare. Thus, pilot testing is critical for determining whether this type of payment program would achieve its intended purpose by identifying program "glitches" and any needed modifications prior to full implementation. For example, we are concerned about the impact of a pay-for-performance program on patients in areas that are under-served or have a high-disease burden. Pilot testing could illuminate appropriate methods for ensuring access for these patients.

A limited demonstration project being conducted by CMS, *i.e.*, the Physician Group Practice Demonstration, began only in April of this year, and thus results from that demonstration will not be forthcoming for some time. Moreover, this demonstration only applies to large group practices and not to the wide array of physician practices across the country. In addition, CMS' Care Management Performance Demonstration, authorized by section 649 of the MMA, is still under development and has not yet begun. Thus, it is not clear when results from this demonstration will be available.

We look forward to further discussing the attached framework and pay-for-performance legislation under consideration by Congress as we work together to improve the quality of care for the Medicare patients we serve.

Questions from Senator Kyl

Question: You state that pay for performance and the current physician reimbursement formula (SGR) are not compatible. How do you propose we link a global physician reimbursement system with aggregate volume targets (like the SGR) and individual physician performance payments?

Answer: **The AMA does not believe that a spending target payment system, such as the sustainable growth rate (SGR), is compatible with pay-for-performance. Thus, it is imperative that Congress ensure that any pay-for-performance legislation replaces the current SGR physician payment formula with a stable, reliable payment system that preserves patient access and reflects increases in physician practice costs.**

Value-based purchasing may save dollars for the Medicare program as a whole by reducing medical complications and hospitalizations. The majority of measures, however, such as those focused on prevention and chronic disease management, ask physicians to deliver more care. A spending target, such as the SGR, penalizes volume increases exceeding the target. Thus, if the SGR is retained, the so-called reward for physicians will be additional pay cuts. This is antithetical to the desired outcome of value-based purchasing and would only compound an ongoing serious problem.

The flaws in the SGR formula led to a 5.4% payment cut in 2002, and additional cuts in 2003 through 2005 were averted only after Congress intervened. The Medicare Trustees project that physicians and other health professionals face steep pay cuts (about 26%) over the next six years (from 2006 through 2011). If these cuts begin, on January 1, 2006, average physician payment rates will be less in 2006 than they were in 2001, despite substantial practice cost inflation. These reductions are not cuts in the rate of increase, but are actual cuts in the amount paid for each service. Physicians simply cannot absorb these draconian payment cuts and, unless Congress acts, physicians may be forced to avoid, discontinue or limit the provision of services to Medicare patients.

The AMA conducted a survey of physicians in February and March 2005 concerning significant Medicare pay cuts from 2006 through 2013 (as forecast in the 2004 Medicare Trustees report.) Results from the survey indicate that if the projected cuts in Medicare physician payment rates begin in 2006:

- More than a third of physicians (38%) plan to decrease the number of new Medicare patients they accept;
- More than half of physicians (54%) plan to defer the purchase of information technology, which is necessary to make value-based purchasing work;
- A majority of physicians (53%) will be less likely to participate in a Medicare Advantage plan;
- One-third (34%) of physicians whose practice serves a rural patient population will discontinue rural outreach services;
- One-third of physicians (34%) plan to discontinue nursing home visits if payments are cut in 2006. By the time the cuts end, half (50%) of physicians will have discontinued nursing home visits.

A physician access crisis is looming for Medicare patients. While the MMA brought beneficiaries important new benefits, these critical improvements must be supported by an adequate payment structure for physicians' services. There are already some signs that access is deteriorating. A MedPAC survey found that 22% of patients already have some problems finding a primary care physician and 27% report delays getting an appointment. Physicians are the foundation of our nation's health care system. Continual cuts put Medicare patient access to physicians' services at risk. They also threaten to destabilize the Medicare program and create a ripple effect across other programs. Indeed, Medicare cuts jeopardize access to medical care for millions of our active duty military family members and military retirees because their TRICARE insurance ties its payment rates to Medicare.

Thus, it is critical that Congress ensure that any pay-for-performance legislation also repeals the SGR and replaces it with a system that reflects increase in medical practice costs.

Question: How will a pay for performance system affect small practices or individual practitioners? What can we expect to see in the rural areas?

Answer: Pay-for-performance programs certainly will affect small practices and individual practitioners, especially in rural areas. For example, smaller practices and solo practitioners may treat patients for many different conditions, but may not treat enough patients with the same condition to develop a valid sample size. These physicians, therefore, may not be able to compile the data needed to properly measure quality performance. In addition, the integration of HIT systems into health care, which is necessary to make pay-for-performance programs work, will be a lengthy and expensive undertaking. The burden of technology investments and training will fall heavily on already overburdened physician offices and their staffs. This burden will be particularly ominous for small practices and solo practitioners.

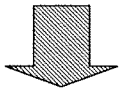
Accordingly, the AMA urges Congress to provide adequate funding to physicians investing in HIT to ensure the success of an undertaking of this magnitude, with due consideration for the constraints already faced by solo physicians and those who practice in rural, inner-city, and medically underserved areas. Also, Congress could help relieve the burden of HIT investment by removing legal impediments under the federal anti-kickback and Stark laws to allow private assistance for physician investment in HIT. This would help physicians absorb the potentially prohibitive cost of integrating this technology into their practices. These protections should allow adequate time for physicians to structure and fully implement such arrangements, especially in light of the likelihood that physicians will be required to make technology upgrades as standards change and the field evolves.

We appreciate the opportunity to provide you with our views on the issues raised by these questions. We look forward to working further with you to improve the quality of care delivered to our patients, as well as to maintain access to that care for our senior and disabled patients across the nation.

2006 Ramp-up

Medicare Update: Total additional dollars allocated to fix the SGR at least equal to the amount required to provide a fee schedule update equal to the increase in the MEI.

Development Period
- Measure Development (ongoing)
- PFP Pilot Tests/Demos

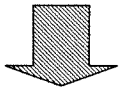


2007 Pay for Reporting

Medicare Update: Total additional dollars allocated to fix the SGR and fund a pay for reporting program are at least equal to the amount required to provide a fee schedule update equal to the increase in the MEI. All physicians guaranteed a payment "floor" of positive updates.

Reporting basic quality information such as:
- Practice structure (e.g. functions of IT use – patient registries)
- Participation in patient safety programs / use of protocols (e.g. mark your site, time out)

Development Period
- Measure Development (ongoing)
- PFP Pilot Tests/Demos

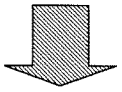


2008-2009 Pay for Reporting / Pay for Participation

Medicare Update: Total additional dollars allocated to fix the SGR and fund a pay for reporting / pay for participation program are at least equal to the amount required to provide a fee schedule update equal to the increase in the MEI. All physicians guaranteed a payment "floor" of positive updates.

- Transition to participation in more advanced quality improvement programs and reporting of evidence-based quality measures. Quality performance data will be transmitted back to physicians for internal quality improvement purposes. This phase would also test the feasibility of collecting data and accurately measuring physician performance in preparation for PFP.

Development Period
- Measure Development (ongoing)
- PFP Pilot Tests/Demos



2010 Pay for Performance

Medicare Update: Pay for performance (PFP) provisions are triggered contingent on repeal of SGR formula. Long term solution must assure that sufficient dollars are allocated to allow for positive annual fee schedule updates linked to inflation and money to be set aside to fund the proposed PFP program. All physicians must be guaranteed a payment "floor" of positive updates.

- % of Medicare payment of physicians (all specialties) based on quality performance
- Program focus on continuous quality improvement
- Performance measured on evidence-based measures of process and/or outcomes with appropriate risk adjustment, valid sample size, etc..
- Any "efficiency measures" used are transparent, evidence based, and focus on clinical quality improvement
- Only after adequate safeguards are put in place to prevent unintended consequences such as patient de-selection is public reporting permitted
- HHS conducts studies on Medicare program savings resulting from Part B quality efforts

TESTIMONY BEFORE THE

SENATE COMMITTEE ON FINANCE

ON

IMPROVING QUALITY IN MEDICARE: THE ROLE OF VALUE-BASED PURCHASING

JULY 27, 2005

WASHINGTON, D. C.

WITNESS: THOMAS "BYRON" THAMES, M.D.
AARP BOARD MEMBER

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Mr. Chairman and members of the committee my name is Byron Thames. I am a physician and a member of AARP's Board of Directors. Thank you for inviting us to testify on the need to link health care payments to quality performance.

Linking Medicare payment to the quality of care beneficiaries receive is a critical step for our nation's health care system. Towards that end, AARP strongly supports the Medicare Value Purchasing Act (S. 1356) sponsored by Chairman Grassley and Senator Baucus. We believe this legislation lays out an appropriate and reasonable framework for achieving vitally needed quality improvement in the U. S. health care system.

America spends more per capita on health care than any other nation in the world. Yet we have a health care system in which preventable hospital-based medical errors cause an estimated 98,000 deaths each year and patients receive recommended health care services only about half the time. Clearly, we are not getting our money's worth.

We can no longer simply pay the bills for health care without using those payments as an incentive to improve the quality of care. The time has come to improve our approach to paying doctors, hospitals, and other Medicare providers. Offering rewards for high quality, quality improvement, and use of health information technology (HIT) simply makes good sense.

Overview of the Quality Challenge

In its 2001 landmark study, *Crossing the Quality Chasm*, the Institute of Medicine found that, "Between the health care we have and the care we could have lies not just a gap, but a chasm." Although the Agency for Healthcare Research and Quality's 2004 annual assessment of the nation's quality of care found improvement in many areas, "the gap between the best possible care and actual care remains large."

There is abundant evidence of quality problems in the U.S. health care system. Experts at the Institute of Medicine (IOM) and elsewhere have described these problems as:

- *underuse of services*, where patients do not receive the care and services they require;
- *overuse*, where patients receive care for which the harm of receiving a particular treatment outweighs its benefits; and

- *misuse*, where medical mistakes, such as avoidable complications, put patients in jeopardy of injury or death.

According to the IOM, preventable adverse events are a leading cause of death in the U.S. On average, Americans only receive slightly over half of recommended care. In addition, researchers have found deficiencies in quality among persons over age 65 across several dimensions of geriatric care. Vulnerable individuals needlessly suffer from malnutrition, pressure ulcers, falls and mobility disorders, and urinary incontinence because they do not receive recommended care.

Moreover, findings from the National Healthcare Disparities Report indicate that disparities in health care are found among racial, ethnic, and socioeconomic groups in the U.S.

African Americans received poorer quality care than Caucasians for about two-thirds of the reported measures. Similarly, Hispanics had worse access to care than non-Hispanic whites for about 90 percent of access measures in the report.

Quality problems are found in all health care settings – such as hospitals, physician offices, and nursing homes – and they occur regardless of payer. Thus, quality problems are found in private plans, the Federal Employees Health Benefits Program, Medicare, and Medicaid. People across the entire life span are affected – young children, workers, boomers, and Medicare beneficiaries.

Clearly, there is a human cost to poor health care quality, but there is also an economic cost. In 2002, health spending in the U.S. was 14.6 percent of our gross domestic product. Switzerland and Germany are the only other nations that spent more than 10 percent of their GDP on health care and both of these countries have a national system of health care for their citizens.

The U.S. is a clear outlier and spends more per capita than any other country. Consumers are feeling the burden of escalating health care costs. Health insurance premiums continue to increase at rates considerably higher than general inflation. In 2004, premiums for employer-provided health insurance rose by 11.2 percent, exceeding the general inflation rate by almost 9 percent. In Medicare, the Part B premium grew 17.5 percent between 2004 and 2005 due in large part to reimbursement increases for providers.

However, spending more on health care does not necessarily yield better results. Medicare beneficiaries who live in higher-spending parts of the U.S. receive more care than those in lower-spending areas, but they do not have better health outcomes or greater satisfaction with care.

Finally, in addition to concerns about quality and cost, we must also recognize the failure of our system to establish access to coverage for all. The absence of universal coverage for individuals under age 65 requires immediate attention. The failure to ensure access to coverage for all Americans inevitably will hamper efforts to improve care and contain health care costs.

Overcoming the Challenges

The concerns enumerated above paint a bleak picture and help to underscore the compelling case for rapid improvement. Although it will be an enormous challenge, there is growing consensus on a course of action to encourage better quality. This multi-pronged approach combines:

- public reporting of standardized quality measures;
- promoting internal quality improvement;
- realigning payment policies; and
- promoting health information technology (HIT), which is an integral component in each of the above areas.

Meaningful progress toward the successful achievement of this strategy can only be made if all affected stakeholders, including providers, health plans, purchasers, researchers, and consumers, work together to accomplish shared objectives. The National Quality Forum (NQF) currently facilitates such collaboration and its diverse membership is becoming increasingly aware of the importance and value of participating on a consensus-driven body.

Standardized Measures

The NQF has articulated a standardized framework for identifying consensus standards to advance quality improvement. A guiding principle of the framework is that common performance measures should be useful in helping consumers make health care choices

about their coverage options, providers, and treatments, *and also* helpful to providers in improving the delivery of care.

In order to minimize burden, the measure set selected should be as concise as possible while addressing the six quality issues or "domains" identified by the Institute of Medicine, including:

- patient safety;
- clinical effectiveness;
- patient-experience;
- equity;
- efficiency; and
- timeliness.

Although significant progress in the field of quality measurement is being made, much of the information needed to better assess the health care system is still lacking. There remains an inconsistent patchwork of information to assess quality and to support improvement efforts. A robust measurement effort that yields standardized, reliable, and objective data is essential.

That is why AARP is very pleased that the Medicare Value Purchasing Act charges the Secretary of Health and Human Services with selecting evidence-based measures of quality that will assess the processes and structures of health care delivery, and patient experience, as well. Selection of these measures should be informed by the deliberations and recommendations of a consensus body like the NQF.

Realigning Payment Policies

Current Medicare payment policies do not support better performance, and in fact reward poor performance with additional payment. Physicians, hospitals, and other institutional providers are now paid whether or not they provide good care. In fact, a hospital, for example, is paid more if it does not prevent a preventable, life-threatening infection because longer stays and more serious conditions automatically place patients in higher payment categories.

The Medicare Payment Advisory Commission has advised Congress that the Medicare program cannot afford for Medicare payments to remain neutral about quality. We agree.

Experience in the private sector as well as CMS' own hospital and physician demonstration projects are beginning to show that rewarding quality can improve results. Most of these reward programs target hospitals, physicians, and health plans and have been initiated by health plans, purchasing coalitions, and employers who purchase coverage for their employees.

In 2004, 35 health plans had some type of program to reward physician performance, and major Fortune 100 companies have participated in the *Bridges to Excellence* and other programs that pay bonuses to doctors for good performance in several dimensions of care. We expect these kinds of programs to proliferate, and we are pleased that this legislation will lay the groundwork for similar activities in Medicare across all health care settings.

It is appropriate and entirely consistent with its history as an innovator of payment methodologies for Medicare to also be a leader in the effort to improve care through redesigned payment policies. We believe that the approach taken in the Medicare Value Purchasing Act to reward both the attainment of good performance as well as quality improvement is the correct one.

Offering all players the opportunity to benefit from financial rewards for better care stands a better chance of success than other approaches.

We agree that the Medicare Value Purchasing Act provision to require data collection as a first step, without financial consequence, is sensible and will allow providers time to gain experience and confidence in the new payment system. However, financial consequences are crucial to changing provider behavior, and we support moving to pay for performance on an aggressive timetable.

Importance of Health Information Technology (HIT)

We agree that measurement should include assessing the capacity of providers to use health information technology (HIT) in providing care because the use of these systems can directly affect the quality of care. HIT can improve quality by:

- giving clinicians decision support that reminds them to conduct tests and treatments based on evidenced-based guidelines;
- helping providers monitor their patients' progress;
- providing timely reports of laboratory and x-ray results;
- reducing errors by improving the accuracy and legibility of patient records;
- enhancing coordination by facilitating shared use of records; and,
- expediting access to medical information and scientific advancements.

Patients also see benefits from HIT through:

- secure email communications with their clinicians;
- rapid access to test results;
- access to their own health records so they can be more engaged in their own care, which is particularly helpful for people with chronic conditions; and
- the convenience of on-line appointments.

Ultimately all of these changes will contribute to better health outcomes.

Finally, HIT can help promote quality improvement by easily and efficiently capturing information that will enable us to use medical encounter data to:

- measure and benchmark performance;
- design interventions for improvement;
- promote public accountability; and
- realign payment methods.

Ultimately, we expect that HIT will lead to greater efficiency and the elimination of wasteful services. Of course, we understand that there are major challenges to overcome, including:

- the cost of HIT acquisition and adoption;
- the lack of "interoperable" standards that allow different systems to communicate effectively;
- the absence of a common nomenclature or standards for data aggregation, storage, and communication; and
- provider and practitioner resistance to these changes.

But we believe that the Medicare Value Purchasing Act is a step towards addressing these and other challenges.

Privacy and Other Concerns

Patients must be assured that "consumer-centric" care standards will be implemented to permit a focus on patient outcomes. We must also recognize that many consumers may be suspicious of the "connectivity" that comes with HIT in the health care setting, and the threat to privacy this may pose.

Therefore, a standardized health information infrastructure that will ensure the protection and security of patient information is absolutely critical.

AARP also agrees that the new payment policies should be implemented without further burdening the Medicare Trust Funds. Medicare beneficiaries deserve the highest quality care from the current level of investment. Using existing funds will provide the necessary incentives to hasten improvement and to ensure that beneficiaries get the high quality care they deserve.

Learning As We Go Forward

There will be many lessons to learn as Medicare embarks in a new direction. It will be critically important to evaluate progress, measure, and publicly report on performance and make mid-course corrections as needed. We note that the Agency for Healthcare Research and Quality (AHRQ) has commissioned a review of the randomized controlled trials on the effectiveness of different "quality-based purchasing" initiatives. Based on the evidence reviewed, the study found that very little is known about the effects of pay-for-performance initiatives on clinical performance, because most of the existing initiatives were not designed as research projects.

Nevertheless, there is much to be learned from the many natural experiments that are underway in which results are very encouraging. It is clear that much more research is needed to better understand the conceptual and theoretical factors that affect performance and that will foster desired behaviors in clinicians and patients. We encourage Congress to ensure that AHRQ is adequately funded to pursue this research as well as continue its work

in developing and testing new quality measures to ensure that there will be a robust, comprehensive set of tools suitable for assessing health care at all levels of the health care system.

In conclusion, we want to reiterate our strong support for the sensible and fair-minded approach you have identified in the Medicare Value Purchasing Act. AARP stresses the urgent need to improve quality. Medicare program resources must be used to obtain real value for the dollars spent for care. The measures selected to assess and reward performance should be well accepted measures that providers will find actionable and useful in their improvement efforts. These measures must also be clinically important and publicly available to consumers to inform decision making.

Measuring and reporting are part of a continuing process of improvement that should be part of the fabric of health services delivery and incorporated into the business model of every clinician and health institution and organization. AARP believes the enactment of the Medicare Value Purchasing Act will point us in the right direction to achieve this goal.

Responses to Questions for the Record From Dr. Byron Thames
Senate Finance Committee Hearing of July 27, 2005

Responses to Senator Baucus's questions

(1) *Using Value-based purchasing to protect Employee and Retiree Health Coverage:* American companies are struggling under high health care costs for employees and retirees. I am concerned about the impact on our country's global competitiveness, the impact on jobs, and the impact on retiree and employee benefits. As companies realize losses, they will begin cutting costs where they can—and health care benefits are a major target. What do you think the federal government can do to protect employee and retiree health care coverage by addressing the issue of health care costs? What role do you think value-based purchasing in Medicare can play?

As the major purchaser of health care services, the federal government can play a major role in several areas to promote value-based purchasing. AARP shares your concern about the cost of health care's effect on global competitiveness and the impact on jobs and employee/retiree coverage of benefits. Ultimately, it is our expectation that reducing errors and providing appropriate care will lower or, at least contain, health care costs. Certainly, there is already ample evidence to demonstrate that improved quality will save lives and will improve the quality of life for our nation's citizens. We believe that the cost of doing nothing—of ignoring quality deficiencies—is too great. Current payment policies ignore performance. Paying the same amount whether care is appropriate or not is simply not a prudent purchasing strategy. AARP believes that Medicare can be strengthened and preserved through more strategic payment policies that include value-purchasing.

(a) Value-based purchasing relies on being able to assess provider performance and to factor performance into payment approaches. Therefore, it is critical that the federal government ensure the development and deployment of valid, reliable, evidence-based measures through financial as well as technical support. Medicare should contribute, but should not be the sole funder of measures development, since the private sector gains from this activity as well. Collaboration among several federal agencies, particularly the Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare and Medicaid (CMS), and the Veterans Administration (VA) have made incalculable contributions towards measurement, and these agencies should be charged with continuing such with adequate financial support.
(b) The federal government should *require* its private health delivery contractors to collect and report on a robust and comprehensive set of standardized quality measures. Voluntary initiatives may not be sufficient to ensure that all entities will report without a mandate unless reporting is tied to meaningful incentives, such as payment.

(c) The federal government must play a leadership role in supporting research to inform quality improvement activities. As noted above, the federal government should be a leader in measures development (which requires research support) to build an infrastructure that will permit measurement in the six domains of quality identified by the Institute of Medicine across care settings, for conditions that are prevalent, and that are cross-cutting. Federal support is necessary to determine how best to communicate results of performance assessment to the public, including presentation formats, reporting summary index scores, etc.

(d) The federal government should partner with the private sector to advance the implementation of health information technology. AARP recognizes that the nation will not see dramatic improvements in quality unless we have the data to assess performance. This will not occur until there is widespread HIT adoption and until the public/private collaboration addresses the current barriers to HIT adoption. Although we are heartened by the growing activity in this area, we remain concerned that consumers' interest may not be fully considered in the HIT debate. AARP is collaborating with other consumer organizations to articulate principles that will ensure a patient/consumer focus as the HIT framework is fleshed out. We would be happy to discuss these with you in greater detail.

(2) *Developing a Quality Measurement System:* What do you think the process to develop a quality measurement system should look like? How would this process resemble what happens now with selecting quality measures, and in what ways would it be different? What role do you think Medicare should play in this process?

Measurement activities are centered on either quality improvement or public reporting. Since measures used for internal quality improvement do not have to be as methodologically rigorous as those used for public reporting and making comparisons, measures for these activities need to be selected differently. Currently measurement activities occur in many different arenas and under the auspices of several sponsors, including: the federal government (*e.g.*, AHRQ, CMS, VA), academic settings, specialty societies, accrediting organizations (*e.g.*, JCAHO, NCQA), and others.

Recently, in recognition of the importance of standardized measurement, several multi-stakeholder groups have emerged to address measures development and selection, namely the National Quality Forum (NQF), the Hospital Quality Alliance (HQA), and the Ambulatory Care Quality Alliance (AQA). These are consensus bodies whose members share common goals, including the need for public reporting and accountability.

In general, AARP is optimistic that those interested in quality improvement are beginning to understand the advantages of working together to further measurement and accountability with the ultimate goal of improving care throughout the health care system. AARP has been very supportive of the NQF, HQA, and AQA, and, in fact, has been a principal in each of the three groups. However, notwithstanding the synergy and common commitment to improving care that exists among the members of these entities, it is clear that a viable and sustainable business model is lacking that potentially jeopardizes the future of these nascent, but promising efforts. Without adequate

resources these groups will fail. Medicare can play an important role in helping to support the work of these groups. But the imperative to improve health care quality is important for all Americans, not just Medicare beneficiaries. Therefore, Medicare should not be the sole source of federal financing for quality initiatives.

Responses to Senator Kyl's questions

(1) In your written testimony (page 2) you state: "We can no longer simply pay the bills for health care without using those payments as an incentive to improve the quality of care." Does AARP acknowledge that better care may require not only payments to incentivize providers, but may also call for patients to pay more appropriately for care?

The U.S. health care system spends more of the nation's gross domestic product on health care than any other nation in the world. Patients and consumers should be able to assume that when they seek health care services they will receive high quality, appropriate care. Regrettably, our health care system is uneven and inconsistent and varies greatly. As a result, patients too often do not receive necessary care, and too often, they are the victims of avoidable medical mistakes. One of the challenges we face as a nation is to transform the American health care system so that everyone has access to adequate, affordable health care that is of high quality. The answer is not to charge patients more for high quality. The answer is to eliminate poor quality to avoid using scarce resources on waste and inefficiency. Patients deserve to receive value for their health care dollars. Patients need information to help them know if the providers and institutions they select perform well. Now, patients have no way of knowing how well their doctors perform because they do not receive adequate information to allow them to make such an assessment. This must change to help consumers obtain maximum value for their health care expenditures.

(2) What can patients do to assist in the quality efforts and also, to ensure the appropriate use (and not the overuse and misuse) of services?

AARP believes that when most patients are informed and supported they will follow directions, adhere to specific clinical regimens, and generally become active partners in their own health care. However, patients need good information and providers who are willing to cooperate and collaborate with their patients to ensure that patients can self-manage their own conditions. AARP believes that helping patients become more involved in their own care is one important by-product of health information technology (HIT). In addition to the many advantages to improve clinical care that HIT brings, it would also enhance opportunities for patient decision support, prompt patients to obtain care appropriately, and generally advance efforts to reduce unnecessary services and reduce errors.

(3) The list of six standardized measures you cited is void of anything related to costs. Does cost factor into your concept of P4P?

The AARP testimony mentioned the six quality domains identified by the Institute of Medicine (IOM) in its landmark study, "Crossing the Quality Chasm." The IOM experts who presented these domains asserted that to provide high quality care, the U.S. health care system must be *safe, clinically effective* (*i.e.,* care should be beneficial), *equitable*, *timely*, and *efficient*. The last domain, efficiency, captures cost, and supports obtaining the best value for the money spent and by eliminating waste. AARP believes that performance measures should be developed to address each of the six IOM domains of quality to paint a complete and comprehensive picture of care in the U.S.

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Statement for the Record
The Advanced Medical Technology Association (AdvaMed)

Senate Committee on Finance

Hearing on
"Improving Quality in Medicare: The Role of Value-Based Purchasing"

Wednesday, July 27, 2005

Bringing innovation to patient care worldwide

AdvaMed and its member companies thank the Committee for holding this important hearing on value-based purchasing for physicians under Medicare. Like the Committee, we support efforts to promote efficiency within the health care system and we represent many of the leaders in developing technologies that reduce cost, increase efficiency and save lives.

AdvaMed is the world's largest medical technology association representing manufacturers of medical devices, diagnostic products and medical information systems. AdvaMed's more than 1,300 members and subsidiaries manufacture nearly 90 percent of the $75 billion of health care technology purchased annually in the United States and more than 50 percent of the $175 billion purchased annually around the world.

AdvaMed supports the concept of measuring and improving the quality of health care provided under Medicare. We appreciate the efforts of Senators Grassley, Baucus, Enzi, Kennedy and others to achieve this objective by introducing the "Medicare Value Purchasing Act of 2005." We believe, however, that the provisions to reward providers for achieving quality standards need more explicit directions to the Secretary to establish mechanisms to assure that quality standards encourage rather than retard the development and adoption of valuable new technology. We are also concerned that the provisions regarding encouraging the efficient delivery of health care may have the unintended consequence of encouraging reduction in needed care, undermining the doctor-patient relationship, and inhibiting the adoption of valuable new technology. We urge refinement of these provisions.

Improving the Quality of Care

Medical technology is improving the quality of care for American patients with such devices as remote patient monitoring and telemedicine devices, remote ICU systems, cardiac and implantable device monitoring, mobile telemetry for hard-to-diagnose heart arrhythmias, and decision support software that is helping physicians provide the right care.

For example, remote patient monitoring (RPM) uses an electronic device in a patient's home to assist with disease management. By linking patients to their doctors, remote patient monitoring also is a particularly useful tool in providing rural health care. Patients use electronic home monitoring devices to transmit basic data – such as weight, blood pressure, blood oxygen levels, and heart rate – to their clinician, who in turn analyze the information to track early warning signs and symptoms as well as contact patients to provide them with feedback, education, and medication changes long before hospitalization would normally be necessary.

Reducing Costs

Technology not only enhances quality, it can often reduce costs. A study of the use of angioplasty found that the net savings from the procedure was $22,000 per case. Technology can cut the length of hospital stays, substitute less invasive and less costly procedures for surgical interventions, and reduce costs by improving health.

Health information technology offers special opportunities for savings. By reducing duplicative care, lowering health care administration costs and avoiding care errors, health information technology could save approximately $140 billion per year, according to HHS. Studies cited by HHS in its 2004

Health IT Strategic Framework Report suggest the use of EHRs can reduce laboratory and radiology test ordering by 9 percent to 14 percent, lower ancillary test charges by up to 8 percent, reduce hospital admissions ($16,000 average cost) by 2 percent, and reduce excess medication usage by 11 percent. Two studies have estimated that ambulatory EHRs have the potential to save all payers $78 billion to $112 billion annually. HHS also cites evidence that EHRs have the potential to reduce administrative inefficiency and paperwork.

A 2004 study in Critical Care Medicine found that using remote Intensivists (intensive care specialists) to monitor patients electronically from a remote location as part of an ICU telemedicine program not only improves clinical outcomes, but also enhances hospital financial revenues.[1] Cost savings resulted both from a reduction in the average length of stay in the ICUs (3.63 days vs. 4.35 days) and from a decrease in daily costs.

In addition, picture archiving and communication systems (PACS) enable hospitals, imaging centers and multi-site health care organizations to manage, store and transmit patient medical images such as digital X-ray, MRI and CR images.. Combining this kind of technology with a digital patient information system allowed several Boston-area hospitals to save an estimated $1 million annually by, in part, reducing the time spent searching for files and manually admitting patients.[2]

Ensuring Access to Innovation Under New Payment Proposals

The concepts of pay-for-performance (P4P) and value-based purchasing are meant to reward health care providers for the value of the care they deliver, not just the cost of the care. The value of medical technology should also be taken into account when implementing payment reforms such as these. P4P and value-based purchasing programs should encourage continued innovation in the best ways to provide care, and quality standards should include mechanisms for prompt recognition of new technologies.

There are three measures for P4P: structural measures, process measures, and outcome measures. Structural measures are used to assess the infrastructure needed to achieve good health outcomes. Process measures are based on adherence to clinical standards thought to improve the outcome of care, such as routine administration of beta blockers after a myocardial infarction or monitoring and control of blood glucose levels in patients with diabetes. Outcome measures are based on actual outcomes of care in terms of reduced morbidity and mortality. We commend the authors of the Medicare Value Purchasing Act for including all three types of measures as standards against which providers will be measured.

Structural measures have historically been embodied in accreditation and licensing standards, and have been a precondition for reimbursement rather than a basis for differential reimbursement. As knowledge about processes and outcomes of care develops, reimbursement for adoption of selected structural measures can become a useful tool for creating greater value in the health care system. Adoption of an interoperable medical record with the capacity for decision prompts is a good example. We commend the authors of the Medicare Value Purchasing Act for including the adoption of HIT infrastructure as one of the quality standards under the act.

Process measures are likely to be the most common method of implementing P4P since health outcomes are so difficult to measure in individual cases. Process measures can be seriously flawed, however, in the way they treat new technology by setting up yet another barrier to its timely adoption of medical technology. Under existing process measure for treatment of myocardial infarction, for example, the developers of new and better technologies to treat the disease would not only have to get it coded, get it covered, and get a reimbursement level for it set. They would have to go through an additional approval procedure for it to be treated as an alternative or replacement for an existing pathway of care.

The gold standard of P4P is the measurement of and reward for outcomes: the degree to which the treatment supplied by a provider improves the health of the patient relative to baseline measures. Measurement of outcomes for reimbursement purposes, however, is often complex. . The ability to carry out risk adjustment at the level of an individual patient is technically challenging. Responsibility for care may be diffused among many different providers. The "outcome" itself may be multidimensional, including not only such more readily measurable factors as mortality and morbidity, but also patient satisfaction, reduction in pain, and improved life-style. The costs of patient tracking and measurement of outcomes over time can outweigh the benefits.

The ability to measure and reward providers based on these factors, as well as our ability to more quickly design and implement process measures for quality, will be vastly enhanced with the adoption of universal, interoperable medical records that follow patients wherever they go. These records will provide a vast deposit of data that can be inexpensively mined and analyzed by health researchers.

The use of efficiency measures to reward providers is even more challenging. Studies by the RAND Corporation have shown that only 50% of patients experiencing common, serious illnesses receive care that meets the accepted standard for quality. Quality deficiencies were much more commonly the result of undertreatment than overtreatment. Unless measures of efficiency are based on conformity to standards of care conclusively established by peer-reviewed literature or by consensus within the relevant medical specialty, financial incentives to achieve efficiency could result in cuts in necessary as well as unnecessary care. Doctors could be faced with a conflict between their obligation to provide the best possible quality care for their patients and their financial interests, undermining the doctor-patient relationship. Measures of efficiency that focus on cost could provide a barrier to adoption of the valuable technology, if its direct cost is greater than the technology it replaces.

Recommendations

AdvaMed has developed a number of principles for pay for performance and quality-based purchasing. These principles are listed below and we urge the committee to consider them as it moves forward with legislation.

- **Quality measures should be created through transparent administrative processes that involve input from all key stakeholders, including physician specialty societies, patient groups, and representatives of medical technology manufacturers.** While the Medicare Value Based Purchasing Act requires the Secretary consult with an advisory entity established under the act, we believe a much more open and formal process of

notice and comment should be required, similar to the current requirements for making national coverage decisions. Medical technology manufacturers should be included as members of the advisory entity.

- **Quality measures should be based on strong evidence or expert consensus, and should utilize private sector standards development efforts.** We are pleased that the Medicare Value Purchasing Act requires the Secretary to take into account quality measures developed by private bodies. The requirement in the statute that standards should be "evidence-based" should be strengthened.
- **P4P incentives should be built on existing payment mechanisms.** Recognizing that not all providers start from the same performance level, P4P measures should reward, where appropriate, progress toward or beyond a quality goal as well as achievement of an accepted standard. We commend the authors of the Value Purchasing Act for including that requirement in the legislation.

In order to assure that process measures do not retard adoption of new technology and do not freeze practices in place that can become obsolete, the following principles are particularly important:

- **Measures should be updated frequently to reflect technological advances.** We are pleased that the legislation provides for updates in measures, but the language should provide for updates at least annually, just as the Secretary now updates the DRG system on an annual basis.
- **Local carriers should be generally free to recognize new technology as meeting a process measure prior to the updating of any national standards.** This is how coverage decisions are made under Medicare. Since new technologies have a development period in which they diffuse (and are continually improved), failure to allow local carriers to recognize a new technology could have a devastating effect on innovation. It would be the equivalent of only allowing coverage decisions to be made at the national level.
- **There should be mechanisms for an individual provider or manufacturer to seek recognition of an alternative process measure based on technological advances.** Evidence could include information presented to either FDA as part of the approval process or CMS or other payers as part of their coverage determination processes.
- **Effective new technologies, such as physician interpretation of data from remote monitoring devices, should be recognized in the standard payment mechanisms in conjunction with PFP incentives.**

With regard to efficiency incentives, we recommend that the legislation restrict efficiency incentives to the following circumstances:

- Savings from conformity to cost-reducing practices that are demonstrated by peer-reviewed literature or professional consensus to not compromise the quality of care and for which exceptions are allowed based on individual patient circumstances.
- Savings that result from improvements in quality, such as reductions in post-operative complications or reductions in morbidity from improved management of chronic disease.

- Savings resulting from improvements in administrative processes, such as reduction in duplicative tests, inappropriate use of the emergency room, and utilization of information technology.

Again, we thank the Committee for holding this hearing today and we appreciate the opportunity to submit testimony for the record. We look forward to working with the Committee as legislation is developed on these issues.

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[1] Breslow MJ, Rosenfeld BA, Doerfler M, Burke G et al. Effect of a multiple-site intensive care unit telemedicine program on clinical and economic outcomes: An alternative paradigm for Intensivist staffing. Crit Care Med 2004;32:31-38.

[2] Networking Health: Prescriptions for the Internet, Institute of Medicine, National Academy of Sciences, p. 81, 2000.

Statement
of
Jack Ebeler
President and CEO
Alliance of Community Health Plans

Submitted
to
the Senate Finance Committee

Hearing on Improving Quality in Medicare:
The Role of Value-Based Purchasing

July 27, 2005

2000 M Street NW, Suite 201 • Washington, DC 20036 • p: 202-785-2247 • f: 202-785-4060 • www.achp.org

The Alliance of Community Health Plans (ACHP) commends Chairman Grassley and Ranking Member Baucus for your leadership in introducing S. 1356, the Medicare Value-Based Purchasing (MVP) Act and for convening a Senate Finance Committee hearing on the opportunities to use value-based purchasing to improve quality across all sectors of Medicare. ACHP was pleased to work with Finance Committee staff during the development of this legislation and appreciates the opportunity to share our perspective today.

ACHP is a leadership organization of non-profit and provider-sponsored health plans that are among America's best at delivering affordable, high-quality coverage and care to their communities. Today, ACHP member plans serve more than one million Medicare beneficiaries—about 20 percent of current Medicare Advantage members.

We have a proud legacy on quality improvement. Our organization was formed more than twenty years ago to help innovative health plans share best practices. One of the earliest products of this collaboration was the creation of the Health Plan Employer Data and Information Set (HEDIS®), which has now become the standard for assessing health plan performance in the commercial and public sector. Through the National Committee for Quality Assurance (NCQA)—which today manages and updates the HEDIS® measurement process—employers, Medicare, Medicaid and other payers regularly monitor and evaluate health plan quality.

Health plan measures are reported annually to the Centers for Medicare and Medicaid Services (CMS) and assess plans' performance in areas such as cancer and heart disease screening and prevention, control of diabetes risk factors, and patients' satisfaction with their plan and physicians. To help Medicare beneficiaries make informed decisions about their health plan choices, CMS makes comparative information about plan performance available on-line through www.medicare.gov and in printed publications. Together, the HEDIS® clinical quality reporting process, coupled with the CAHPS® survey of patient satisfaction, provide a vital and meaningful assessment of health plan performance for beneficiaries and for public and private payers.

Quality Matters

A 2003 comprehensive, peer-reviewed RAND Health assessment of health care quality published in the *New England Journal of Medicine* found that Americans received recommended health care only about half of the time. NCQA's 2004 *State of Health Care Quality* report documented that the gap between the quality of care delivered through the nation's best health plans and the care most Americans receive results in an estimated 42,000 to 79,000 premature deaths each year. Yet, as the Medicare Payment Advisory Commission (MedPAC) has said, the Medicare program is largely neutral or negative towards health care quality. Medicare providers are paid the same regardless of the quality of service provided and, at times, are paid more when quality is worse.

To address the quality chasm in health care, the Institute of Medicine (IOM) has called for realigning financial incentives to achieve better patient outcomes. MedPAC also has

recommended the introduction of quality incentive payment policies in Medicare for health plans, physicians, hospitals, dialysis facilities and home health agencies.

ACHP shares the IOM and MedPAC's assessment that pay-for-performance is an idea whose time has come. We applaud the Committee leadership's commitment to advancing the use of quality measures and value-based purchasing strategies in both Medicare Advantage and fee-for-service Medicare. For beneficiaries to make well-informed health care choices, they need to be able to make "apples-to-apples" comparisons between the quality of care in Medicare Advantage plans—which they can evaluate through publicly reported data on a range of quality measures—and the care offered by fee-for-service Medicare providers—for which public reporting is just beginning. They also need Medicare to use its leverage as the nation's largest purchaser of health care to promote and stimulate quality improvements. The introduction of the MVP Act and today's hearing are important steps in advancing these goals.

The MVP Act

ACHP shares many of the policy objectives of S. 1356, the Medicare Value-based Purchasing Act of 2005, including promoting Medicare quality improvement through rewarding high-quality health plans, physicians, hospitals and other providers, and creating incentives to encourage others to improve. We are pleased that the bill:

- Includes fee-for-service Medicare in addition to Medicare Advantage,
- Establishes a quality award pool that recognizes high performers and improvement,
- Requires the majority of the award pool to be allocated to high performers, and
- Encourages the Secretary of Health and Human Services to, where possible, weight measures in favor of clinical performance.

We applaud the MVP Act's introduction of value-based purchasing in both the Medicare Advantage and fee-for-service Medicare sectors. The broad application of pay for performance to all of Medicare will accelerate the identification and adoption of quality measures in fee-for-service Medicare and create incentives for quality improvement throughout the Medicare program.

In addition, ACHP shares the bill sponsors' belief that pay-for-performance initiatives should recognize and favor excellence, while also creating incentives to reward improvement. We are pleased that the legislation reserves the majority of the quality award pool for high performers. Recognizing that the performance and improvement thresholds are to be determined by the Secretary, we are anxious to work with you and the Secretary to ensure that the performance threshold is set in a way that appropriately identifies and rewards excellence.

We are encouraged that the bill includes language that, to the extent possible, directs the Secretary to favor clinical quality measures as he identifies measures on which to award performance. As MedPAC has said, "The Medicare payment system does not currently reward strong plan performance on the clinical measures...Payment incentives tied to clinical quality measures, however, do have the ability to reward strong plan performance on those measures."

(MedPAC, *Report to Congress: Medicare Payment Policy*, March 2004.) MedPAC has suggested weighting in favor of clinical measures and we are pleased that the MVP Act incorporates that recommendation.

To identify the measures on which Medicare plans and providers would be evaluated, the MVP Act requires the Secretary to consult with a private, non-for-profit entity comprised of measurement experts and other stakeholders. We would encourage the Committee to consider specifying that for Medicare Advantage the Secretary begin with the quality measures that are currently in place for local Medicare health plans. Local Medicare Advantage health plans report on a number of clinical measures that assess health plans' ability to not only screen for chronic conditions but also to help patients manage conditions such as high blood pressure, high cholesterol and diabetes. These measures have been developed through an evidence-based, consensus-driven process and are in widespread use in both the public and private sector.

Finally, ACHP continues to be concerned with the financing mechanism outlined in the bill. Although we recognize the efforts to phase-in the payment withholds and to introduce an initial year of "shadow reporting" to help plans prepare for the new payment approach, we nonetheless believe that payment withholds do not provide the firm financial foundation for sustainable quality improvement that the legislation envisions. To achieve our shared goal of transforming health care quality for all beneficiaries, we strongly believe that health plan pay for performance requires an alternative funding source.

Conclusion

ACHP has been a consistent advocate for the inclusion of value-based purchasing strategies in the Medicare payment system. We are delighted with the Committee leadership's strong commitment to moving the Medicare program toward a more performance-driven system and are pleased to have had the opportunity to work with the Committee in this effort. Medicare has unparalleled purchasing power and ability to influence quality throughout the health care system. Leveraging those strengths to give Medicare beneficiaries both higher quality health care choices and access to better information about their choices will be an invaluable step toward a truly modernized Medicare program.

Testimony

of the

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

to the

Senate Committee on Finance
United States Senate

July 27, 2005

Improving Quality in Medicare: The Role of Value-Based Purchasing

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July 27, 2005

The Honorable Charles Grassley
Chair, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Max Baucus
Ranking Member, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Grassley and Baucus:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), representing 49,000 physicians and partners in women's health, thank you for the extraordinary leadership and commitment you've shown in your effort to correct a serious problem in the Medicare program by repealing the flawed Sustainable Growth Rate (SGR) formula and putting in place a system that works for physicians, and helps ensure access to high-quality care for our patients.

ACOG has long been dedicated to maintaining the quality of care provided by obstetricians and gynecologists and has a robust ongoing process where we provide women's health physicians and providers with current, quality information on the practice of obstetrics and gynecology. For nearly two decades, ACOG's Committee on Quality Improvement and Patient Safety has regularly reviewed practice and patient safety issues and encouraged our members to incorporate ACOG's recommendations into their practices. ACOG's Practice Committees regularly publish practice guidelines developed by committees of experts and reviewed by leaders in our specialty and the College. Each of these guidelines is reviewed periodically and reaffirmed, updated, or withdrawn based on new clinical evidence to ensure continued appropriateness to practice.

In 2004, in cooperation with the American Board of Obstetrics and Gynecology (ABOG), an independent, non-profit organization that certifies obstetricians and gynecologists in the United States, ACOG created Road to Maintaining Excellence, an initiative to allow ob-gyns to evaluate their own practice activities, reinforce best practices and assist in improving others. Currently in pilot stages, Road to Maintaining Excellence will require ACOG Fellows to complete questionnaire-based modules that focus on a single aspect of clinical practice, like prevention of early-onset group B Streptococcal disease in newborns and prevention of deep vein thrombosis and pulmonary embolism. As Fellows complete each module, data will be summarized and compiled by ACOG, and periodically reported to our members. Road to Maintaining Excellence will provide Fellows with valuable information about how their practice patterns compare to

those of their colleagues but is not intended to be used as a performance measurement set or as a basis for payment.

ACOG has been working collaboratively with our primary care colleagues, as well as our colleagues in specialty and surgical care, to be supportive of moving toward value-based physician payments, linked with fixing the SGR. As Congress moves forward in establishing quality incentives in Medicare, ACOG believes that certain principles should be kept in mind.

- All physicians should receive a positive Medicare payment update as a floor for additional reporting or performance incentives. Under the current SGR formula, physicians will receive unsustainable payment cuts of nearly 30 percent over the next six years. Some performance measures may involve additional office visits, lab tests, imaging exams or other physician interventions that would only exacerbate the current volume formula. Physicians must not be penalized for any volume increase resulting from compliance with performance measures. To ensure an equitable accounting of the costs and savings generated from pay-for-performance, Medicare should account for savings to Part A generated by Part B performance improvements.

- The new payment system should be phased in, beginning with an administratively simple "pay-for-reporting" period that provides information about the quality and safety processes physicians are engaged in and assesses the availability of health information technology. Quality and safety process measures used in the Medicare system should have widespread acceptance in the medical community. One such process measure in obstetrics could involve use of a prenatal flowsheet, a performance tool developed by ACOG that was recommended for use by an ACOG-led prenatal workgroup of the American Medical Association's Physician Consortium for Performance Improvement. In ob-gyn surgery, ACOG supports the procedural measures laid out in the first phase of the American College of Surgeons Framework for Surgical Care, including confirmation of operative site and side marking, pre-operative "time out," immediate post-operative documentation, post-operative pain management and appropriate post-operative care.

- Clinical performance measures should be developed by each specialty in a transparent process that considers scientific evidence, expert opinion and administrative feasibility of each measure. Measures should be appropriately risk-adjusted to account for a variety of factors, including patient compliance and complexity. Increased quality should be the goal of efficiency measures, and these measures, too, should be driven by data-based clinical evidence and expert opinion when data are lacking.

- Health information technology is prohibitively expensive for some small practices, particularly for the 23 percent of ob-gyns in solo practice, but is a necessary efficiency and a vital component of pay-for-performance. Acquisition of this technology should be encouraged with federal financial assistance for the purchase of hardware and software and for system training. National standards for health information technology would facilitate physician adoption of these systems, by reassuring physicians that the technology they invest in would not become obsolete. Because use of health information technology may be among the elements of the early "pay-for-reporting" system, it is vital that these steps be taken promptly.

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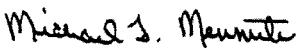
- Congress needs to address the universe of legal issues surrounding data reporting. Information collected by CMS must be protected from use in medical liability litigation against physicians or as a basis for negligent hiring or retention claims. This may necessitate specifically exempting physician data from Freedom of Information Act requests. Care should be taken to avoid other unintended and unfortunate consequences of public data reporting, such as physician selection of patients with the fewest medical risk factors or the best history of compliance with instructions. This is essential to ensure continued access to care for low-income and minority populations who tend to enter the health care system at an acute stage of disease and illness and suffer worse outcomes regardless of the quality of care they receive.

We recognize the challenges in creating a quality improvement program for Medicare that leads us to meaningful clinical measures and improved quality for beneficiaries. We applaud your commitment to this effort and we sincerely thank you for your willingness to work cooperatively with ACOG and the medical community in these important discussions. ACOG stands ready to work with you as we embark on this historic change in Medicare.

Sincerely,



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Statement of the American College of Physicians

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for the Record of the
Hearing on "Improving Quality in Medicare:
The Role of Value Based Purchasing"

United States Committee on Finance

July 27, 2005

The American College of Physicians (ACP), representing over 119,000 doctors of internal medicine and medical students, is pleased to provide this statement for the record on the issue of value-based purchasing for physicians under Medicare. This testimony is provided for the July 27, 2005 hearing held by the United States Committee on Finance. This statement focuses on the following areas:

1. The steps the College is taking to lay the groundwork for value-based purchasing by helping internists understand how to incorporate proven quality improvement methods in their practices and to provide them with the technological capacities to support quality improvement.
2. The College's leadership role in selecting performance measures for ambulatory care that could be used in a Medicare value-based purchasing program as well as in other quality improvement programs.
3. The College's views on how to design a legislative framework for value-based purchasing that will support and strengthen the ability of physicians to engage in continuous quality improvement.
4. The College's views on the importance of carefully assessing the impact of provider-based purchasing on practicing internists and the relationships they have with their patients.
5. The College's views on the need to engage in a comprehensive re-examination and restructuring of Medicare payment policies to support quality improvement, particularly for patients with multiple chronic diseases.

I. LAYING THE GROUNDWORK FOR VALUE BASED PURCHASING

ACP firmly believes that the medical profession has a professional and ethical responsibility to engage in activities to continuously improve the quality of care provided to patients. ACP was among the first medical professional organizations to support the concept of linking payments to physician performance on evidence-based measures. We recognize, however, that pay-for-performance cannot by itself lead to quality improvements if physicians in practice lack the capabilities to incorporate proven quality improvement methods in their practices. Accordingly, the College is engaged in *over forty projects* to improve the quality of care provided to patients, including two new grant-funded programs to improve the care of patients with diabetes and to implement quality measures for the frail elderly.

ACP is also actively engaged in initiatives to develop the health information technology infrastructure to support quality improvement. We serve on the boards of the Certification Commission for Health Information Technology and the Electronic Health Initiative; co-chair the Physicians Electronic Health Record Coalition (PEHRC), and are actively involved in the Connecting for Health initiative. We have developed recommendations for legislation to provide initial funding and sustained reimbursement support to help clinicians, particularly those in small practices, acquire and use HIT to support their participation in quality improvement projects. The

College has joined with other stakeholders to submit proposals in response to Secretary Leavitt's requests for proposals on standard harmonization and certification of electronic health records. The College is also committed to providing practice internists with practical tools to help them improve quality. ACP's Physicians Information and Education Resource (PIER) provides ACP members—at no cost to them—with access to "actionable" evidence- based guidelines at the point of care for over 300 clinical modules. PIER has also been incorporated into several electronic health record systems. PIER is currently in the process of aligning its evidence-based content to support a starter set of measures selected by the Ambulatory Care Quality Alliance (AQA). PIER is also creating paper order sets that imbed such quality measures in the order set, so that physicians who have not made the transition to electronic health records could still rely on PIER content to support their participation in performance measurement initiatives.

ACP's Practice Management Center has developed resources to help internists go through the decision-making process on electronic health records and is in the process of working with other entities in the College to provide internists with tools and best practices to help them redesign their office processes to improve health care quality.

ACP is also directly involved in supporting several federal demonstration projects to improve quality. We are directly involved in implementation of the Chronic Care Improvement Program/Medicare Health Support pilots in Mississippi and Pennsylvania as authorized by Section 721 of the Medicare Modernization Act, working with the awardees to develop mechanisms to support physicians' roles in coordinating and improving care of patients with diabetes and congestive heart failure. The College has also endorsed the Doctor's Office Quality Information Technology (DOQ-IT) demonstration project and is working with the American Health Quality Association to support the 8th Scope of Work.

Through these and other initiatives, the College is laying the groundwork for Medicare value-based purchasing by educating internists on how to incorporate performance measurement and improvement in their practices, by providing them with evidence-based clinical decision support, by partnering with others to develop the health information technology infrastructure to support quality improvement, by providing internists with practical tools to help them redesign office processes to improve quality, and by gaining first-hand knowledge from federal demonstration projects and pilot programs on how to incorporate quality improvement in the Medicare program.

II. SELECTING PERFORMANCE MEASURES FOR AMBULATORY CARE

ACP's long-standing commitment to evidence-based medicine and continuous quality improvement is also evidenced by our active involvement in the Ambulatory Care Quality Alliance (AQA), which in May 2005 took a major step toward improving the quality of the U.S. health care system by selecting a "starter set" of 26 clinical performance measures for the ambulatory care setting. (We ask that the starter set of measures, which is attached to this statement, Attachment 1, be recorded in the official record on this hearing.) ACP is one of four original organizations that organized and convened the first AQA meeting in the fall of 2004 (the other three co-conveners are America's Health Insurance Plans, the American Academy of Family Physicians, and the Agency for Healthcare Research and Quality) and we continue to serve on its steering committee.

The AQA, a national consortium of large employers, public and private payers, and physician groups, aims to improve health care quality and patient safety through a collaborative process in which key stakeholders agree on a strategy for measuring, reporting and improving performance at the physician level. The AQA also works to promote uniformity in order to provide consumers and purchasers with consistent information and to reduce the burden on providers. This approach is similar to the Hospital Quality Alliance, which involved a broad array of stakeholders with the goal of producing a standardized set of measures for inpatient care.

The AQA's starter set of ambulatory care measures is intended to provide clinicians, consumers and purchasers with a set of quality indicators that may be utilized for quality improvement, public reporting and pay-for-performance programs. The rationale behind the measurement starter set is to allow physicians to get used to tracking a few simple performance goals, while more sophisticated measurements and implementation guidelines are developed. While the College and other medical groups would prefer to take an evidence-based approach by waiting for results from pay-for-performance pilots and demonstrations, the market simply will not wait. Instead, ACP is confident that the AQA's starter set of measures represents the first of several generations of increasingly sophisticated performance measurement sets that can be used with confidence to measure quality of care in the ambulatory area.

AQA's uniform starter set comprises prevention measures for cancer screening and vaccinations; measures for chronic conditions including coronary artery disease, heart failure, diabetes, asthma, depression, and prenatal care; and, two efficiency measures that address overuse and misuse. Except for the two efficiency metrics, the AQA limited its review to those measures that are currently under review by the National Quality Forum.

ACP, and the other members of the consortium, worked hard to ensure that the initial set of measures relied principally on administrative data that is readily available for most practices, thereby reducing the administrative burden of having to extract information from medical records. In addition, they ensured that the starter set met the standards of scientific validity, feasibility, and relevance to physicians, patients and purchasers. AQA participants are also beginning to seriously address the complex issues associated with creating the infrastructure for performance reporting. The AQA is also working on a model for aggregating, sharing and stewarding data that maintains appropriate restrictions on privacy and confidentiality, as well as principles for reporting information to providers, consumers and purchasers.

The College is also an active member of the National Quality Forum. The NQF plays an essential role in the selection of measures but in a way that is distinct from but complimentary to the role played by the AQA. The NQF uses a multi-stakeholder process to validate measures that are developed from many different sources, including medical specialty societies, voluntary health agencies, and accreditation groups. Approval by the NQF provides a strong degree of assurance that the measures are supported by the best available medical evidence. The AQA compliments the role of the NQF by focusing on *implementation* of measures: selecting as subset of measures for implementation from those approved by the NQF by applying additional criteria that focuses on ease and practicality of implementation in the ambulatory care arena and particularly in the small practice setting.

III. ACP'S VIEWS ON A LEGISLATIVE FRAMEWORK FOR VALUE BASED PURCHASING

The College recently released a detailed draft proposal for a legislative framework for Medicare that linked financial incentives to performance quality, which was shared with the staff of the Senate Finance Committee. ACP, along with other national organizations representing primary care physicians, also sent a letter to Congressional leaders that affirmed our joint commitment to work with Congress to develop effective legislation on Medicare quality improvement (Attachment 2). There are several key elements, as outlined in our recommended framework and in the joint letter that we believe should be incorporated into any legislation to establish a Medicare value-based purchasing program.

A. THE USE OF AQA PRINCIPLES IN A VALUE-BASED PURCHASING SYSTEM

First, it is critical that any value-based purchasing system that links physician reimbursement to evidence-based performance measures follow principles similar to those that guide the NQF and

AQA processes. For one, there must be an explicit role for a consensus-oriented multi-stakeholder group to select and validate quality and efficiency measures for clinical conditions and to evaluate issues of feasibility and meaningful data collection. It is absolutely necessary that this process be transparent. It is also important that adequate feedback be provided on why certain measures are not selected in order to allow the measures to be further refined and resubmitted and to ensure that the scientific evidence behind the measure, administrative feasibility of data collection, and other elements are well considered. This multi-stakeholder group must also have strong representation of national physician specialty societies in the leadership and governing board structure of the entity. The leadership of ACP and others in the AQA process has been essential for the credibility of the process, and we would hope to maintain a comparable leadership role in any new entities created by legislation.

B. THE USE OF EFFICIENCY MEASURES

Second, ACP supports evidence-based clinical performance measures in a value-based purchasing program that address overuse, underuse and misuse, but we are concerned that efficiency measurement will be driven by statistical economic profiling rather than a review of the clinical evidence. Appropriate quality measures take into account evidence to support or not support particular interventions based on evidence-based guidelines on overuse and underuse rather than just using a statistical profile of cost and volume. A strict volume/cost analysis derived from claims data for utilization patterns will not provide accurate data on quality or cost and should not be used to determine payments based on performance. Comparisons of utilization patterns are not a substitute for true efficiency measures that consider the quality *and* costs associated with treatment of particular conditions.

It is unlikely that a risk adjustment methodology will soon be developed that can adjust for all problems related to reporting on the efficiency of individual physicians in providing care to patients based on a comparative analysis of claims. Statistical comparisons need to take into account not only the need to risk adjust for severity of illness, but also for socioeconomic factors such as income, race, culture, and language proficiency, which significantly influence a patient's willingness to trust the health care provider and comply with recommended treatments. Without such adjustments, physicians who see a disproportionate number of low-income or racial/ethnic minority patients would be penalized for factors outside their control and dissuaded from participating in quality improvement programs. Quality improvement programs should not inadvertently exacerbate health disparities or create other unintended consequences for patients or physicians who have sicker patient populations as well as noncompliant patient populations.

C. PUBLIC REPORTING

Third, while ACP understands that public reporting *potentially* provides patients and purchasers with a more informed choice about physicians; public reporting can create severe adverse unintended consequences for patients if not done correctly. Studies show that public reporting can create unintended incentives for physicians to avoid higher risk or non-compliant patients that will result in their public report being less favorable. This is particularly a concern for patients with certain ethnic, racial, socioeconomic or cultural characteristics that make them less compliant with recommended treatments, less likely to see a physician for preventive care, and less likely to take prescribed medications. Sufficient risk adjustment and methodologies to reduce the risk that public reporting will create such unintended consequences are essential before physician-specific quality data are released to the public. In addition, many patients function at a health literacy level that makes it difficult for them to understand basic medical information given to them by their clinician, never mind comparative data on quality. More studies are needed on whether patients benefit more from seeing reports on whether or not their physician surpasses a minimum threshold of quality improvement or from ranking of physicians based on quality indicators. For this reason, the College

has advocated for a well-designed demonstration project on public reporting of quality improvement data.

ACP agrees with the Medicare Payment Advisory Commission (MedPAC) recommendation that physician performance profiling first be shared confidentially with physicians as an educational tool. Furthermore, ACP believes that when public reporting is implemented, physicians should be allowed to not only review data before it is released but to appeal it to an independent reviewer that would be charged with resolving concerns relating to the public report in a way that assures that all information that is reported is unbiased and accurate. Physicians should also have the right to have their comments on the report included along with the data that are reported.

D. A PHASED IN APPROACH

Fourth, ACP strongly supports a phased in approach to valued-based purchasing linked to physician performance. The College believes that a Medicare value based purchasing program should start with pay for achieving basic structural measures (pay-for-reporting), followed by payment for participating in quality improvement programs that use evidence-based clinical measures (pay-for-participation), followed by pay for achieving quality gains as measured by such evidence-based measures (pay-for-performance):

Stage One: Pay-for-Reporting

ACP recommends Medicare institute a *pay-for-reporting* initiative beginning in 2007 using a structure along the lines of the MedPAC recommendation to begin paying for structural measures (i.e., assessing whether the provider has the capability to deliver quality care) consisting of quality-enhancing functions and outcomes facilitated by the use of information technology (HIT) and other improvements. A process should be created for physicians to begin reporting during the calendar year that they have the structural capabilities to support quality improvement. Additional payments would then be allocated to physicians, during the same calendar year, who met the pay-for-reporting requirements.

Stage Two: Pay-for-Participation

ACP recommends that Medicare should institute a more robust and voluntary *pay-for-participation* program beginning in 2008 that would allocate additional payments (i.e., in addition to and separate from the annual Medicare fee schedule update) to physicians on a *graduated* basis who agree to voluntarily participate in quality improvement programs that use *evidence-based measures* for clinical conditions that have the greatest potential to yield the greatest quality improvements and potential system-wide savings stemming from improved quality. During the pay-for-participation phase, payment should be based on documentation of participation in such programs, not on how well the individual physician does in meeting the actual measures.

Such additional payments should be graduated and proportionate to the level of commitment on the part of the physician to participating in approved performance measurement programs. Because participation in performance measurement programs involves substantial costs (for HIT, data collection and reporting) and time commitment from physicians and their staffs, pay should increase proportionately based on the number of dimensions of care being measured, the number of measures, the time and costs associated with documenting performance based on the measures, and the level of HIT acquired by the practice to support participation in approved quality improvement programs. For example, physicians who just meet the basic structural measures as outlined in Stage One should receive a lower bonus payment than physicians who are participating in programs that use multiple evidence-based measures designed to improve care of patients with high cost chronic diseases. A graduated payment structure would create stronger

incentives for physicians to participate in performance improvement programs (and for specialties to develop evidence-based measures of performance) than paying all physicians the same amount regardless of their level of commitment to such programs.

Stage Three: Pay-for-Performance

ACP recommends that HHS be directed to consult with medical professional societies and other stakeholder groups on development of a *pay-for-performance* program that would be initiated no earlier than calendar year 2010. The pay-for-performance program would provide graduated bonus payments to physicians who demonstrate success in meeting evidence-based performance measures.

E. ASSURING SUFFICENT FUNDING

Fifth, the College believes it is essential that Congress assure adequate funding for the value-based purchasing program, starting with repeal of the sustainable growth rate (SGR) formula. The need for a long term solution for updating the Medicare physician fee schedule is underscored by continued projections of deep cuts. Despite Congress' success in preventing cuts from taking effect in 2003-2005, payment reductions of over 4 percent next year and 26 percent from 2006-2011 are forecast. The underlying flaw of the SGR formula is the link between the performance of the overall economy and the actual cost of providing physician services. The medical needs of individual patients are not related to the overall economy.

ACP strongly urges Congress to pass legislation to replace the SGR formula once and for all. In the future, annual updates in Medicare payments should instead be linked to increases in the actual costs of medical practice. ACP supports basing updates on the projected change in input prices less an adjustment for productivity growth, as has been recommended by MedPAC. Applying this methodology would result in a 2.7 percent increase in the fee schedule conversion factor next year and a similar increase in 2007 (currently projected to be 2.4 percent).

ACP also supports the MedPAC recommendation that volume should be managed through a process in which the reasons for each significant volume increase are identified, and specific measures be taken either administratively or through legislation to control those increases not related to improvements in quality of care. Addressing volume through careful analysis and consideration, with appropriate policy interventions, will be far more effective in assuring that appropriate care is provided than the flawed SGR.

IV. APPLYING ACP'S RECOMMENDED FRAMEWORK TO S. 1356

Again, we applaud the commitment of Chairman Grassley and Senator Baucus to creating a quality improvement program for Medicare and reaffirm our commitment to working with you and others in Congress in support of this shared goal. While we believe the "Medicare Value Purchasing Act of 2005 (S. 1356), has many positive elements, such as the strong emphasis on validating measures based on a multi-stakeholder process with strong physician input, we also believe that there are elements that should be revised to assure that the program truly provides an effective, realistic and practical pathway toward continuous quality improvement.

Our principal areas of concern relate to funding for the program and the impact of pending Medicare payment cuts to physicians; the timetable for phasing in the quality improvement measures; the substantial time gap between when physicians would begin reporting data and information and when they would be reimbursed; the linking of payment to comparative statistical measures that are not yet developed to the point where they can provide accurate data on the quality and appropriateness of care being provided by individual clinicians; and the need to develop better information on how best to report meaningful data to the public so that it facilitates informed decision-making without resulting in unintended adverse consequences to patient care.

While we strongly appreciate the Sense of the Senate language included in this legislation, ACP's support of any proposed pay-for-quality program is contingent on Congress also enacting legislation prior to the end of the year to stabilize physician payments in light of the flawed sustainable growth rate (SGR) formula. Congress must provide sufficient incentives for physicians to participate in the program without adversely affecting access to care. Performance improvement requires an investment of resources from physicians in health information technology (HIT) and process improvements that cannot take place if Medicare payments are cut due to the SGR.

Specifically, the College's support for the program is contingent on having an assurance that the 2006 and 2007 physician updates are set at a level that provides positive updates for all physicians and additional funds to physicians who meet the requirements for bonus payments related to reporting and participation in quality improvement activities. We propose that the levels recommended by MedPAC be accepted (2.7% for 2006), and that each physician at least receive a 1.5% update which aligns with payment for 2004 and 2005. A payment freeze in 2006 and 2007 would not provide sufficient funding for physicians to implement quality improvement programs in the current environment. Physicians are operating in an economic environment where their Medicare payments have not kept up with inflation. To continue the same payment level, while at the same time requiring further administrative burdens is not sustainable for our members.

The 2% reduction in the update for 2006 for physicians who do not submit quality data is of particular concern. Without knowing what the update will be, a 2% reduction could result in an untenable penalty on those who do not submit quality data while providing no incentive in terms of adequate funding for those who do. For instance, under current law, a 2% reduction in the update would result in a 6.3% cut for those who do not submit the quality data and a 4.3% cut for those who do. Although we understand and applaud you for your commitment to enact separate legislation to assure an adequate baseline update to physicians, the College cannot support a 2% cut in the update factor without knowing that the update will be sufficient to provide a positive increase for all physicians and additional monies for those meeting the reporting requirements.

Further, continued implementation of the quality improvement program beyond 2007 must be accompanied by a long term "fix" of the SGR problem so that sufficient funding would be available for physician payment increases to be tied to inflation with additional money (that grows over time) to fund a physician pay-for-performance quality bonus pool. For this reason, the College's support for continued transition to the value-based purchasing program in 2008 and thereafter is contingent on Congress enacting legislation to assure adequate updates to all physicians and sufficient dollars to fund the pay-for-quality program. It is important to note that the quality improvement programs that have worked well in the private sector have all had sufficient funding to ensure that physicians can successfully implement the programs.

As stated above, ACP generally supports the establishment of a phased in value-based purchasing program for Medicare that creates incentives for physicians to voluntarily participate in quality improvement programs. However, we do feel that an interim phase needs to be added to your bill to allow for a more seamless phase-in of the program. Please see section III D of this statement regarding the phased in approach recommended by ACP.

To make this program meaningful, there must be enough money to incentivize physicians who are able to adopt an accelerated timetable for implementation of quality reporting rather than paying all physicians the same amount regardless of their level of demonstrated commitment to quality improvement. We strongly recommend that the bill explicitly require the Secretary to reward effort — that is, those physicians who participate in programs that measure multiple dimensions of care involving an investment of resources in their practices should be rewarded more than those that are implementing only very basic reporting of structural measures or participating in a more limited number of dimensions of care. Bonus payments should increase proportionately based on the

number of dimensions of care being measured, by the time and costs associated with documenting performance, and the level of health information technology acquired by the practice to support quality improvement. A graduated payment structure would create stronger incentives for physicians to participate in quality improvement programs and continue increasing their level of participation. There will be a huge burden associated with implementing these programs into physician practices so the ultimate assessment of this legislation will be whether the burden is commensurate with the potential reward. We very much appreciate that the language specifies that a "majority" of the money goes to those exceeding thresholds, but the actual weight is at the Secretary's discretion. The legislation should instruct the Secretary to put more weight toward physicians demonstrating more commitment to quality improvement. It is imperative to the College that payment under this program be aligned with effort.

We also strongly request that the Secretary be instructed to expressly incorporate the law and regulation factor for the SGR so that any increase in volume and expenditures in categories of services measured by the SGR that result from participating in quality improvement programs will not lead to additional cuts in Medicare payments to physicians. Physicians must not be penalized under the SGR for volume increases that may occur due to compliance with performance measures. For example, many evidence-based measures require that physicians consistently provide certain services (tests, procedures, and referrals) that have been shown to improve health care quality, which could lead to an increase in total volume and expenditures for services that fall within the SGR. Similarly, the number and intensity of office visits may increase as physicians are required to see patients more frequently and to spend more time with them. Physicians should not be penalized under the SGR because they are providing care consistent with evidence-based measures.

The College is very concerned that efficiency measures have been broken out from the general evidence-based measures and are given separate consideration in the bill, primarily in the portion of Sec. 301 dealing with the Comparative Utilization System. We are also concerned about issues of risk adjustment, health disparities and public reporting. Please see sections III B and C of this statement regarding these issues.

The College objects to the provision that physicians participating in quality improvement programs are not paid for these activities until 12/31 of the following year. Further, we are very concerned that during Phase I, 2% would be withheld from Medicare payments to physicians and given back the following year for those reporting data. In essence, this constitutes a physician payment cut on 1/1/07 with no opportunity for physicians to receive additional payments until 12/31/08. We would like to work with the committee to explore alternative ways of approaching this issue.

The experience in the private sector shows that incentivizing quality improvement requires that the financial return to physicians who engage in such activities needs to be as immediate as possible. Deferred "rewards" will not be an effective incentive, particularly since physicians will need to make the upfront investment of resources in practice improvement at substantial cost. Further, payments to physicians are deferred in the bill for a much longer period of time than for hospitals and other providers. Fairness and equity should demand that at a minimum all providers be treated equally in terms of the timeliness of the bonus payments.

The College is pleased with the basic criteria for measures as mandated in the legislation including that they be evidence-based, reliable and valid, and feasible to collect and report. We also agree that the measures should include measures of process, structure, outcomes, beneficiary experience, efficiency, equity, overuse and underuse, as well as measures targeted at the frail elderly and those with multiple complex chronic conditions. We particularly appreciate that feasibility is a key requirement as that is important to protecting physicians from undue burdens. We also suggest adding explicit recognition that elements of care that are measured for performance should be elements that are directly attributable to physician decisions and actions. Finally, we are very pleased at the inclusion of measures of health information technology.

The College is also extremely pleased that the legislation includes an open and transparent process for a multi-stakeholder group to select and validate measures. We also greatly appreciate that the process described acknowledges a role for other entities such as the Ambulatory Quality Alliance (AQA) to evaluate issues of feasibility and meaningful data collection. Adequate stakeholder input is critical to the success of a Medicare quality improvement program, and we are very pleased that this is reflected in the legislation. We also greatly appreciate the requirement that the entity contracting with CMS not require membership dues, and that all parties have an equal vote as we believe these are appropriate criteria for this body.

V. ASSESSING THE IMPACT OF VALUE-BASED PURCHASING ON INTERNISTS

As Congress moves forward on developing a Medicare value-based purchasing program, we believe that it is essential that Congress be mindful of the potential impact on practicing internists and potential unintended adverse consequences.

Internists are encountering an aging population that requires substantial care and support as a result of an increasing number of chronic conditions. These practitioners, who provide the predominance of care to our Medicare beneficiaries, are also aware of the significant gaps in health care quality as reflected by the landmark Institute of Medicine report, *Crossing the Quality Chasm.* Our members are primed to meet this challenge to improve healthcare quality, safety and access, and make the necessary changes in their practices to better meet the needs of their patients. These changes include the increased need to coordinate care, to reach out to patients to ensure they are following their treatment regimens and to implement available health information technology (e.g. electronic health records, patient registries, e-prescribing, clinical decision support tools) into their daily office routine. These changes are difficult to make in an environment characterized by the specter of payment cuts throughout the foreseeable future. Repealing the SGR is an essential first step, but by itself, will not stabilize the economic environment for many internists sufficiently to allow them to provide high quality care and engage in continuous quality improvement.

For most primary care physicians, Medicare payments are not keeping up with their practice expenses. Many are reluctantly considering closing their doors to new Medicare patients or even getting out of practice. They worry that pay-for-performance will be another unfunded mandate, leading to more paperwork, more expense, less revenue, and less time with patients. They are concerned that it could create unintended adverse consequences for sicker and non-compliant patients. It is not just physicians in practice who express these concerns. Medical students do not see a future in primary care, as evidenced by the marked decline in recent years in the number of physicians who are being trained in general internal medicine and family practice.

Done correctly, value-based purchasing can help. By doing it right, it means assuring that Medicare money is sufficient to provide updates based on inflation and to create positive incentives for performance improvement. It means providing rewards commensurate with an individual physician's commitment of time and resources to support quality improvement. It means lifting up all boats rather than leaving some to founder. It means assuring that the data collection does not impose a heavy administrative burden. It means supporting the crucial role played by primary care physicians, working with a team of skilled subspecialist consultants, in assuring that patients get the best care possible. Most importantly, it means that better quality must be the measure of success; cost savings should be the *result* of quality improvement but never at its expense.

Primary care is at an important crossroads at this time. Fewer physicians are choosing to enter into primary care and those in the profession are expressing increased dissatisfaction. Primary care can be re-energized to the extent this current pay-for-quality discussion in Congress results in an improved payment system that adequately rewards physicians for providing the coordinated quality care required and implementing necessary practice changes. If the discussion results in a pay-for-quality

system perceived as punitive by our practitioners, replete with additional unfunded demands and unproductive "time stealers" from the physician and their staff, it can serve as the straw that figuratively breaks the camel's back and leads to an unfortunate acceleration in the shortage of primary care practitioners. Reduced access to primary care physicians would be very detrimental to our Medicare beneficiaries. The majority of Americans have demonstrated a preference for a sustained relationship with a primary care provider and studies indicate that a continuous patient-physician relationship correlates with patient satisfaction, improved health, positive outcomes, reduced malpractice litigation, as well as reduced emergency department use and reduced health care costs per patient.

VI. RE-EXAMING AND REFORMING DYSFUNCTIONAL PAYMENT POLICIES

Finally, the initial framework should be followed by a comprehensive re-examination of Medicare payment policies. Unfortunately, Medicare payment policies are based on the way that care was provided in *1965*—not the way it is being delivered today *or will be in the future*. When Medicare was created in 1965, patients generally were treated only when sick (acute condition); there was little or no emphasis on prevention and coordination; care was based on doctor's best judgment as informed by continuing medical education and journals but not on scientific guidelines; and payment was made only for work involved in a specific visit or procedure, not on results. Medical care today and in the future will involve treating patients' chronic conditions, not just acute illnesses; preventing and managing illness rather than just treating disease; care will be rendered by coordinated teams of health professionals; clinical judgment will be informed by evidence-based clinical decision support; and the results of care will be rewarded.

The College specifically advocates a new payment model to reward physicians for coordinating team-based care of patients with chronic diseases in a way that will result in better quality and potential cost-savings, including the work that falls outside of the traditional office visit, such as working with family caregivers on helping patients manage their own diseases and arranging for team-based care involving other health professionals. This "patient-centered, physician-guided" chronic care model is based on the work of Ed Wagner, MD, FACP and it provides physicians designated by beneficiaries as their "medical home" with payments based on their ability to effectively manage and coordinate care. We welcome the opportunity to discuss our ideas with the subcommittee.

VII. CONCLUSION

In conclusion, the College supports the goal of aligning Medicare's incentives with physicians' commitment to improve quality and we commend Chairman Grassley and Senator Baucus for their leadership on this issue. We look forward to working with you as this legislation moves through the legislative process.

As Congress moves forward on the legislation, we ask that you keep in mind two critical questions: will we end up with a system that supports the physician-patient relationship by providing resources to help physicians improve care of their patients? Or will it be a system that undermines that relationship, resulting in more paperwork, more expense, less revenue, and less time with patients? The College is dedicated to working with the subcommittee to assure that it is the first question, not the second, which gets a resounding yes from physicians and their patients.

August 3, 2005

Senate Committee on Finance
Attn. Editorial and Document Section
Rm. SD-203
Dirksen Senate Office Building
Washington, DC 20510-6200

To Whom It May Concern:

Enclosed please find a letter and attachment for inclusion in the record for the Senate Committee on Finance hearing, "Improving Quality in Medicare: The Role of Value-Based Purchasing," held on July 27, 2005 at 10:00 a.m. in 215 Dirksen Senate Office Building. Please let me know if you have any questions or concerns regarding this submission.

Sincerely,

Shawn R. Friesen
Government Affairs Associate
American College of Surgeons
Division of Advocacy and Health Policy
1640 Wisconsin Avenue, NW
Washington, D.C. 20007
Phone: 202.337.2701

July 26, 2005

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Max Baucus
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Grassley and Senator Baucus:

The undersigned surgical specialty organizations welcome the Senate Finance Committee's hearing on "Improving Quality in Medicare: The Role of Value-Based Purchasing." We are grateful for the accessibility that you and your staff have demonstrated in discussing proposals to link Medicare payment to quality improvement incentives, and we appreciate the public forum you are making available to continue these discussions and to provide an opportunity for studying the implications of value-based purchasing proposals for both physicians and patients. We also want to express our appreciation for your public statements about the need to address the upcoming Medicare physician payment reductions that threaten the financial viability of physician practices and patient access to care.

As the Committee on Finance continues to review these issues, especially the many practical concerns involved in developing a meaningful value-based purchasing program, it is important to keep in mind the diversity of physician practices and services. In particular, it seems that much of the discussion to-date has focused on ambulatory services such as chronic disease management and preventive care, with little acknowledgement of the very different concerns associated with acute care procedures or hospital-based care. Even within surgery, there are substantial differences between hospital and ambulatory services that must be taken into account. The implications and the strengths associated with such diversity must be assessed carefully if the changes that are being considered for the Medicare physician payment system are truly aimed at improving the quality and processes of patient care.

With that in mind, surgery offers the attached framework for consideration if Congress is to develop a broad-based quality improvement program for Medicare. This framework envisions a phased approach that begins with broadly applicable and relevant measures that can be reported by physicians through administratively simple means. The starter set of five potential surgical measures addresses key patient safety goals and can be implemented promptly. Over time, more complex specialty- and service site-specific measures and systems—including but not limited to those described in the document—can be developed to ensure broad applicability and participation across specialties and across sites of service.

Thank you again for your efforts on these issues. We look forward to working with you to repeal unsustainable cuts in Medicare physician payments and toward meaningful and practicable value-based purchasing under Medicare that preserves beneficiaries' access to quality surgical care.

Sincerely,

American Academy of Ophthalmology
American Academy of Otolaryngology—Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Surgeons
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of Plastic Surgeons
American Society of General Surgeons
American Urological Association
Congress of Neurological Surgeons
Society for Vascular Surgery
Society of American Gastrointestinal Endoscopic Surgeons
Society of Gynecologic Oncologists
Society of Surgical Oncology
The Society of Thoracic Surgeons

cc: Members of the Senate Finance Committee

DEVELOPING A QUALITY IMPROVEMENT FRAMEWORK FOR SURGICAL CARE

Surgical organizations have long stood for quality and safety. They were among the first to champion peer review reporting in morbidity and mortality conferences, and were at the forefront of developing standards for the facilities in which surgical care is provided. Although surgeons continue to advance evidence-based care, surgical specialists and the research and processes they have developed have largely been omitted from recent debates on ways to report and measure healthcare quality in a Medicare pay-for-performance program. Instead, the focus has been principally on public health and primary care services, and on processes that are relatively simple to measure through ambulatory service claims. If policymakers begin to pursue the development of pay-for-performance, surgical participation is vital.

It is important to highlight key distinctions in surgical quality improvement from preventive and chronic care quality measures. For example, surgery is more episodic and less focused on chronic disease management, preventive services, and screening. In surgery, the ultimate outcome produced by a specific intervention is much more immediate and clear than disease management strategies that may span many years. As a result, surgery lends itself much more readily to rigorous clinical outcome measurement. And, while it is typical for generalist physicians to see a wide array of patients, surgeons tend to have more focused areas of practice that make it difficult to apply broad quality measurement sets. Administrative records other than the operative report—such as claims records--provide much less useful information about processes of care because of the way surgery is packaged and billed. Finally, successful patient management in a primary care setting generally results in increased utilization of preventive services. In surgery, "more" rarely means "better" care. For surgery, the best measures focus on elaborate decision-making processes that call for direct action to determine the right procedures, at the right time, for the right patient. Surgical quality initiatives limit acute complications and provide immediate cost savings, with enhanced outcomes and improved operational efficiencies through process development.

Of course, individual physicians and specialties are in different stages of preparedness for participation in meaningful pay-for-performance programs. Some individuals do not have access to sophisticated information technology that facilitates participation, and some specialties have yet to develop the rigorous clinical evidence that is needed to identify processes of care that improve patient outcomes. Nonetheless, there is general consensus among leading surgical societies on an overall framework for any program intended to promote high-quality surgical care.

We envision a phased approach that will afford a process of continuous improvement in the overall quality of surgical patient care while allowing further progress on the development, testing, and refinement of new measures.

First Phase

Phase I would essentially implement a "pay for reporting" system focusing on administratively simple, self-reported information about processes that are widely accepted and promoted for their contribution to improving patient safety and advancing the principle of patient-centered care—which are among the aims included in the Institute of Medicine's framework for improving the health care system, *Crossing the Quality Chasm*. In this phase, which can be implemented through claims-based reporting, we envision a set of standards that assures the surgeon's role in improving quality and safety. These standards might include the following:

- **Confirmation of Operative Site and Side.** While rare, wrong-site or wrong-patient operations do occur. A wide range of physician organizations and specialty societies, along with other provider groups, payers, and accreditation organizations have not only called on surgeons but also on surgical team members and patients to ensure that the operative site is appropriately signed and confirmed by either the patient or a representative for the patient. So-called "sign

your site" programs have been endorsed by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Agency for Healthcare Research and Quality (AHRQ), Department of Veterans Affairs (VA), American Academy of Orthopaedic Surgeons, American College of Surgeons (ACS), and other national organizations representing surgical specialists and perioperative nurses.

- **Pre-Operative "Time-Out."** When errors do occur in the operating room, poor communication among surgical team members is often cited as a key cause. In addition, after signing the site for surgery, a variety of circumstances, such as a change in scheduling or operating rooms, can occur and potentially lead to a wrong-site or wrong-patient procedure, or to an operation for which the surgical team lacks the necessary tools or equipment. For these reasons, a broadly-endorsed technique known as the surgical "time-out" --a checklist type process based on airline safety practices—should occur prior to making the surgical incision. This process is currently endorsed and promoted by JCAHO, AHRQ, the VA, and a variety of national organizations representing members of the operating room team, including ACS.

- **Immediate Post-Operative Documentation.** In addition to improving communication through a pre-operative time-out for the surgical team prior to surgery, an important aspect of patient care is to prevent so-called "hand-off" errors by ensuring that those who provide post-operative care have essential information about the patient's condition. Prompt documentation in a brief post-operative report by the surgeon that includes any specific directives for care can help ensure that the post-operative health care team is prepared for potential complications that may need to monitored or addressed. This practice fulfills one of JCAHO's 2006 National Patient Safety Goals across various care settings.

- **Post-Operative Pain Management.** Pain management is an important but sometimes neglected component of a patient's treatment and important in speeding recovery. Surgeons need to incorporate into their post-operative care processes discussions with their patients about the level of their pain, followed by appropriate pain management. The Centers for Medicare and Medicaid Services (CMS) included pain management in its demonstration project for cancer patients undergoing chemotherapy; in addition, the CMS and AHRQ Hospital CAHPS venture surveys patients regarding the management of pain provided by their hospital.

- **Appropriate Post-Operative Care.** As important as the care the patient receives in the hospital is the care and the directives for care that the patient receives upon discharge. These follow-up steps may include: 1) scheduling post-operative visits with the surgeon or other relevant providers; 2) prescribing medications with the necessary instructions; 3) counseling for particular patient lifestyle choices, such as smoking cessation;

  4) directives for patient representatives regarding care for the patient at home; and 5) any other directives appropriate to the patient's condition, such as wound care.

These measures are broadly applicable across surgical specialties and across sites of services, and should be reportable through relatively straightforward administrative mechanisms. In addition, they are likely to have an immediate positive impact on the quality of care and, taken as a group, will produce little if any increase in service utilization. Indeed, collectively they may well produce system cost savings by preventing complications.

Second Phase

Phase II of Medicare's pay-for-performance program could call more directly for surgeons to "pay for participation," and involve targeted goals that rely on more complex process and outcomes measures that are applicable to broad service categories. For surgical care provided in the hospital setting, a widely endorsed set of measures that is applicable to most surgical specialties is incorporated into the Surgical Care Improvement Program (SCIP). SCIP addresses the following surgery-related quality and safety issues:

- **Surgical site infections** (SSIs) account for 14 to 16 percent of all hospital-acquired infections and are a common complication of care, occurring in 2 percent to 5 percent of patients after clean extra-abdominal operations and up to 20 percent of patients undergoing intra-abdominal procedures. Among surgical patients, SSIs account for 40 percent of all hospital acquired infections. By implementing projects to reduce SSIs, hospitals could recognize a savings of $3,152 and reduction in extended length of stay by seven days on each patient developing an infection. Among the practices known to prevent surgical site infections are timely administration and proper duration of antibiotics, glucose control, and proper hair removal.

- **Adverse cardiac events** are complications of surgery occurring in 2 to 5 percent of patients undergoing non-cardiac surgery and as many as 34 percent of patients undergoing vascular surgery. Certain perioperative cardiac events, such as myocardial infarction, are associated with a mortality rate of 40 to 70 percent per event, prolonged hospitalization, and higher costs. Current studies suggest that appropriately administered beta-blockers reduce perioperative ischemia, especially in patients considered to be at risk. It has been found that nearly half of the fatal cardiac events could be preventable with beta-blocker therapy.

- **Deep vein thrombosis** (DVT) occurs after approximately 25 percent of all major surgical procedures performed without prophylaxis, and **pulmonary embolism** (PE) occurs in 7 percent of operations conducted without prophylaxis. More than 50 percent of major orthopaedic procedures are complicated by DVT, and up to 30 percent by PE, if prophylactic treatment is not instituted. Despite the well-established efficacy and safety of preventive measures, studies show that prophylaxis is often underused or used inappropriately.

- **Postoperative pneumonia** has been associated with high fatality rates, according to the Centers for Disease Control and Prevention (CDC). Postoperative pneumonia occurs in 9-40 percent of patients and has an associated mortality rate of 30-46 percent. Studies have found that many of the factors that can lead to post-operative pneumonia respond favorably to medical intervention and so are preventable. A conservative estimate of the potential savings from reduced hospitalization due to postoperative pneumonia is $22,000 to $28,000 per patient per admission. Again, SCIP proposes tests that can be applied to test whether prevention strategies for postoperative pneumonia have been followed.

The SCIP measures were proposed in a partnership that includes CMS, AHRQ, CDC, VA, JCAHO, ACS, and other national organizations representing members of the surgical team.

Employing the SCIP criteria in a pay-for-performance program would involve coordinated efforts with hospitals and with Medicare's quality improvement organizations. Indeed, since hospital adherence to the SCIP protocols depends on surgical leadership, one way to align hospital and physician incentives in the payment system would be to pay "bonuses" to surgeons who refer their patients to hospitals participating in the SCIP.

Of course, because SCIP measures focus on hospital care, other widely-accepted and clinically relevant goals, processes, and measures must be developed that are appropriate for physicians and surgeons whose practice is narrower in scope and those who practice in non-hospital settings. Participation by the relevant professional organizations is key to this effort, as is adequate time for pilot testing and implementation.

Third Phase

Phase III, the most forward reaching effort, would place greater emphasis on the outcomes of surgical care. Such quality initiatives will require large infrastructures to house and analyze data and to provide the professional expertise to define, refine, and report on quality and outcomes. This phase will also involve professional review of outcomes data that, in turn, will produce new performance processes

that will further improve care. It may be possible during this stage to benchmark performance of individual surgeons for the purpose of public reporting.

Surgery generally accepts the principle that reporting on outcomes provides the first step in a multi-step process toward quality improvement. Once risk-adjusted outcomes are identified, we can define opportunities for improving care and even highlight areas of exceptional care, and then use expert panels of clinicians to identify the processes that are involved in high-quality care delivery.

Various patient databases can be used to launch this effort, including some developed in the private sector by surgical organizations such as ACS and the Society of Thoracic Surgeons (STS). The National Surgical Quality Improvement Program (NSQIP), developed first by the VA and now under development in the private sector by ACS, as well as the STS National Database for cardiac surgery, hold promise for providing the data and measures needed to identify the processes that improve patient care.

Again, it is important to keep in mind that specialties are in various stages of preparedness in developing and adopting such systems, and this must be accounted for in any pay-for-performance framework that is ultimately adopted. This is particularly true for office-based practices and those in smaller communities where resources are more limited. Further, adequate time for developing and pilot testing new measures and processes is essential, because of the considerable risks associated with implementation of poorly constructed data collection and reporting systems.

For this phase, in particular, the administrative investments will be significant and the potential for Medicare program costs savings outside the physician fee schedule can be substantial. So, alternative means of financing performance awards (e.g., shifting unspent funds from Medicare Part A to Part B, broader allowance of so-called gain-sharing, and so forth) must be developed.

Pay-for-Performance

It will be challenging to produce payment incentives that are fair for all physicians and across specialties and service settings. Nonetheless, surgery generally agrees that a Medicare performance-based payment system should incorporate the following principles:

- The primary goal of pay-for-performance programs must be improving health quality and safety.
- Physician participation in pay-for-performance programs must be voluntary, and a non-punitive audit system should be implemented to ensure the accuracy of data.
- Because of differences across specialties and in the federal government's ability to collect and analyze meaningful data, any Medicare pay-for-performance program must be pilot tested across settings and specialties and phased-in over an appropriate period of time.
- Practicing physicians and their professional organizations must be involved in the design of Medicare pay-for-performance measures and programs.
- Physician performance measures used in Medicare pay-for-performance programs must be evidence-based, broadly accepted, and clinically relevant. The metrics must be fair and balanced across specialties and developed using evidence-based work or consensus panels of expert physicians. They must also be kept current to reflect changes in clinical practice.
- Physician performance data must be fully adjusted for case-mix composition including factors of sample size, age/sex distribution, severity of illness, number of co-morbid conditions, and other features of physician practice and patient population that may influence the results. The program should foster the patient-physician relationship, and must not discourage physicians from treating patients with significant health problems or complications out of fear that they will have a negative influence on quality scores and reimbursement. There also must be a mechanism for exceptions

to pay-for-performance compliance metrics for clinical research protocols, and in situations where measures are in conflict with sound clinical judgment.

- Performance measures should be scored against both absolute values and relative improvement in values, as appropriate.

- Medicare must positively reward physician participation in pay-for-performance programs, including physician use of electronic health records and decision support tools. Pay-for-performance programs must also compensate physicians for any administrative burden for collecting and reporting data.

- Pay-for-performance programs must not be budget neutral within the Medicare physician payment system or be subject to artificial Medicare payment volume controls such as the sustainable growth rate mechanism. Pay-for-performance programs should not penalize physicians for factors beyond their control.

- For surgical procedures performed in the hospital setting, the processes that improve care frequently involve a surgeon-led team approach. Many of these processes are directed toward preventing costly complications, reducing length of stay, and avoiding readmissions, which substantially reduce hospital costs covered under Medicare Part A reimbursements. Mechanisms must be established to allow performance awards for physician behaviors in hospital settings that produce cost savings outside the physician fee schedule.

- Physicians must have the ability to review and correct performance data, and those data must remain confidential and not subject to discovery in legal proceedings.

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STATEMENT

of the

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE

to the

COMMITTEE ON FINANCE
UNITED STATES SENATE

on

"IMPROVING QUALITY IN MEDICARE: THE ROLE OF VALUE-BASED PURCHASING"

July 27, 2005

Washington, DC

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The National Association for Home Care & Hospice (NAHC), the nation's largest organization representing home care and hospice agencies and the patients they serve, appreciates this opportunity to provide our views regarding "Improving Quality in Medicare: The Role of Value-Based Purchasing." We commend the efforts of the Chairman and Members of the Senate Finance Committee to ensure that quality care is delivered in the Medicare program. We at NAHC have long been committed to the delivery of high quality home and hospice care, and believe that quality should be acknowledged and rewarded.

The home care community has actively supported efforts to develop quality measures over many years. NAHC was among the first organizations to support development of the Outcome and Assessment Information Set (OASIS) to measure outcomes in the home health field, a data set that has been used not only to measure quality but also to determine reimbursement under the home health prospective payment system. With significant input from home care providers, CMS has developed Outcome-Based Quality Indicators and created a website titled "Home Care Compare" that reports on the quality of care provided by home health agencies nationwide through use of 11 outcome measures taken from OASIS data. These measures are currently being revised, but concerns persist about the adequacy of the measures. Nevertheless, NAHC joined HHS Secretary Tommy Thompson and CMS Administrator Tom Scully in celebrating the unveiling of Home Care Compare to help Medicare beneficiaries choose a home health agency based on their quality of care performance.

PAY FOR PERFORMANCE LEGISLATION

The Medicare Value-Based Purchasing Act of 2005 (S. 1356), introduced by Chairman Grassley and Ranking Member Baucus, would establish within the Medicare home health benefit a value-based payment system, often referred to as "pay for performance." It would provide payment incentives for agencies to provide good quality care through the use of performance measures.

We commend the provisions in the bill that call for extensive stakeholder involvement and input into the development of the performance measures by CMS. We hope that out of this process quality standards will be adopted that fairly assess performance and do not negatively affect patient access to care. The first principle of medicine, "Do No Harm," should also apply as we embark on value-based purchasing.

LACK OF APPROPRIATE QUALITY INDICATORS TO MEASURE PERFORMANCE FAIRLY

Considerable investment has been put forth in recent years to develop quality measures in the home health setting that accurately assess performance. Despite these efforts, existing measures fall short of the ideal in terms of conveying a clear picture of the impact of care provided on patient outcomes. The OASIS data set, for example, was developed over a ten year period, yet a number of problems related to the validity of these measures remain unresolved. The Centers for Medicare and Medicaid Services

(CMS) has been working on OASIS refinements for the past several years in an effort to correct underlying problems.

More recently, in 2004, the National Quality Forum (NQF) undertook work to identify home health quality measures. In the investigation NQF identified 81 potential measures. After initial evaluation the number of acceptable measures was reduced to 28. Included were both outcome and process measures. However, upon completion of the full NQF approval process only 15, all outcome measures based on OASIS, were approved by the NQF Board of Directors.

Of the 15 measures identified by NQF as appropriate quality indicators for home health, many have underlying shortcomings that indicate their use for payment rewards may be improper. For example, the outcome for independence in medication management is limited in that it fails to recognize successful teaching of caregivers in cases where home health patients lack the capacity to be totally independent with their own medication management. NQF recommended further research on home health measures that would remedy these shortcomings, including the failure of OASIS outcomes to measure quality in the chronic care patient population

OASIS outcomes measures are not available to small providers, despite the fact that they collect OASIS data, because they have an insufficient number of patients needed to produce statistically significant results.

Only a few process measures, which assess whether best medical practices have been followed, were identified for inclusion in the initial rounds of assessment by NQF. These were later eliminated because of lack of research and evidence of validity in the home health setting.

CRITICAL IMPORTANCE OF RISK ADJUSTMENT

Quality measures must be risk adjusted to form the basis for a fair assessment of an agency's performance. Socio-economic factors play a major role in health outcomes, as those with limited incomes and limited education are at a severe disadvantage in accessing health services and in navigating the health care system. Dual eligible individuals who must rely on Medicaid have been shown to suffer worse outcomes. Those who live without the assistance of a willing informal caregiver typically have poorer outcomes. Those who are unable to understand and comply with medication regimens do not do as well as compliant patients. Those who engage in risky behaviors beyond the control of their caregivers, such as smoking, will often do poorly. None of these factors are within the control of a home health agency, yet they have a profound impact on outcomes.

The Medicare home health benefit provides only part time or intermittent services, which also limits the control that a home health agency has over patient outcomes. Moreover, patients see many different providers during a spell of illness. They may see a succession of physicians and receive care from a hospital or skilled

nursing facility at various intervals while they are sporadically cared for by a home health agency. It would be inappropriate to hold the home health agency responsible for a bad outcome when poor care was delivered by another provider or the home health agency had not had adequate opportunity to care for the patient. Insuring that accurate risk adjustment is included in the system is key to its success.

NEED FOR PROCESS MEASURES

We believe it would be premature to initiate a reward system based upon the outcome measures that have been developed thus far. Although they identify some measures of the status of individuals at the end of care, they cannot be relied upon solely as proof that the care produced the results. Process measures that assess whether best medical practices have been followed are needed together with outcome measures. These process measures should be scientifically tested and identified as effective in producing good outcomes to ensure that quality care was provided by the home health agency.

From our past experience with CMS implementation of OASIS data collection and home health outcome reports, we believe that it will not be possible to develop evidence-based, reliable, and valid measures of quality, including process measures, in the time frame contemplated by this important legislation. For this reason we urge that the new value-based purchasing system be pilot tested before full implementation.

Reliance on outcome measures alone could have a harmful effect on patient access to care. It would create incentives for agencies to avoid hard to care for patients, a practice often called "cherry-picking," who pose a risk of a poor outcome because of factors beyond the agencies' control.

ACCURATE CODING ESSENTIAL

Reliance on outcome measures alone would also provide an incentive to manipulate the coding of patients so as to maximize their acuity at the outset of care and show the greatest improvement at the conclusion of care. Agencies could manipulate the data, either intentionally or through lack of training in accurate coding. This would have to be carefully monitored. CMS efforts to educate providers about how to accurately code patients under OASIS have been under-funded and would need to be enhanced.

UNIQUE PROBLEMS OF SMALL AGENCIES AND THOSE LOCATED IN RURAL AND INNER CITY AREAS

There are particular problems with using outcome measures for small agencies. Their caseloads are frequently not large enough to meaningfully assess quality through outcome measures. Even one patient outcome for a very small agency could unfairly skew the results. Rural and inner city agencies will also be disadvantaged because of the at-risk populations they serve.

SPECIAL CONSIDERATIONS IN DEVELOPING TECHNOLOGY MEASURE

Since the bill provides that at least one of the quality measures relate to the use of technology, we believe it important that special care be given that initial technology measures chosen are within agencies' ability to finance. Likewise, we are concerned that small agencies may not be able to afford the latest technologies and urge legislative support for programs to provide them with assistance in acquiring them.

NEED FOR PILOT TESTING

Before such a major system change is implemented, it would be prudent to conduct a pilot program to test out how effectively the selected measures assess the quality of care provided and whether the system encourages improper behavior such as patient "cherry-picking" and coding manipulation. This is especially important in light of the fact that the bill could increase data collection costs, reduce payments for some providers, and delay receipt of full payment for all providers for as long as two years. This could cause considerable hardship for many home health agencies, over a third of which are currently losing money under the Medicare program. Also, overall agency margins from Medicare, Medicaid, and other payment sources combined stand at about 1.2 percent, so a cut of 1 to 2 percent to pay for the new value-based purchasing system will have a significant impact.

PILOT PROPOSAL

Reducing provider reimbursements to finance bonus payments should only be incorporated once the system has been perfected through a well crafted pilot program. The following is a proposal for pilot testing pay for performance submitted by NAHC, the American Association for Home Care (AAHomecare), and the Visiting Nurse Associations of America (VNAA):

1) Require that the Secretary develop the new quality measures that are risk adjusted and valid (process, etc.) with input from stakeholders by the end of '06.
2) Begin requiring collection of quality data 1/1/07, assuming risk adjusted and valid quality measures have been determined by then, with stakeholder involvement.
3) Implement pay for performance pilot project beginning 1/1/08.
4) The Secretary would choose agencies that apply to participate in the pilot. Selections would be made to ensure that the sample would be representative and sufficient to provide usable results. For example, the Secretary might choose agencies from five geographically diverse states with representation from both rural and urban agencies. The pilot would not have to actually withhold funds and make bonus payments; instead it could assess from the quality data submitted who the winners and losers would have been and how effective the data is for assessing quality.
5) Depending on the testing of quality measures from the pilot project, the Secretary and stakeholders should determine if there is consensus on whether such measures

accurately measure quality care. When consensus is reached (no later than January 2010), then proceed to begin implementation of pay for performance.

FLEXIBLE TIMELINE

Given the limited experience federal payers have with pay for performance, CMS should not be locked into a rigid timetable for full implementation of pay for performance. After the extensive stakeholder input from expert panels envisioned by the legislation, CMS could decide that going forward with a starter set of quality measures and a reduction in provider payments was too risky without adequate testing and evaluation. CMS should be granted the authority to revise its implementation strategy if the timeframes laid out are problematic.

NEED TO PRESERVE FULL FUNDING FOR HOME HEALTH CARE TO ENSURE QUALITY CARE

We note that there is a sense of the Senate provision in the bill that calls on Congress to prevent cuts in Medicare payments to physicians in light of the fact that physicians will be taking on the added burdens of implementing a new pay for performance system. Given that the home health payment system has undergone considerable change in recent years, and agencies have sustained both real cuts and reductions to their inflation updates, it would be particularly reassuring if a provision were included expressing the intent that under a pay for performance system providers' inflation updates be preserved (rather than reduced to meet deficit reduction targets).

Medicare home health funding was nearly cut in half since 1997 and the benefit is serving almost a million fewer patients today. The proportion of total Medicare spending allocated to home health care has dropped from about 9 percent in 1997 to 3.8 percent today, and CMS projects that it will drop to 2.6 percent by 2015. Maintaining full funding for home health care would make the greatest contribution to ensuring that quality health care is provided in the home.

CONCLUSION

We look forward to working with the Chairman and members of the Finance Committee on this initiative to ensure that Medicare beneficiaries have access to high quality care. We appreciate your support for those who wish to receive care in their homes and communities.

Statement for the Hearing Record

Submitted by

Premier, Inc.

U.S. Senate Committee on Finance

**"Improving Quality in Medicare:
The Role of Value-Based Purchasing"**

July 27, 2005

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Statement for the Hearing Record
Submitted by Premier, Inc.

U.S. Senate Committee on Finance
"Improving Quality in Medicare: The Role of Value-Based Purchasing"
July 27, 2005

On behalf of its nearly 1,500 allied not-for-profit hospitals and health systems across the U.S., Premier, Inc. appreciates the opportunity to provide a statement for the record of the Senate Finance Committee hearing, entitled "Improving Quality in Medicare: The Role of Value-Based Purchasing." Premier is dedicated to facilitating its hospitals' and affiliated care sites' achievement of high clinical quality and financial performance. Premier applauds the leadership demonstrated by Finance Chairman Charles Grassley (R-IA) and Ranking Member Max Baucus (D-MT) in the area of healthcare quality improvement through the introduction of S.1356, the "Medicare Value Purchasing Act of 2005."

Premier, Inc. is a strategic alliance in U.S. healthcare, entirely owned by 200 of the nation's leading not-for-profit hospital and healthcare systems. These systems operate or are affiliated with approximately 1,500 hospital facilities in 50 states and thousands of other care sites. Premier provides an array of resources in support of health services delivery in the key areas of supply chain improvement, group purchasing, comparative data, benchmarking, and insurance. Premier Healthcare Informatics offers performance measurement, benchmarking, reporting products, and related advisory services and methodologies to support health systems' and hospitals' quality improvement efforts. For more information about Premier Healthcare Informatics, visit www.premierinc.com/informatics.

CMS/Premier Hospital Quality Incentive Demonstration Project

Since October 2003, Premier has partnered with the Centers for Medicare and Medicaid Services (CMS) in the CMS/Premier Hospital Quality Incentive (HQI) Demonstration Project. The HQI demonstration is designed to determine whether economic incentives are, in fact, effective at improving the quality of inpatient hospital care. Currently underway with more than 270 hospitals participating nationwide in 38 states, the participants represent 29.9 percent rural and 70.1 percent urban; 26.8 percent teaching and 73.2 percent non-teaching hospitals. The three-year project tracks hospital-specific performance on a set of standardized and widely accepted clinical quality indicators for heart attack (acute myocardial infarction, or AMI), congestive heart failure, community acquired pneumonia, coronary artery bypass graft (CABG), and hip and knee replacement patient populations. Incorporating 34 measures across the five aforementioned conditions, quality measurement in the HQI demonstration has greater depth and breadth than Medicare's Hospital Compare initiative. The latter tracks 17 measures for three conditions, and reporting ten of them secures hospitals' receipt of full-inflation payments updates until 2007.

The HQI demonstration is the first-ever national test of performance-based payments/incentives, across a broad array of acute care conditions, in Medicare. It is designed to recognize and provide financial reward (i.e., greater Medicare reimbursement or bonus payments) to hospitals demonstrating higher quality performance. Such reward would come in the form of annual incentives paid to top performers. Participating hospitals are categorized by clinical area—AMI (myocardial infarction); CABG (coronary artery bypass graft); community-acquired pneumonia; heart failure; and hip/knee replacement. Those that perform in the top 10 percent of a clinical area—for instance, CABG—will see a 2.0 percent increase in their applicable Medicare base rates. Under the same guidelines, hospitals performing in the second decile will receive a 1.0 percent boost for the clinical area in which they are measured.

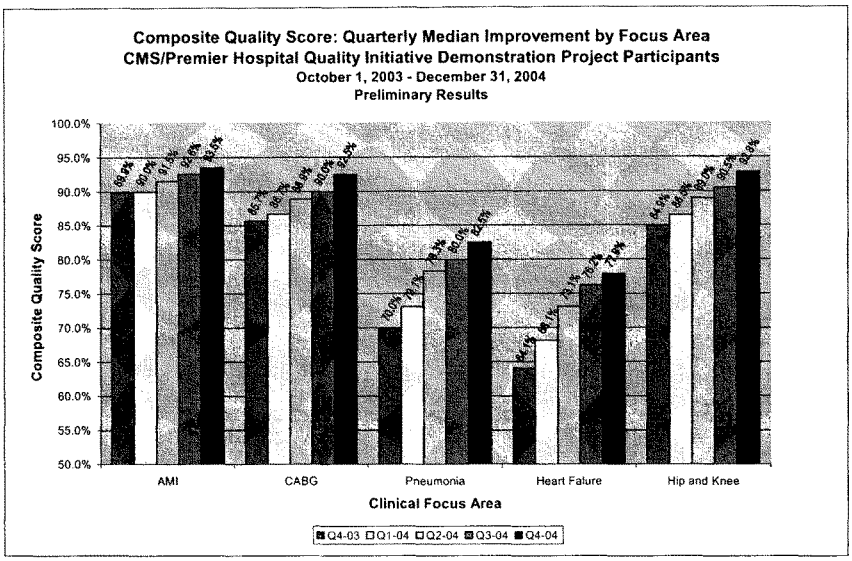
Scores are calculated at least semi-annually, and bonus payments are distributed annually in a lump sum. In the third year of the project, hospitals that fail to improve their performance in a specific clinical area beyond a *minimum threshold* established in the first year be subject to a payment *reduction* of 2.0 and 1.0 percent for the bottom and second-to-bottom deciles, respectively. Thus, hospitals are motivated by bonus payments to improve as well as hold the gains achieved during the project and by the threat of penalties to surpass the minimum threshold.

CMS estimates that Medicare will pay approximately $7 million each year in additional payments to "top performers" in the demonstration, for a total of $21 million over the three-year period. CMS anticipates that the project will be budget neutral based on assumptions that as quality increases, the cost of care should decline due to fewer readmissions, complications and unnecessary treatments. An analysis is curently being conducted by CMS to evaluate the savings.

Promising Early Results among Participating Hospitals

In May 2005, CMS released preliminary data and analysis from the first four quarters of the demonstration. The early returns revealed a clear trend toward significantly improved quality among participating hospitals across *all* clinical conditions tracked. Premier is pleased to be able to share data from an additional, fifth quarter with the Finance Committee today, which show even greater improvement than the previous quarter. The performance scores for each clinical condition are as follows:

- Acute myocardial infarction has improved by 3.6 percentage points since the demonstration began;
- Coronary artery bypass graft (CABG) has improved 6.8 percentage points (compared to a 4.0 percent improvement reported in the fourth quarter);
- Pneumonia has improved 12.5 percentage points (2.5 percentage points higher than was reported in the fourth quarter);
- Heart failure has improved 13.8 percentage points; and
- Hip/knee replacement has improved 7.9 percentage points.



Among the more than 270 HQI participants, we have observed improvement ranging from 12 to 33 percent across the measure areas. The average improvement across all 34 measures is over 10 percent. These improvements push the decile thresholds increasingly upward. In fact, with several metrics, such as aspirin prescriptions for open heart surgery patients (coronary artery bypass graft — CABG), have reached nearly 100 percent compliance. As was expected before the project's launch, a renewed focus on standard processes and clinical consistency has led to improved scores across the board. In fact, within the pneumonia focus area, a hospital that had ranked in the 10th decile in the first quarter of the project improved its overall quality score by 54 percent across the five quarters to reach top decile. *In addition to the rising thresholds, the data shows a compression of the ranges, or a reduction in variation, across project participants.* This is significant because reductions in variation and increased reliability in clinical care are directly related to positive quality outcomes.

Lessons Learned from the HQI Demonstration

Premier has conducted site visits with top-performing hospitals to document best practices and share them with other participants and the rest of the healthcare community. These site visits have revealed that the improvements necessary to achieve top performance need not be onerous, expensive or dependent on technology.

Key lessons learned to date include the following:

- *Leadership and culture are critical.* Top-performing hospitals make quality of care a core value and a chief priority. They also compete in the marketplace on quality.

Quality is the priority of the executive team, which actively engages physicians in the process of quality improvement. Top-performing hospitals prioritize the implementation of best practice methodologies and dedicate resources to ensure their success.

- *Clinicians must be engaged in actively harvesting and disseminating best practices.* Clinicians must be engaged in quality improvement activities guided by improvement methodologies and change theory, based on valid data. Established, evidence-based best practices are quantified and documented, and collaboration forums are used to exchange real results. Top performers actively implement these practices and track progress over time.

- *A focus on process improvement is crucial:* Effective improvement strategies begin with evaluation of processes for improving care delivery. Significantly, the technology infrastructure at individual facilities is not necessarily a barrier to process improvement. Simple solutions such as posting signs on operating suite doors stating "Stop – Have pre-op antibiotics been given?" can lead to significant improvements in outcomes. Improving ineffective processes, regardless of technology sophistication, has led to significant quality improvement among the diverse hospitals participating in the project.

Premier is sharing these 'lessons learned' from the demonstration with broader audiences at national conferences and teleconferences, and improvement resource publications. Further, top performers are sharing their processes and results with peer institutions and other healthcare providers in an effort to bring clinical quality to the forefront of the industry, regardless of participation in the project.

Recent Evidence Suggests Financial Incentives Do Increase the Pace of Performance Improvement

In a recent study[1], the following question was explored: "Did hospitals participating in the HQI demonstration project have significantly different rates of improvement in quality performance compared to similar hospitals within the same health system that did not participate in the first year of the voluntary demonstration project? Within the system studied, four hospitals joined the HQI demonstration project, and six opted not to join. The study limited analysis to three of the five clinical areas included in the HQI demonstration project: acute myocardial infarction (AMI), heart failure, and pneumonia. While both participating and non-participating hospitals improved over the year studied and both performed above national averages for these conditions, the hospitals participating in the HQI demonstration project improved at a faster rate than the non-participants and achieved significantly higher composite quality scores in the three clinical areas studied.

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[1] Grossbart, Stephen (2005). "What's the return? Assessing the effect of 'Pay-for-Performance' initiatives on the quality of care delivery." Boston, Academy Health, June 26, 2005, http://www.academyhealth.org/2005/ppt/grossbarts.ppt.

Medicare Value Purchasing Act of 2005

Pay-for-performance initiatives, if thoughtfully implemented, have great potential to improve quality of care. For that reason, Premier appreciates the support for pay for performance that Senators Grassley and Baucus have demonstrated with the introduction of the "Medicare Value Purchasing Act" (S. 1356). The introduction of this legislation represents an initial step in advancing health care quality improvement in Medicare.

The Grassley-Baucus legislation is consistent with the HQI demonstration in that it seeks to use validated quality measures and indicators that are widely accepted among stakeholders. Successful implementation of pay-for-performance programs requires that all stakeholders participate in the design and selection of measures.

Beyond this crucial, common approach to identifying measures, the hospital provisions in the Grassley-Baucus legislation differ from the HQI demonstration in some key respects:

- *Opportunity to achieve bonus payments and avoid penalties:* The HQI demonstration awards bonus payments to top performers on an annual basis. In each clinical area, hospitals in the top ten percent receive a 2.0 percent increase in payments for that area, and hospitals in the second decile receive a 1.0 percent increase. *In the third year of the project*, hospitals that fail to improve their performance in a specific clinical area beyond a *minimum threshold* established in the first year of the project will be subject to a payment reduction of one or two percent. It is significant that all hospitals have the opportunity to avoid a reduction in Medicare payments by reaching the minimum threshold. This incentive arrangement differs from the Grassley-Baucus bill, in which hospitals would seek to recapture dollars that have been deducted from their initial payment rates. It is important to note that CMS is *not* required to give hospitals the full amount originally reduced even if they achieve the benchmark established by CMS.

- *Use of efficiency measures and measures based on health information technology infrastructure:* The quality measures used in the HQI demonstration are based on 34 nationally standardized and widely accepted *clinical* evidence and industry recognized metrics. Twenty-seven of the measures are process and 7 outcomes (with four of the seven outcome measures being patient safety indicators). The Grassley-Baucus bill would also place importance on evidence-based, valid and reliable clinical measures related to outcomes and processes – many of which could replicate the 34 measures in the HQI demonstration. The legislation would appropriately leave the identification of specific measures to the HHS Secretary, with input and recommendations from a multi-stakeholder body. But the Grassley-Baucus bill also requires the Secretary to utilize efficiency measures, equity, structure and at least one measure based on adoption of health information technology (IT). These measures are less recognized and hospitals have considerably less experience with their implementation compared to the aforementioned clinical process and outcome measures.

These differences are important to keep in mind as Congress considers pay-for-performance legislation.

Technology

In addition to hospital quality improvement, Premier supports the efforts of the Office of the National Coordinator for Health Information Technology (ONCHIT) to accelerate healthcare IT projects and initiatives, as well as the goals outlined in *The Decade of Health Information Technology: Delivering Consumer-centric and Information-Rich Health Care*, unveiled by Dr. David Brailer in July 2004. Premier supports the ONCHIT framework and believes that healthcare IT *can be* an important tool in improving care quality. However, a lack of automation across the sector is not a justification for delaying process improvement. While automating the measurement process into electronic medical records (EMR) is a desired goal, the Premier HQI demonstration project is being implemented without the use of EMR. It is more important to fix ineffective processes than to implement technology that supports retention of broken process systems.

Data submission

With respect to data used to support quality initiatives, Premier believes that the procedures for data submission and validation should be improved for coherence and consistency, and that hospitals should not be penalized when technical issues outside their control impede data reporting. The ability of hospitals and their vendors to comply with the requirements for timely and accurate data submission has been challenged by miscommunication over data edits, technical ambiguities, and other issues. The attached document summarizes Premier's views on data submission and validation issues. It was included in Premier's comments on the FY'06 hospital inpatient PPS proposed rule.

Recommendations and Conclusion

As Congress considers legislation to improve care quality through financial incentives, Premier believes:

- Quality of care must be measured routinely at the national and provider level.
- Quality measures must be transparent.
- An appeals process for hospitals should be established within CMS to address data and hospital-specific issues/challenges, with regard to data submission/certification.
- Measuring and reporting hospital performance should avoid approaches involving numerical ranking of facilities. As quality improves and composite scores cluster, small differences in percentage become less meaningful. For example, a hospital with a score of 92.5 percent would be "ranked" higher than a hospital with a score of 92.4 percent. However, the real difference in performance would be insignificant. In sum, the overall goal of any pay-for-performance initiative should be to drive quality improvement.

Premier is pleased by key policy makers' interest in the results and lessons learned from the HQI demonstration. On behalf of its alliance hospitals and health systems, Premier looks forward to continuing to work with Sens. Grassley and Baucus and other members of the Finance Committee as this bill is considered in Congress. Thank you again for the opportunity to submit a statement for the record.

ATTACHMENT

June 22, 2005

The Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-1500-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed rule

HOSPITAL QUALITY REPORTING

1. Improve the procedures for data submission and validation for coherence and consistency, and do not penalize hospitals when technical issues outside their control impede data reporting.

The ability of hospitals and their vendors to comply with the requirements for timely and accurate data submission has been challenged by miscommunication over data edits, technical ambiguities, and other issues. Therefore, Premier believes that the final rule governing the FY'06 Inpatient PPS should establish a clear documentation and communications process for this purpose. Additionally, Premier believes that hospitals should not be penalized when technical issues specific to the Centers for Medicare and Medicaid Services (CMS) or Quality Improvement Organizations (QIOs) hinder their ability to meet specific data requirements.

Data Submission

- The parameters of the data submission process should be stated explicitly and documented. This includes exact specifications, all edits or audits to be applied, and other related information. Hospitals and vendors must be privy to such parameters to ensure timely data submission. Plus, CMS should communicate any changes to submission file requirements no less than 120 days prior to the effective or implementation date. No changes should be permitted once a submission quarter has begun, as this puts the integrity of the process at risk.

- For greater reporting accuracy, Premier believes that a test process should be established for validating data files and measuring calculations. Hospitals and vendors should be provided with a test file in the appropriate file specification format for internal verification prior to testing a submission. The process should permit submission of test file(s) to verify format, accuracy of data

calculations, and other audit criteria. An appropriate test process should be permitted each time changes in data submission or measure specifications are prescribed.

- In the proposed rule, there is no mention of a minimum sample size for hospitals that elect to sample. Alternately, if hospitals that do not sample elect to submit all of their qualifying cases for a given study (i.e., 425 pneumonia cases for a given quarter) and three get "rejected," will they still meet the data requirements—or, must such hospitals correct the case errors so that every one gets into the warehouse? Under our reading of the proposed rule, it appears that they do not—so long as such hospitals have met the minimum number of cases required by the "aligned" JCAHO/CMS sampling requirements, however they are established.

Data Validation

- The parameters of the validation process should be stated explicitly and documented. This includes clear definitions, all applicable skip logic, all edits or audits to be applied, and other related information. Hospitals must know exactly what is being validated so they may adhere to the specifications during the data collection process. Under the current process, by the time hospitals receive feedback on one quarter's validation, they have already moved onto the next quarter's data collection and can not make changes quickly enough to impact the next quarter. If the validation specs and requirements were clear and well- documented, hospitals could be proactive. Any changes must be communicated clearly and within a timeframe sufficient for hospitals to react and changes their attendant processes. Premier proposes that any modifications to the technical processes be published 120 days prior to the effective/implementation date.

- Premier believes that the validation process should incorporate only data associated with the ten specified measures. Under the current system, a hospital that submits multiple data sets may earn an overall quality score of 80 percent; however, if errors occur more frequently in the subset required for the annual payment update, the quality of such data may be considerably lower. In this way, payments risk being based on inconsistent calculations and inaccurate data.

- The validation process is directed at medical record documentation and abstraction, not at the appropriateness of provided care. Consider, for example, the comparison of blood culture collection time, as documented by the RN, with the time printed on the corresponding lab report to verify data abstraction. The important point is that the blood culture was drawn prior to the first antibiotic. Premier believes that ensuring patients' receipt of the right care at the right time should be incorporated into the validation process.

- Further, Premier believes that hospitals should be notified of any validation rule changes at least 120 days prior to the hospital data abstraction period. The validation rules applied by CMS as of June 6, 2005 are, in fact, retroactive to the July—September 2004 data. CMS validated the three test LDL measures for the AMI clinical focus group. Consequently, hospitals are receiving mismatches for not collecting this optional data. The validation documentation for the July 1, 2004 discharges is dated April 29, 2005. Since the data was submitted at the end of January, hospitals have not had sufficient time to make the appropriate change.

- CMS proposes allowing ten days for a hospital to appeal its validation. Whether such days are "business" or "calendar," neither scenario offer sufficient time for hospitals to respond. Therefore, we propose allowing hospitals 30 calendar days to appeal their validation findings.

- Many Premier hospitals report having received inconsistent communications relating to the "data reporting for annual updates" provision of the Medicare drug law (MMA). Premier believes that all communications and directives regarding this initiative should be centralized and disseminated to all stakeholders (hospitals, vendors, and QIOs) simultaneously. Such a strategy would simplify and standardize message generation. It would also eliminate the confusing and often contradictory communications typical of the current process, which requires state QIOs to interpret a given communication before forwarding it to hospitals.