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MEASURING PHYSICIAN QUALITY AND EFFICIENCY OF CARE FOR MEDICARE BENEFICIARIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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CONTENTS

	Page
Advisory of March 8, 2005 announcing the hearing	2

WITNESSES

Center for Medicare Management, Centers for Medicare and Medicaid Services, Herb Kuhn, Director	6
Society for Thoracic Surgeon's Task Force on Pay for Performance, Jeffrey Rich	12
National Quality Forum, Kenneth Kizer	31
Pacific Business Group on Health, Peter Lee	36

SUBMISSIONS FOR THE RECORD

Alliance of Community Health Plans, Jack Ebeler, statement	63
Alliance of Specialty Medicine, statement	64
America's Health Insurance Plans, Behrends Foster, statement	66
Ethical Health Partnership, Dawn Lipthrott, statement	70
National Business Coalition on Health, Andrew Webber, statement	75

MEASURING PHYSICIAN QUALITY AND EFFICIENCY OF CARE FOR MEDICARE BENEFICIARIES

TUESDAY, MARCH 15, 2005

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:10 a.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson, (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 08, 2005
HL–3

CONTACT: (202) 225–3943

Johnson Announces Hearing on Measuring Physician Quality and Efficiency of Care for Medicare Beneficiaries

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on measuring physician quality and efficiency of care in Medicare. **The hearing will take place on Tuesday, March 15, 2005, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include a representative from the Centers for Medicare & Medicaid Services (CMS) and representatives from groups experienced in measuring quality and efficiency of care. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Medicare currently pays physicians equally for the same service, regardless of the quality of that care or the efficiency of its delivery, but does adjust for geographic differences in the costs of delivering care. As the long-term financial security of the Medicare program is challenged by rising health care costs and increased enrollment from aging baby-boomers, Congress will examine recommendations by the Medicare Payment Advisory Commission (MedPAC), including its recommendation that Congress establish a quality incentive payment policy for physicians practicing in the Medicare program.

CMS has a number of demonstrations underway to examine how to improve the quality of care under Medicare delivered by physicians or integrated health systems. These include a demonstration to reward physicians for improving the quality and efficiency of health care services delivered to fee-for-service beneficiaries in 10 large group practices (200+ physicians) across the country. A second demonstration promotes the adoption and use of health information technology to improve the quality of patient care for chronically ill Medicare patients provided by small and medium-sized physician practices in four states. In addition, CMS is funding several demonstrations on disease management and chronic care improvement which include payment based on quality of care. As part of the demonstration process, CMS has worked with providers and other groups to develop performance measures, data infrastructure, data collection and evaluation procedures, and linked these measures to payment or reporting criteria.

Some physician specialty groups have well-developed systems to identify quality care and some private payers have begun to link payments to quality and efficiency. Other specialty groups have not yet developed quality and efficiency indicators applicable to the care they deliver. CMS is working with physician groups to identify measures that could be linked to payment for performance; measures identified by this group are under review by the National Quality Forum, a group that develops consensus about quality measures among various stakeholders.

In announcing the hearing, Chairman Johnson stated, "MedPAC has recommended that Congress vary payment to physicians based on quality. It is time to examine the quality and efficiency of care delivered to our seniors under Medicare, and to begin to develop a system to reward providers differentially based on that quality. This hearing will offer the Subcommittee an opportunity to hear what CMS is doing to relate physician payment to quality and what some physician groups are able to achieve with their systems of quality improvement."

FOCUS OF THE HEARING:

The hearing will focus on identifying the steps being taken by CMS and others to measure quality and efficiency of physician care. Witnesses will outline actions to pay for better results in Medicare.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*109th Congress*" from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=17*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record.*" Once you have followed the online instructions, completing all informational forms and clicking "*submit*" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Thursday, March 24, 2005. **Finally,** please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at http://waysandmeans.house.gov.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON OF CONNECTICUT. The Subcommittee will come to order. Today we hold our second hearing of this Congress on physician reimbursement under Medicare. At the first hearing I stated that we need to fundamentally rethink how we pay physicians, and I said that because today we are truly at the brink of a new era in health care. Remarkable advances have been made in medical science, technology and pharmaceuticals. The next frontier is improving the health care delivery system to realize the quality of care these advances make possible. Improving the quality of health care in America requires systemic changes in the structure of our delivery system, and you will hear some of that today; the widespread adoption of interoperable electronics, describing the health record technology to reduce errors and better integrate patient information and relevant specialty knowledge, and a reform of our payment systems to foster the dissemination of best practices, and the coordination that disease management requires.

As we move toward the new system to better reward physicians who deliver higher quality care, quality measurements must be clearly defined and reasonably achievable; be developed with input from the physician community, and recognize improving the quality of care delivered; reward, not penalize; recognize that e-mails, phone calls and many new forms of communication and care delivery must be integrated into the payment system to enable physicians to avoid more expensive care settings like hospitals, nursing homes and emergency rooms for their patients. The Medicare Payment Advisory Commission (MedPAC), recently recommended that Medicare establish a quality incentive payment policy for physicians. The Centers for Medicare & Medicaid Services (CMS) has begun to lay the groundwork for payments based on the quality of care delivered. The CMS already collects quality data from many Medicare providers and makes the information publicly available to allow beneficiaries to compare the quality of care provided by different nursing homes, dialysis facilities and home health agencies. The CMS will begin to report quality information for hospitals soon, to provide new resources for beneficiaries when they are searching for a hospital or other care givers.

Other steps must be taken to lay the foundation for a system of payment based on results. First, key stakeholders including Congress, CMS and providers must develop measures of quality. This must be a collaborative effort involving significant provider input. Second, we must develop the data infrastructure to support collection of better information. Third, we must collect and evaluate the data. Finally, we must use the information to improve quality, or as a basis for payment. The CMS is operating a number of demonstrations to gain experience in linking payments to the delivery of quality care. One of these, the Physician Group Practice Demonstration, will begin operation in April. It will reward physicians for improving the quality and efficiency of the care delivered to beneficiaries in fee-for-service medicine. Of considerable interest to us, this demonstration is trying to encourage coordination of services under part A and Part B.

The private sector is also moving forward with links between payment and performance. We took testimony from several wit-

nesses on these developments in our hearing in February and will continue that exploration today. Our first witness is Herb Kuhn, the Director of the Center for Medicare Management at CMS. He will provide us with more details about CMS's efforts to measure quality and reward providers for better care. Next we will hear from Dr. Jeffrey Rich, representing the Society of Thoracic Surgeons (STS), who will present some exciting results demonstrating the improvement in care that is possible with the extensive database developed by the Society. Dr. Kenneth Kizer from the National Quality Forum (NQF) will discuss efforts to identify measures of quality in the ambulatory care setting. Finally, Peter Lee from the Pacific Business Group on Health will share some experience from the private sector on measuring quality and efficiency and linking these to payments for physicians. Now it is my pleasure to turn to Mr. Stark.

Mr. STARK. Madam Chair, I genuinely want to thank you for holding this hearing today. We should be getting value for our money in Medicare and I am glad we are focusing on this issue. I am interested in hearing the panel's advice as to how this would be done. I have to make some comments about what we are doing in Congress, in general, and before I do that I have to suggest that I am not directing these remarks at the Chair, who I am not sure is a complete free agent in setting the overall policy that is set by leadership on her side of the aisle. It seems to me that this hearing is 18 months late and dollars short. The Medicare Modernization Act (P.L. 108–173) really begins to privatize Social Security and threatens the whole stability of the entire fee-for-service system. We used to deal with these issues on a bipartisan basis when both sides were interested in continuing Medicare as an entitlement, improving its benefits and keeping it fiscally solvent. Over the last 10 years, this has changed, and we have been excluded, as you know, from conferences, and many of these issues have been decided without both sides of the aisle participating. That again has not been the Chair's decision, and I want to emphasize that.

In privatizing, if we are not doing that, why else would we overpay private plans even though it shortens the solvency of our system and raises premiums? Why would we structure a prescription drug benefit that is unlike any insurance plan known to man, and then not allow or prohibit, in effect, the Secretary to negotiate lower prices? We negotiate with the doctors on the panel. We negotiate with our hospitals. Why we give PhRMA (The Pharmaceutical Research and Manufacturers of America) a pass on that escapes me. Then why would we set up an acute care program to, so-called, compete with private plans when they give private plans an advantage and they have an uneven playingfield?

The Modernization Act shortened the life of the trust fund, contributed to the highest increase in beneficiary premiums in the history of the program, and I suspect later this month what we are going to see, I would almost bet you a nickel, Madam Chair, we are going to see the 45 percent trigger on general revenue spending. We will probably have the second warning next year and then the fat is in the fire. Fundamental changes really aren't that necessary. We just need to stop this rush to privatization, and deal with issues as you are dealing with this morning. We have to shore up

the trust fund to accommodate the next generation, and not privatize this so that we, by doing away with Medicare as an entitlement, add probably another 20 million people to the uninsured rolls in this country. So, while I think this is a small bite at the apple, I only wish, Madam Chair, that we could deal with the question of, "Are we going to privatize Medicare and what would that do to the system?" I think that is the real danger that lays before us.

Chairman JOHNSON OF CONNECTICUT. Thank you, Mr. Stark. Since your remarks were more focused on the partisan rhetoric that prevents constructive discussion between the parties, let me just say I know of no one that wants to change Medicare from an entitlement to a private program on either side of the aisle, and that your prescription drug bill, until the last motion to recommit, also had the same negotiating process that our bill had and was far more expensive. If we were dealing with that, now we would be in greater trouble. Now, that isn't to say that it would be nice that we have a challenge in the prescription drug area, some of which is in our jurisdiction and most of which is not, but if we don't address ourselves to the kind of issue—and we do agree on this incidentally—if we don't address ourselves to some of the system's problems, then no matter what else happens, Medicare is going to fail. So, I am pleased to welcome this panel. We have structured this hearing differently than we have other hearings. There is only one panel, and each participant has 10 minutes. We talked about that earlier, and we welcome you. Mr. Kuhn, if you will please begin.

STATEMENT OF HERB KUHN, DIRECTOR, CENTER FOR MEDICARE MANAGEMENT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, BALTIMORE, MARYLAND

Mr. KUHN. Chairman Johnson, Congressman Stark, Members of the Subcommittee, thank you for inviting me to testify on CMS's initiatives to provide financial incentives for health care providers to improve the quality of care they provide to seniors and people with disabilities. The Administration is committed to rewarding innovative approaches to achieve better patient outcomes at lower cost, and CMS initiatives will help achieve this goal. One of the changes made under the Medicare Modernization Act that has the greatest potential to improve quality and cut costs in Medicare, is pay-for-performance, and that is a huge priority for CMS today. Right now nearly 95 percent of Medicare spending is for dealing with health problems after they happen. Clearly, we can do better. Pay-for-performance means Medicare pays not simply for certain procedures for admitting a patient to a hospital, but rather for high-quality, efficient results. It means changing Medicare's reimbursement incentives to reward better outcomes, such as avoidable complications or hospital readmissions.

Currently, there are several important pay-for-performance initiatives and demonstrations underway that will support quality improvement while also making the Medicare Program a more cost efficient purchaser of health care. For example, the Hospital Quality Initiative (HQI), is linking the market basket increase to reporting

of hospital quality information. Already this initiative has shown that financial incentives can have a positive impact on quality.

One of our most exciting pay-for-performance projects is a pilot fee-for-service program called the Chronic Care Improvement Program (CCIP). The CCIP is for Medicare beneficiaries with chronic diseases such as congestive heart failure, complex diabetes and chronic lung diseases, who collectively account for the majority of Medicare spending. There are proven approaches to managing these diseases and preventing complications that require hospitalization, but until now patients in the traditional Medicare Program have had little access to these approaches. Under the CCIP program participating organizations will manage patient care and will be paid if they satisfy patients and providers, improve clinical outcomes and reduce our costs. They will have tremendous freedom to implement quality improvement techniques. Madam Chairman, if I just may add here that I personally want to thank you for your work on this program. It is going to make a difference in the lives of many Medicare beneficiaries. Thank you very much.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Mr. Kuhn. Dr. Rich.

Mr. KUHN. I just want to finish up just one additional thing.

Chairman JOHNSON OF CONNECTICUT. Sorry, I thought you were finished.

Mr. KUHN. I was just paying you a compliment on CCIP.

Chairman JOHNSON OF CONNECTICUT. Thank you.

[Laughter.]

Mr. KUHN. Importantly, CMS is conducting a demonstration to test payment for performance and Medicare's fee-for-service payment system for physicians. Physicians influence, either directly or indirectly, almost all areas of Medicare spending. For example, physicians deliver services, admit beneficiaries to hospitals, and authorize home health visits. Under the Physicians Group Practice Demonstration, which you mentioned in your opening comments, which was announced in late January and will become effective on April 1, participating physician groups will be able to earn performance-based payments for implementing care management strategies that improve the quality of care. Under the demonstrations physician groups will continue to be paid on a fee-for-service basis. Physician groups will implement care management strategies designed to anticipate patients' needs, prevent chronic disease complications and avoidable hospitalization, and improve quality of care.

This demonstration will reward 10 physician groups in various communities across the Nation. It reflects the hard work of physicians, consumer advocates and other health care payers and purchasers to develop valid measures of quality and efficiency, and use them effectively to support better care. The CMS is also exploring opportunities to implement payment for performance systems in nursing homes, home health care agencies and dialysis facilities, and that is why payment for performance is so exciting. It gives us the opportunity to support doctors for cultivating strong patient relationships, providing personalized care, and doing whatever it takes to improve quality and efficiency in our health care system. For pay-for-performance mechanisms to be successful, they must be

based on valid measures of quality. In this regard, CMS, as evidenced by the success of our Physician Group Practice Demonstration program, is collaborating with a variety of stakeholders, including the groups at this witness table here today, to develop and implement uniform standardized sets of performance measures for various health care settings. In addition to establishing quality measures, we must investigate how best to structure performance-based payment systems.

The CMS recognizes that pay-for-performance is a departure from the traditional way of conducting business. The CMS will seek input concerning actions we can take administratively to best implement a pay-for-performance system and achieve our goals of promoting better quality care and reducing program cost. 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 dialog on key technical and statutory issues. Chairman Johnson, Congressman Stark, thank you again for this opportunity to testify today about CMS's pay-for-performance initiatives. Performance based payment is a key next step in CMS's overall efforts to help health care professionals improve the quality and efficiency of the care that beneficiaries receive.

I will be happy to answer any questions the Subcommittee may have.

[The prepared statement of Mr. Kuhn follows:]

Statement of Herb Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, Baltimore, Maryland

Chairman Johnson, Congressman Stark, thank you for inviting me to testify on the Centers for Medicare & Medicaid Services' (CMS) initiatives to provide financial incentives for health care providers to improve the quality of care they provide to seniors and people with disabilities. The Administration is exploring innovative approaches to achieve better patient outcomes at lower costs, and the initiatives we are setting could help CMS realize this goal. The Administration also recognizes that pay-for-performance is in the early stages of development, and a great deal of work still must be done to develop a full set of widely applicable quality performance measures. Supporting efforts by health professionals to improve the quality and efficiency of care for Medicare beneficiaries is the motivation behind CMS' various efforts to develop pay-for-performance models, as inefficient health care is costly to the patient and to the government. Despite innovations in medical science, limited advancements have been made to integrate advanced capabilities with high quality medical practice.

Financial incentives such as pay-for-performance, however, are only one part of CMS' efforts to support high-quality efficient care. For example, CMS is helping to support the development of valid quality measures and quality improvement efforts in a variety of care settings, including long-term care facilities. When clear, valid, and widely accepted quality measures are in place, pay-for-performance is a tool that could provide additional support. Furthermore, as demonstrated by our Hospital Quality Initiative, small percentages in financial incentives can encourage provider interest in quality, while keeping the payment system predictable for health care providers.

In this context, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) recognizes additional opportunities for CMS to encourage and support high quality care. For example, the Chronic Care Improvement Program (CCIP) will test a population-based model of disease management. In addition, this program will generate data on performance measures that will be useful as we examine ways to improve the Medicare program as a whole. The program will use pay-for-performance to provide beneficiaries with better outcomes, and we expect, at a lower cost. Madam Chairman, I would like to take this opportunity to thank your for your work on this program, which will help to make a real difference in improving the lives of beneficiaries. I also would like to note that CMS is supporting qual-

ity initiatives for chronic illnesses in Medicare Advantage plans through payments based on risk adjustment. Using risk adjusted payments ensures plans are paid more accurately for the health status of their members. As a result, plans with sicker beneficiaries are paid more than plans with healthier patients

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. The current Medicare payment system pays physicians and other health care providers based on the number and complexity of the services provided to patients. We are examining our current system to better anticipate patient needs, especially for those with chronic diseases, and how the incentives can be better aligned with the kind of care we want, expensive procedures and hospitalizations can be reduced, which benefits both patients and taxpayers.

Developing Standardized Quality Measures

We are working toward improving quality in every setting in which Medicare pays for care. Based on collaborative work by a broad range of stakeholders, combined with experience in the private sector, there is a growing view that recognizing providers who furnish effective care can lead to better quality care. Valid consensus-based quality measures are critical to any system based on quality. This prevents providers from receiving conflicting directions and gives them meaningful support in providing better care.

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. Ambulatory care measures have also been developed by CMS working in an extensive process with the American Medical Association's Physician Consortium for Performance Improvement and the National Committee for Quality Assurance to measure improvements in care. The measures from this process were submitted late last year for review and comment to the National Quality Forum, a non-profit organization that represents a broad range of health care stakeholders and provides endorsement of consensus-based national standards for measurement and public reporting of healthcare performance data.

These efforts build upon the success of CMS' other quality initiatives—Nursing Home Compare, Home Health 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.

In addition, CMS recognizes the potential for information technology to improve the quality, safety and efficiency of health care services provided to all Americans. Through the Doctors' Office Quality—Information Technology (DOQ–IT) pilot project, CMS is exploring the adoption and effective use of information technology by physicians' offices to improve quality and safety for Medicare beneficiaries and all Americans. The pilot project promotes greater availability of affordable and effective health information technology by providing assistance to physician offices in adopting and using such technology.

CMS also is working with Quality Improvement Organizations (QIOs) to improve the quality of care delivered to beneficiaries. In addition to CMS' various quality initiatives, CMS is 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. Pay-for-performance has the potential to promote payment incentives that do not hamper, but rather encourage health care professionals to use the most clinically appropriate procedures.

Supporting Quality Through Pay-for-Performance

Measuring quality and providing support for quality improvement is only the first step. The MMA provides CMS with the authority to conduct pay-for-performance initiatives and demonstrations, which will allow us to consider ways payment systems might provide appropriate incentives to providers. We expect these pay-for-performance initiatives will support quality improvement in the care of Medicare beneficiaries and make the Medicare program a more cost-efficient purchaser of health care services. Even small financial incentives can spur provider interest in quality of care projects, as evidenced by the high percentage of hospitals participating in the Hospital Quality Initiative.

Pay-for-performance initiatives are currently underway in a variety of health care settings where Medicare beneficiaries receive services, including physicians' offices and hospitals (described below). Because patients with chronic conditions often require care 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.

Improving Inpatient Care through Hospital Initiative and Demonstration Programs

Since 2003, CMS has operated the Hospital Quality Initiative, which is designed to stimulate improvements in hospital care by standardizing hospital data, data transmission, and performance measures to ensure that all payers, providers, oversight and accrediting entities use the same measures when publicly reporting hospital activities. Under the MMA, an initial set of 10 quality measures will be linked to Medicare hospitals payments. Hospitals that submit the required data will receive a market basket increase of 0.4 percentage points higher than facilities that do not. For FY 2005, virtually every hospital in the country that is eligible to participate (98.3 percent) has submitted the required data and received the higher payment.

CMS also has partnered with Premier Inc., a nationwide alliance of not-for-profit hospitals, to conduct a demonstration program that is designed to improve the quality of inpatient care for Medicare beneficiaries by providing financial incentives. Under the Premier Hospital Quality Incentive Demonstration, about 300 hospitals are voluntarily providing data on 34 quality measures related to five clinical conditions: heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. Using the quality measures, CMS will identify hospitals in the demonstration with the highest clinical quality performance for each of the five clinical areas. Hospitals scoring in the top 10 percent for a given set of quality measures will receive a 2 percent bonus payment in addition to the normal payment for the service provided for Medicare discharges in the corresponding Diagnosis Related Groups (DRGs). Hospitals in the next highest 10 percent will receive a 1 percent bonus payment. In the third year of the demonstration project, hospitals that do not achieve absolute improvements above the demonstration baseline will be subject to reductions in payments.

Encouraging Physicians to Improve Patient Outcomes

CMS recently announced a demonstration project to test pay-for-performance in Medicare's fee-for-service payment system for physicians. The Physician Group Practice demonstration will access 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 will participate in the demonstration, which will begin operations in April 2005. Participating physician groups will continue to be paid on a fee-for-service basis, but they will be able to 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 strengthen the Medicare program.

CMS also will test a pay-for-performance system to promote the adoption and use of health information technology to improve the quality and efficiency of care for chronically ill Medicare beneficiaries treated in small- and medium-sized physician practices. The Medicare Care Management Performance 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. This demonstration currently is under development and will be implemented in Arkansas, California, Massachusetts, and Utah. Participating practices will receive technical assistance from the Quality Improvement Organizations in their areas, as well as bonus payments for achieving the project's objectives.

CMS also is investigating how to enhance quality and safety in 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 will soon seek public comment on the parameters for this initiative, and it will be open to physician groups and integrated health systems.

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.

- *Chronic Care Improvement Program*—This pilot program will test a population-based model of disease management. Under the program, participating organizations will be 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 also 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 Medicare Beneficiaries*—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 pilot 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 announcement for this demonstration was published in the Federal Register on October 6, 2004 and CMS accepted applications through January 2005. 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.

Conclusion

Chairman Johnson, Congressman Stark, thank you again for the opportunity to testify today about CMS' ongoing pay-for-performance initiatives and demonstrations. CMS is examining performance-based payments in its overall efforts to help health care professionals improve the quality and efficiency of care beneficiaries receive. By working with providers, payers, and other stakeholders, CMS believes pay-

for-performance mechanisms have the potential to improve the quality of care delivered to beneficiaries, while at the same time improving the efficiency of the Medicare program. Thank you again for this opportunity and I would be happy to answer any questions you might have.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Mr. Kuhn. Dr. Rich.

STATEMENT OF JEFFREY RICH, M.D., CHAIRMAN, SOCIETY FOR THORACIC SURGEON'S TASK FORCE ON PAY FOR PERFORMANCE, NORFOLK, VIRGINIA

Dr. RICH. Thank you, Madam Chairman and Members of the Subcommittee for inviting me to speak to you today about quality measurement, quality improvement and achieving clinically appropriate cost-containment in health care. I believe that for the first time since the inception of Medicare the attainment of value, or higher quality for each Medicare dollars spent, is within our reach. My name is Jeffrey Rich. I am a practicing cardiac surgeon in Norfolk, Virginia. I am testifying today on behalf of STS, where I serve on the Board of Directors, and am Chair of the STS Pay-for-Performance Task Force. I also serve with Dr. Kizer on the NQF Board and importantly, as a Chair of the Virginia Cardiac Surgery Quality Initiative, a regional consortium that deals with quality improvement and cost containment. The STS takes this hearing very seriously, as evidenced by the fact that Dr. Sid Levitsky, our current president, is seated behind me at this hearing.

We are in a unique position among physician specialties for one reason; our cardiac surgeons have been collecting uniform clinical data for their patients for the purpose of quality improvement for 15 years. With over 2.7 million records in our database we have been able to learn valuable lessons about what works and what does not work in physician quality measuring and improvement. We are very aware that most physician groups are not yet ready to participate in pay-for-performance, but we do believe that this should not be a barrier to moving forward. There are three action items all physicians can take immediately to reach the level where quality can be improved and value can be achieved. They are, number one, adopt structural measures. Use pay for participation in a systematic database as the cornerstone for quality improvement. Number two, once the data is collected, have the physicians create performance measures which address both process and outcomes. All of these measures should go through a review of scientific credibility process and be vetted through the NQF.

These are the steps in the roadmap that will lead to higher quality care and lower cost for Medicare beneficiaries. Incentives should be created to help physicians reach each of these levels. Returning to the structural measure, the most important initial ingredient in quality measurement and quality improvement is uniform clinical data. Claims-based data, although easy to collect, has very limited application for quality improvement. Claims or administrative data simply will not allow physicians to make the crucial links between co-morbidities and the outcomes of treatments for their patients. Additionally, several studies have shown that errors in Medicare

administrative data vary widely across hospitals, averaging 15 percent statewide when compared to the STS database. We began collecting clinical data on open heart surgery in 1989. For 15 years and with over $12 million invested, we have the largest physician-led database in existence. This slide demonstrates some of the major elements of it. There are 600 hospitals that participate and 2.7 million patient records. Each patient has 200 clinical data points collected, and as a result of the information transfer, the information is analyzed at Duke Clinical Research Institute and sent back to physicians with reports on their quality and outcomes.

With this database 58 peer-reviewed studies have been published and 11 more await publication. These studies have improved quality and have addressed important issues such as racial and gender disparities in health care. Since the creation of the database we have seen increasing complexity of patients, as seen on this slide.

[The exhibits referenced in Dr. Rich's statement can be seen in his prepared statement below.]

The blue line illustrates that our patients are getting sicker. They are older, they are more overweight and have more complex problems, yet at the same time, through the systematic participation in the database, our observed and expected mortalities have fallen, and I do note that this has occurred in the era of reimbursements declining by over 40 percent. This is a crucial example that physicians can do the right thing at the right time for the right reason.

How did we do this? The answer is that we, as a specialty society, have developed the infrastructure through the database for the collection, analysis and feedback of data, and we compare it against regional and national benchmarks. This process of collection and sharing of clinical data in and of itself has led to significant improvements in quality. In essence, pay-for-participation as a start will lead to quality improvement in cardiac surgery and all other areas of medicine. Once data is collected, physicians must develop performance measures, and these are both process and outcome measures. We have cooperated with the Agency for Health Care Research and Quality in the largest clinical study ever performed. Identified were two process measures that were linked to quality improvement, implemented nationwide, with improvements in mortality. The success of this trial highlighted the shortcoming of implementing a bonus payment system that rewards compliance with process measures only which are not linked to quality improvement. A pay-for-performance system designed like this would pay bonuses to doctors to prescribe more medications and order more tests that have little clinical relevance to the care they provide. Such a process-oriented system has the potential to increase costs rather than decrease costs.

Outcomes measures: STS has developed significant and very scientifically credible outcomes measures and have brought those to the NQF. We have developed the National Voluntary Consensus Standards for Cardiac Surgery last year. Of the 21 approved measures, 16 are derived from the STS database. Armed with these measures and our database we can promote best practices nationwide, improve quality of care, and focus on cost containment. In Virginia, we took quality improvement one step further. Fellow

heart surgeons and I established the Virginia Cardiac Surgery Quality Initiative. This is a map of the State. These are the members, which include 10 surgical practices and 16 hospitals. We all participate in the STS database. We formed an inclusive collaborative effort to improve quality in programs of all size, eliminating no programs. We focused on containing costs by focusing on quality, and wished to test new methods of reimbursement.

To accomplish this we developed a new database. This database took the STS database and mapped it into the Medicare database using the ARMUS Corporation. This claims-based database is the one that we all use to submit claims for Medicare beneficiaries. Now we can look at quality improvement and its linkage to cost and tell whether this quality improvement is actually creating cost containment or value in the system. As you can see, we have taken the International Classification of Diseases (ICD)-nine codes for all of the charge codes for cardiac surgery and placed them in 21 revenue categories and are able to examine these cost buckets individually on a hospital basis or on a surgeon basis. We can compare hospitals with lower spending to those with higher spending in each category, and we can correlate outcomes with spending. By maintaining a focus on quality, we can begin to examine resource utilization management that is patient centered and without negative consequences. Basically, we have developed cost savings models that lead to improved quality of care.

As you can see from this slide, there still remains variation in cost by hospitals. These are eight hospitals that I have chosen to use as a demonstration. The lowest cost hospital for coronary bypass had a cost of $18,000, while the highest was $28,000. We looked into the cost buckets within these hospitals and found that these were the six categories that were driving costs. In addition we looked within these categories at the surgeons practicing at those hospitals, and discovered that there was still cost variation in the ability to deliver the same quality care. With that, we were able to initiate cost containment models that did not impact quality and in fact improved quality. As you can see, in this slide—that cost, is lowest for the two hospitals on the right-hand side. If you look on the bottom of the slide you will see something called an observed to expected ratio. This is the observed to expected mortality for hospitals. The observed mortality is what is reported to the STS. The expected mortality is what the STS database says we should be experiencing based on the complexity of the patients. The two hospitals to the right have the lowest ratio, meaning they have the highest quality within the State and have the lowest cost within the State.

One of the key questions facing you today is how to pay for performance and how that can be implemented in the current difficult budget environment. The current recommendation is to repeal the sustainable growth rate formula and replace it with incentive payments to physicians, enabling them to make information technology (IT) investments required for quality improvement. This repeal will not be easy and it must be done thoughtfully. A budget neutral framework for pay-for-performance must not be the tournament model where the funds are taken from the lowest performers and given to the best. We feel strongly that the tournament model will

not produce the savings you seek and could hurt access to care for vulnerable populations. The primary goal of pay-for-performance must be quality improvement. Savings will accrue from this improved quality, as you can see from the previous slide.

Let me demonstrate how this works with an actual example from the State of Virginia. One of the common complications of open heart surgery is atrial fibrillation. This is where the heart's electrical system is out of sync and cannot pump blood efficiently. While not often deadly we found that each instance of this complication adds $2,366 to the direct cost of care during the hospitalization. In addition, it can lead to much more serious and expensive consequences such as stroke and hospital readmissions. In analyzing our cost and quality data, we found that one hospital had significantly lower atrial fibrillation rates, as you can see on this slide. While this rate nationwide was 16 percent, this particular hospital had a 10-percent rate. We took their treatment protocol and adopted it and implemented it statewide with an anticipated reduction to 10 percent in our atrial fibrillation, yielding an estimated cost savings of $1.3 million over the next 2 years. If applied nationally using the STS database and its quality improvement processes there will be $80 million saved alone in reducing atrial fibrillation in cardiac surgery.

A point I must stress to you is that to achieve these savings you must improve the care of the lowest performers until inter-institutional variation is minimized and all quality is improved. That improvement would not have occurred had there been a budget neutral or tournament style pay-for-performance system in place. The creation of winners and losers discourages the best performers from sharing their practices with others. In short, up front budget neutrality that robs Peter to pay Paul stifles communication, stifles quality improvement and stifles cost containment. In Virginia, we have looked at other complications and have seen that there are incremental costs associated with complications related to cardiac surgery and these are the costs that occur as a result of post-operative complications. If we achieve modest improvements in these measures in the State of Virginia and nationally in the country using the STS database, we have estimated that there can be $346 million saved annually with over $1 billion saved in 3 years.

This is where funding for pay-for-performance should be generated. Incentives to reduce costly complications have immediate savings potential for the health care system. We strongly disagree with the MedPAC recommendation to use an across the board reduction for all physician fees to create a bonus pool. Although that would be a windfall for us, it would not be for others. We recognize it is costly to create these models, as STS members spend $50—to $100,000 per practice to participate in the database. We feel it is important.

Lastly, we appreciate the need for budget neutrality and the need for the Office of Management and Budget (OMB) to have evidence of more tangible immediate savings in order to score these programs accurately. In this regard I would recommend a national demonstration project to evaluate the effects of incentives on participation and to document the cost savings that can be achieved through a collaborative quality improvement effort. This can be in-

stituted immediately given the high level of readiness of STS with the potential for rapid replication in other specialties. Congress and CMS must recognize that not all physicians have reached the same level of readiness, but recognize that the system of quality improvement and cost containment can be employed nationwide by use of the STS database.

For this reason Congress and CMS must do everything in their power to create incentives and promote the inclusive collaboration of physicians and all providers to improve health care quality for Medicare beneficiaries and contain costs. If a common theme must emerge from this hearing, then let that be one of "include and improve" rather than "divide and conquer." In conclusion, we believe that supporting the development of condition-specific databases which are clinically driven is critical. Comparative effectiveness of treatments, long-term efficacy of drugs and devices, and appropriateness of care can all be answered. If we have the foresight to prevent cuts mandated by an ineffective formula, let that excess money flow toward quality improvement and database development. Thank you for this opportunity and honor to appear before you.

[The prepared statement of Dr. Rich follows:]

Statement of Jeffery Rich, M.D., Chairman, The Society for Thoracic Surgeon's Task Force on Pay for Performance, Norfolk, Virginia

Thank you Madame Chairman and members of the subcommittee for inviting me to speak with you today about quality measurement, quality improvement, and clinically appropriate and achievable cost containment. I believe that for the first time since the inception of Medicare, the attainment of "value", or higher quality for each Medicare dollar spent, is within our reach. I am here today to demonstrate to you that within our specialty of cardiothoracic surgery and applicable to all of medicine in general, there is a developing body of evidence that links quality improvement to cost containment in healthcare delivery.

We have all witnessed the past and present attempts to contain costs in U.S. healthcare delivery: the poorly designed control of access and resource utilization by HMOs and other payers; the application of the principle of "picking the low hanging fruit" by streamlining purchasing, eliminating easily identifiable excesses, and discharging patients earlier without appropriate safety nets; the attempts to control physician services through the Sustainable Growth Rate Formula. Although some short-term transient gains have selectively been realized, we remain in a healthcare financing crisis with costs rising at multiples of inflation and an unsustainable physician payment system. The hearing today focuses on quality based payments to physicians and their impact on cost of care efficiencies for Medicare beneficiaries. Is Pay for Performance an answer to the problem?

The Society of Thoracic Surgery believes that the answer to this is "yes" if done correctly. We believe that only through a focus on quality can sustainable reductions in healthcare costs be achieved. By lowering complications and using quality-guided resource utilization management, savings can be achieved for all of medicine, with these savings accruing immediately. But to accomplish this we must collect clinically relevant data and allow providers to develop reliable, valid and trusted measures of care that are scientifically credible. They must then be used to guide quality improvement and meaningful, safe cost containment. This is exactly what we have accomplished through the use of the Society of Thoracic Surgery National Cardiac Database (STS NCD).

My name is Jeffrey Rich, and I am a practicing cardiothoracic surgeon in Norfolk, Virginia. I am testifying today on behalf of The Society of Thoracic Surgeons (STS), where I serve on the Board of Directors, and chair the STS Pay for Performance Task Force.

I am also a board member of the National Quality Forum, and serve as Chairman of the NQF Research and Quality Improvement Council. Last, but not least, I am the Chair of the Board of Directors of the Virginia Cardiac Surgery Quality Initiative (VCSQI), a regional STS-based consortium that is in the process of dem-

onstrating the link between quality improvement and cost containment in cardiac surgery.

The Society of Thoracic Surgeons is in a unique position among physician specialties for one reason. Our cardiac surgeons have been collecting uniform clinical data on their patients for the purpose of quality improvement for fifteen years. With over 2.7 million patient records in the STS NCD we have been able to learn valuable lessons about what works and what does not in physician quality measurement and improvement. I would like to share with you how we measure quality of care in cardiac surgery, and how our experience can be used to simultaneously improve care for our beneficiaries and reduce costs to the health care system. In short, physicians can save lives and improve health while saving money.

I would also like to discuss the process for achieving Medicare savings in pay for performance, and outline what we believe is a road map that should get all physicians to the point where savings can be generated through higher quality, reduced complications, and more efficient care.

We are well aware that most physician groups are not yet ready to participate in pay for performance. However, we do not believe that this should be a barrier to moving forward with this important new concept in physician reimbursement. There are three action items that Congress, CMS, and all physicians along with their respective specialty societies can take to reach the level where quality can be improved and value can be achieved. They are:

1. Adopt structural measures using Pay for Participation: In the March 2005 Report to Congress, MedPAC urged the development of **clinical** IT systems by physicians and that "functions of IT systems that are linked to quality improvements be included as measures in pay-for-performance initiatives." Creating incentives for the collection of relevant clinical data by providers—eventually through electronic health records (EHR)—is the cornerstone of quality improvement. This is best accomplished through the development of relevant measures by providers and collected through participation in a database.
2. Develop a consensus set of process measures for each specialty or disease area that is linked to quality improvement, and
3. Develop a consensus set of risk-adjusted outcomes measures that will lead to reductions in death and complications. Both sets of measures should be subject to the consensus-building process at the National Quality Forum.

Systematic participation in a standardized clinical database should be used to foster a culture of quality and quality improvement utilizing data collection, analysis, the development of evidence-based medicine and Continuous Quality Improvement (CQI) processes of care for performance improvement and cost containment. These steps are the road map to higher quality care and lower costs for all Medicare beneficiaries. Incentives should be created to help physicians reach each of these levels.

Structural measures—We must start with clinical data

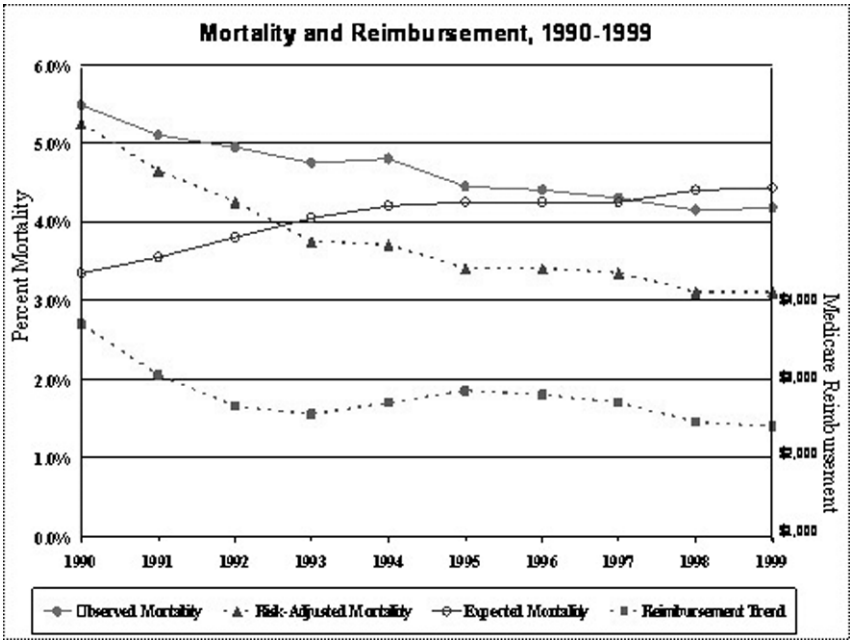
The most important initial ingredient in quality measurement and quality improvement is uniform clinical data. This is where the rubber meets the road in determining what works in healthcare. Claims based data—though easy to collect—presently have limited application for quality improvement. Claims or administrative data simply will not allow physicians to make the crucial links between comorbidities or disease conditions and the relative outcomes of treatments for their patients. Additionally, a Virginia study showed that errors in Medicare administrative data varied widely across hospitals, averaging 15% statewide when compared to the STS National Cardiac Database (NCD).

The STS began collecting clinical data on open-heart surgery patients in 1989. We now have over 2.7 million patient surgeries in our National Cardiac Database, collected from almost 600 heart surgery programs across the country. This database contains nearly 200 data points on each patient, ranging from demographic factors to clinical risk factors, encompassing the whole spectrum of the complexities of cardiac surgery

Fifty-eight peer reviewed studies have been published using our database; 11 more await publication. These studies have improved quality of care in areas from racial and gender disparities to efficacy of specific devices and techniques.

Since the creation of the database in 1989, we have documented the trend that our Medicare patients have become sicker, older, more overweight, with a higher prevalence of previous cardiologic interventions. In short, the ***expected*** mortality rate for bypass patients has significantly increased by approximately 35%. However, over the same period from 1990 to 1999, both the ***observed and risk-adjusted mortality in this Medicare CABG population decreased by approximately 30%***. The chart below shows that risk-adjusted mortality rates have dropped mark-

edly despite this increase in preoperative risk. It is important to note that over this period, Medicare payment rates for CABG surgery decreased approximately 40% as shown in the lower line on the chart. All of these trends, increasing expected mortality, decreasing observed mortality and decreasing payment rates have continued through 2003.



So, how did we improve survival despite increasing co-morbidities? *The answer is that we, as a specialty society have developed the infrastructure through the NCD for the collection, analysis, and feedback of local data compared against regional and national benchmarks of care. This process of collection and sharing of clinical data led to significant improvements in quality.* Our physicians consider it an important part of their professional responsibility to continually improve the quality of the care they provide.

In essence, we feel that a correctly designed "pay for participation" model as a start to rewarding performance will lead to quality improvement in cardiac surgery and other areas of medicine.

Process measures—Clinical interventions that improve care must be communicated

The existence of this clinical database, which is warehoused and analyzed at the Duke Clinical Research Institute, has allowed us to make a quantum leap in quality measurement and quality improvement. With these clinical data, we have completed the largest randomized trial in medicine of Continuous Quality Improvement in a study sponsored by the Agency for Healthcare Research and Quality. This national trial studied 267,917 patients undergoing coronary artery bypass graft (CABG) surgery at 400 hospitals across the country. Identified were two potential best practices, which when communicated to our physicians, altered their behavior significantly in a period of 18 months (*Ferguson, JAMA 2003; 290, 49–56).* This proved the ability to rapidly communicate, improve, and measure two care processes in medicine. Importantly, it was demonstrated at the end of the trial from parallel studies that incorporation of these two measures into clinical care reduced risk-adjusted mortality for CABG; this link to improved mortality provides the scientific basis for incorporating these process measures into evidence-based practice for CABG patients.

The success of this trial highlighted the shortcoming of implementing a bonus payment system that rewards compliance with process only, without linkage to improvement in outcomes. A pay for performance system designed like this could pay bonuses to doctors to prescribe more medications and order more tests that may have little clinical relevance to the care they provide. Such a process-oriented system has the potential to increase costs, with little if any knowledge of whether the patient's condition actually improved or if complications, ER visits, and other problems were reduced.

To ensure that improvements in processes of care actually improve Medicare beneficiary health in the real world, we must measure risk-adjusted outcomes.

Outcome measures—Risk-adjusted patient outcomes must be measured to show health quality improvement

With the use of the STS database, we are able to correlate performance measures to outcomes and judge their relative impact on patient health and survival. As mentioned earlier, in an era of increasingly older and more severely ill patients, the mortality for Coronary Artery Bypass Grafting has fallen. This alone has validated the concept that participation in a clinical specialty driven database without linkage to payment has worked to improve patient care. Last year in an unprecedented move by a physician specialty group the STS worked with the National Quality Forum to create the "National Voluntary Consensus Standards for Cardiac Surgery" through their consensus building process. Out of over 160 proposed measures, the NQF Board approved a set of 21 measures that are most relevant to cardiac surgery. Of the 21, 16 are derived from the STS database.

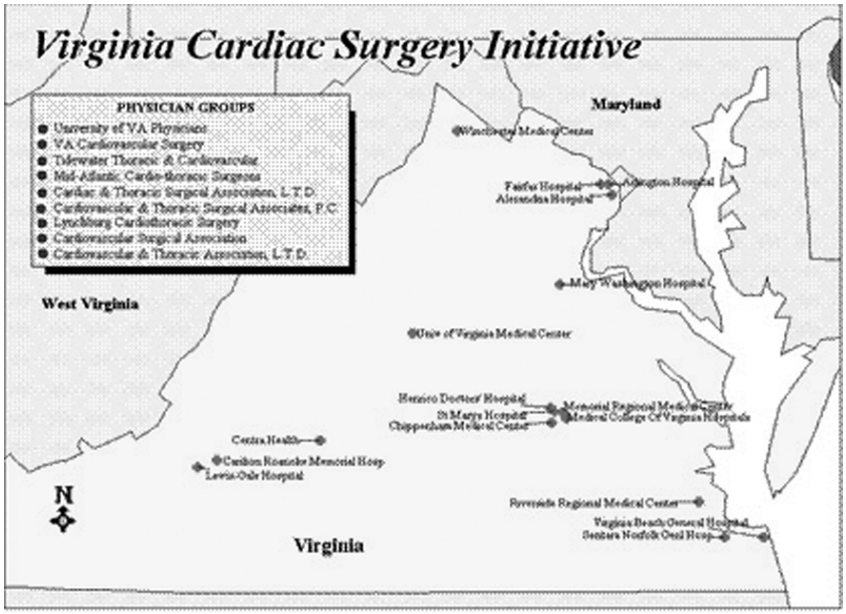
Now, armed with consensus measures (six of which are risk-adjusted outcome measures), and a clinical database, all stakeholders can evaluate cardiac surgical care with a level playing field across the nation using clinical data, processes, and outcomes. Every cardiac surgical program can be measured against the same yardstick. This allows doctors to see where care in specific areas can be improved, with the ability to analyze the techniques of "Best Practices" and apply these processes of care to improve quality and lower costs in their own practices.

Of course, the integrity of the data is crucial. The STS is developing a three-part approach for validating the data in its database. First, there are internal checks for data accuracy with rejection of data that are out-of-bounds. This will be coupled with a newly developed on-site audit. Secondly, the STS is in discussions with CMS about a partnership involving a chart abstraction audit through their CDAC mechanism. We are hopeful that this will be approved at CMS shortly. And lastly, we are pursuing a longer-range validation of mortality data by using the social security National Death Index to validate deaths 18 months after surgery.

Validation and audit mechanisms allow both providers and payers to rely on data for quality and cost implications. Trust is the foundation that physicians must have

to participate in the process and to make changes in their care patterns based on feedback they get from a database. It is important that the STS NCD is a VOLUNTARY effort by the participants performing these cardiac surgical procedures, and an example of what the medical profession can do when agendas are aligned.

In Virginia, we took this quality improvement feedback loop one step further. Fellow heart surgeons and I established the Virginia Cardiac Surgery Quality Initiative (VCSQI), to systematically improve care while reducing costs. The VCSQI is a voluntary consortium of 16 hospitals and 10 cardiac surgical practices providing open-heart surgery in Virginia. They are diverse in patient population, geographic location, size and resources.



We used the clinical quality data in the STS database, and using a third-party software solution from ARMUS Corporation, mapped it to the Medicare Part A payment data from the standardized UB–92 files. This enables us to examine the relationship between quality improvement and cost, and to address the question of whether improved quality can equal reduced costs. In short we can now evaluate VALUE in health care delivery.

Please allow me to give you a demonstration of how we are in the process of reducing costs by improving quality using real data from actual patients in Virginia.

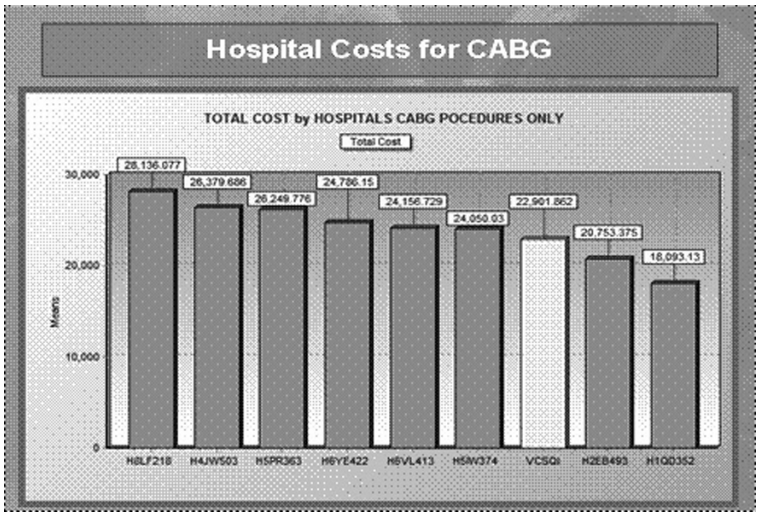
We allocated all costs into 21 revenue categories to better illustrate where resources were being spent. These categories are shown below, and include drugs, ICU costs, OR costs, lab, etc.

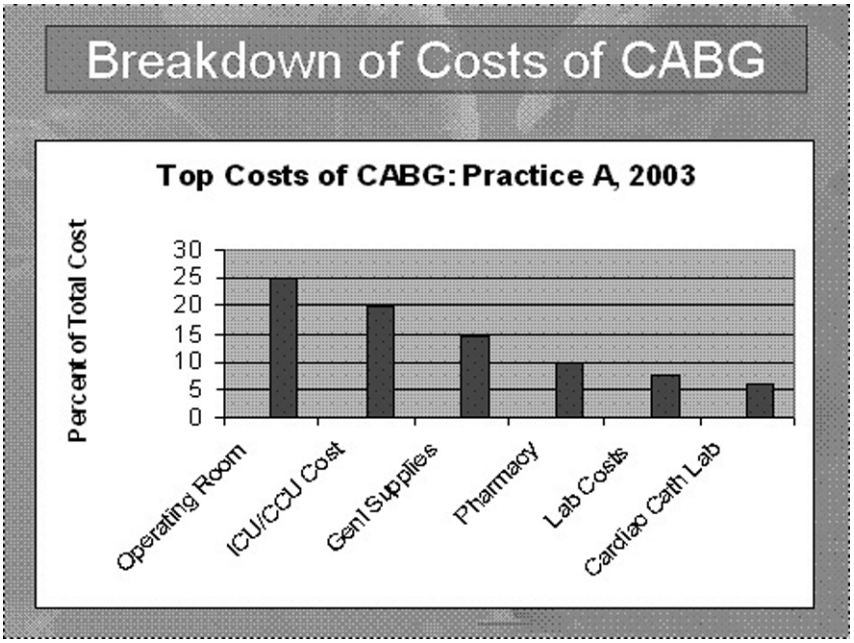
Revenue Code Categories

- Regular Room/Step Down
- Operating Room
- Peripheral Vascular Lab
- ER
- Cardiac Dx
- Dialysis
- IV
- General Supplies
- Implants (Pacers, ICD, Valve)
- Blood
- Miscellaneous/Other

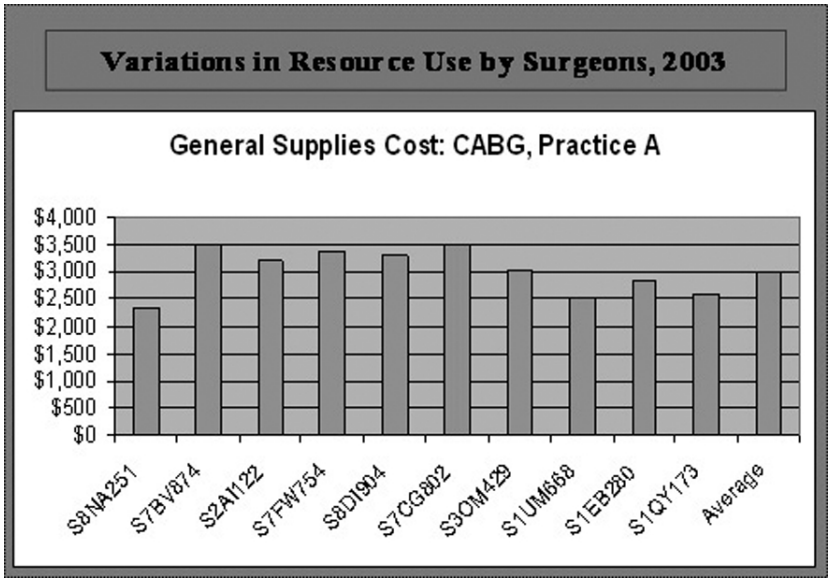
ICU/CCU
Recovery Room
Cardiac Cath Lab
Therapies (PT, OT, Cardiac Rehab)
Radiology (including MRI, CT)
Pharmacy
Respiratory Therapy
Anesthesia
Lab
Telemetry

Now we can compare the hospitals with lower spending to those with higher spending in each category. We can examine how higher spending in any particular category correlated with outcomes, and can identify interventions or treatment protocols that lead to better and more efficient care. By maintaining a focus on quality we can begin to examine resource utilization management that is patient-centered, safe and without negative consequences. In short, we have developed cost savings models that lead to improved quality of care.

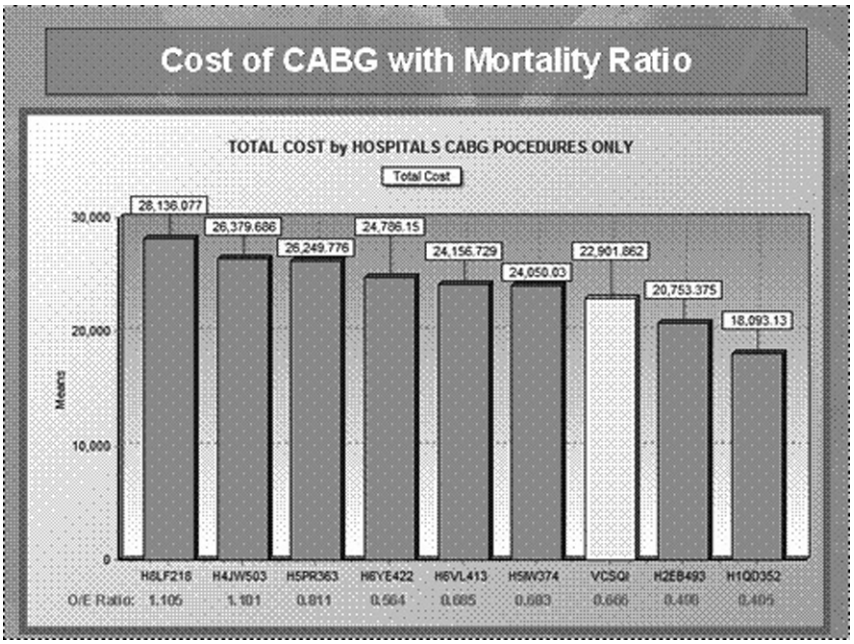



Breakdown of Costs of CABG
Top Costs of CABG: Practice A, 2003
Percent of Total Cost
30
25
20
15
10
5
0
Operating Room
ICU/CCU Cost
Gen'l Supplies
Pharmacy
Lab Costs
Cardiac Cath Lab

We also measure costs by surgeon . . .



And when we compared spending to mortality rates, we found that higher spending does not necessarily equal higher quality. In fact, in Virginia, the lowest spending hospital had the lowest observed to expected mortality ratio.

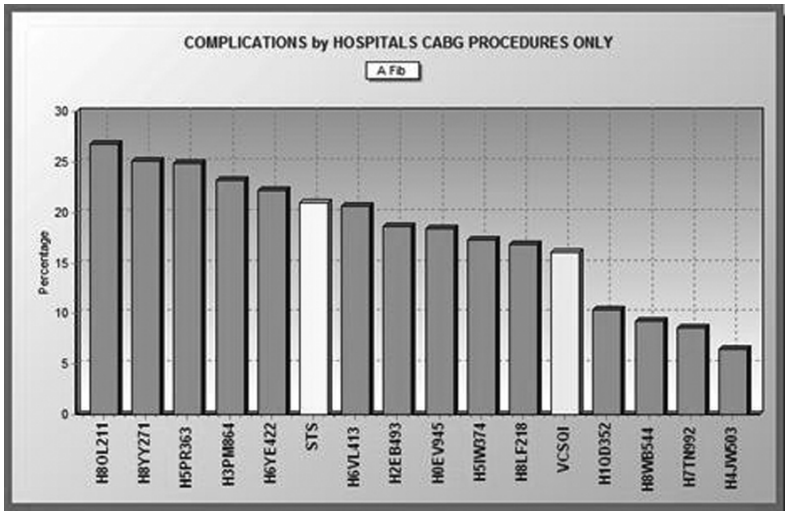


One of the key questions facing you today is how pay for performance can be implemented in the current difficult budget environment. The recommendation to repeal the SGR and replace it with incentive payments to physicians enabling them to make the IT investments required for quality improvement will not be easy, and must be done thoughtfully.

A budget neutral framework for pay for performance must not be the "tournament model" where the funds are taken from the lower performers and given to the best. We feel strongly that the tournament model will not produce the savings you seek and could hurt access to care by *vulnerable populations.* By punishing lower quartile providers, system capacity may be reduced, adversely affecting disadvantaged or minority patients. The primary goal of pay for performance must be quality improvement. Savings will accrue from improved quality.

Let me demonstrate how this works using an actual example from our Virginia initiative:

One common complication from open-heart surgery is atrial fibrillation. This is where the heart's electrical rhythm is out of sync and cannot pump blood efficiently. While not often deadly, we found that each instance of atrial fibrillation (A-fib) adds $2,366 to the direct cost of care during the hospitalization. In addition, it can lead to much more serious and expensive consequences such as stroke and hospital readmissions.



In analyzing our cost and quality data, we found that one hospital had significantly lower rates of A-fib after surgery. While the rate statewide was 16%, this "best practice" had a rate of 10% A-fib. The treatment protocol to accomplish this was shared with all other programs in the state and implemented within their practices. With an anticipated reduction of A-fib statewide to 10%, estimated cost savings to the healthcare system will be $1.3 million dollars every two years.

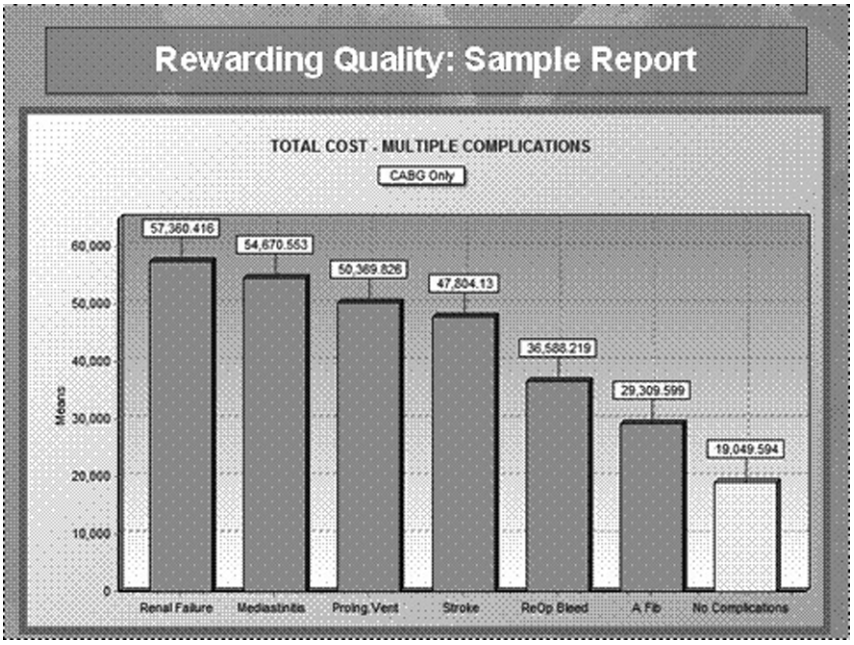
Cost Savings from Reduced A-Fib

- Virginia Cardiac Surgery Quality Initiative (VCSQI) CABG surgery w/o complications: $19,049
- VCSQI CABG Post-op atrial fibrillation (afib): $21,415
- Incremental cost: $2,366 (p=.0001)
- **With 16.2% incidence of afib in CABG patients (2003 VCSQI), a reduction to 10% (best practice) saves $1,279,666 over 2 years in Virginia**
- **Applied nationally using the STS database and QI processes, there will be $80,000,000 reduction in healthcare spending by addressing afib only**

When extrapolated nationally using the STS database, cost savings can reach as much as $80 million dollars over 2 years

Again, a key point here is that to achieve savings, you must improve the care of the lower performers until inter-institutional variation is minimized, and all quality is improved. That improvement would not have occurred had there been a budget neutral or "tournament style" P4P system in place. The creation of winners and losers discourages the best performers from sharing their best practices with others. In short, up-front budget neutrality, that robs Peter to pay Paul, stifles the communication that is essential to quality improvement and cost containment. The strides that the VCSQI is making in quality improvement would not be occurring without effective and open communications.

In Virginia, we can also measure the costs of other common complications following cardiac surgery, and can show the incremental cost of each complication, as in the table below:



Using modest estimates of achievable reductions in the rate of each of these complications, one can estimate the potential savings to Medicare beneficiaries at the national level using the STS database and its CQI processes.

National Business Case for Quality

- Applying same QI goals for following:
- Reoperation = $51,000,000/year
- Mediastinitis = $18,000,000/year
- Stroke = $45,000,000/year
- Prolonged Ventilation = $192,000,000/year
- Atrial Fib. = $40,000,000/year
- Total annual savings = $346,000,000

As you can see, we believe that through achievable improvements in quality, we can save $346 million in the U.S. *each year* by reducing these 5 complications in cardiac surgery. That equals a billion dollars every 3 years—imagine the savings you could achieve if all physicians were systematically participating in a clinical database and its associated CQI processes and reducing their specialty-specific complications. This system is designed to be replicated in other specialties and implemented in outpatient and chronic disease care as long as the process improvements are linked to outcomes measurement and quality improvement.

This is where the funding for pay for performance should be generated. Incentives to reduce costly complications have immediate savings potential for the healthcare system. We strongly disagree with the MedPAC recommendation to use an across-the-board reduction from all physician fees to create a bonus pool.

Although that approach would be a windfall for cardiac surgeons who are ready, it would likely have the unintended effect of taking resources from those who need them most to invest in health IT and develop clinical datasets.

Physician practices are very different than hospital systems in terms of their readiness and ability to purchase needed technology. Reducing physician fees would not be the positive incentive needed for investment in new systems. STS database participants pay an average of $50,000 per practice to submit and analyze clinical data. They must purchase software, hire a data manager, and spend their time improving care processes. These costs are not reimbursed in any way and they are not recognized by Medicare.

This is also why currently mandated SGR cuts threaten our ability to move forward with quality improvement. Facing larger than 5 percent fee reductions each year, physician practices are not in a position to invest scarce funds in new technology. We believe that the answer to inappropriate care lies in performance measures based on clinical data created by each specialty. Compounding the inability to invest is the uncertainty brought by the lack of standards for electronic health records.

Lastly, we appreciate the need for CBO and OMB to have evidence of more tangible, immediate savings in order to score these programs accurately. In this regard, I would recommend a national demonstration project to evaluate the effect of incentives on participation in the STS National Cardiac Database and to document the cost savings that can be achieved through a collaborative quality improvement effort. This can be instituted immediately given the high level of readiness of the STS with the potential for rapid replication in other specialties.

Congress and CMS must recognize that not all physicians have reached the same level of readiness as the STS, but must also recognize that the system of quality improvement and cost containment employed by the STS can be effective for every physician participating in Medicare. With this in mind, we believe that incentives should be established to encourage development and attainment of each component of a meaningful Pay for Performance Program that lends itself to quality measurement and improvement:

1. Structural measures—pay for participation: collect, analyze and share clinical data with providers.
2. Process measures—develop clinically relevant measures through a voluntary consensus process and measure compliance with a link to patient outcomes.
3. Outcome measures—develop consensus risk-adjusted measures of patient outcomes to evaluate better care.
4. Compare costs and link quality improvement to cost savings.

It is crucial to understand that these incentives must be positive updates to the current Medicare rate. The avoidance of reductions in payment as proposed by MedPAC is not incentive enough for physicians to make the IT investments necessary to participate in these programs. More importantly, a system whereby the best performers are rewarded by reductions in pay to the lowest performers is counterintuitive to the spirit necessary to allow sharing of best practices. This approach will pit providers in the healthcare system against each other, stifling improvement and ultimately cost containment. In fact, many argue that the biggest incremental gains in quality improvement will occur by focusing on the lowest performers, and that incentives should be provided there equally.

For these reasons Congress and CMS must do everything in their power to create incentives that promote the inclusive collaboration of physicians and all providers to improve healthcare quality for Medicare beneficiaries AND contain costs. If a common theme must emerge then let that be one of "Include and Improve" rather than "Divide and Conquer".

In conclusion, we believe the answer to many of the questions policy makers have sought in health care is to re-engage the profession in husbanding what is an in-

creasingly scarce resource, the health care dollar. We believe that incentivizing and supporting the development of condition-specific databases is one step in that process. Comparative effectiveness of treatments, long term efficacy of drugs and devices, appropriateness criteria for utilization, and racial or gender disparities can all be answered with valid clinical data.

If we have the foresight to prevent cuts mandated by an ineffective formula, it will allow us to take the major steps that will move us from making budget-based health policy, to making clinically appropriate health policy. And that is what our patients and your beneficiaries deserve.

Thank you for this opportunity and honor to appear before you.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Dr. Rich. Dr. Kizer.

STATEMENT OF KENNETH W. KIZER, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL QUALITY FORUM

Dr. KIZER. Chairwoman Johnson, Mr. Stark, Members of the Subcommittee, I am pleased to be here this morning to make some comments on improving Medicare quality and efficiency through performance measurement and payment incentives, and especially how those relate to physicians. I would like to touch on three things in these oral comments. First, I would like to briefly describe the role of the NQF as it relates to the subject of the hearing. Second, I would like to say a couple things about getting physicians to practice better evidence-based care based on my experience. Third, I would like to offer some personal thoughts about Medicare's potential to drive improved quality and efficiency of care.

First, on behalf of the more than 260 organizations that belong to the NQF, I am happy to tell you that we currently have under way a major project to identify performance measures that can be used to assess physician quality of care. I expect that the first set of those measures will be ready for implementation by late summer or early fall. I should probably say a few additional words about the NQF and the special role that it plays in this regard. The NQF is a not-for-profit membership organization that was created in 1999 to standardize national performance measures and quality indicators for health care. It does a number of other things, but it is most known for its work in performance measurement. The idea that there should be a private sector entity, with which the public sector was very much involved to standardize healthcare performance measures came out of a Presidential advisory commission. The commission felt that a forum was needed where both the private and public sectors could come together and where all health care stakeholders, i.e, consumers, purchasers, researchers, providers, manufacturers, and so forth, could be at the same table and working together to achieve some sort of coherent approach to quality improvement. The NQF is classified as a voluntary consensus standards setting body as specified by the National Technology and Transfer Advancement Act 1995 (P.L. 104–113) and the OMB Circular A-119. That means that we use a formal consensus development process to achieve or reach consensus on performance measures, preferred practices, quality indicators, and other things that come through the pipeline.

Since the Forum began operations in February of 2000 we have endorsed national performance measures for acute care hospitals, for nursing homes, for home care, for nursing sensitive care, for cardiac surgery, and, as Dr. Rich mentioned, for diabetes. We have work under way on cancer, deep vein thrombosis and ambulatory care. We have endorsed safe practices that should prevent medical errors, serious to reportable events that a number of States are now using for their adverse event reporting practices, and a number of other things that are currently under way. In particular, I think the ambulatory care project that is jointly supported by the Robert Wood Johnson Foundation and CMS will go a long ways toward addressing some of the needs here for performance measures that can be used for physician practices.

With that, let me shift gears and just comment a little bit on changing physician behavior, especially as it relates to improving quality and efficiency of physician-related care. I base these comments on a variety of perspectives, not the least of which is many years as a practicing physician, but also having run the largest Medicaid program in the country for many years. I worked with physicians on issues where payment was often, I think we all agree, not—they were not overpaid for their services and we often had to use other mechanisms to encourage improvements in care. Also more recently, for 5 years I served as a CEO of the largest health care system in the United States, in which I oversaw the care providers, more than 20,000 physicians, and during which time we engaged in a major quality improvement effort that is often used today as a example of radical organizational change.

I would offer two sets of observations that are related regarding changing physician behavior, especially as it relates to improving quality of care. First, to be successful at changing physician behavior, the prescription for change has to entail three elements. One, we should make changes that are clinically the right thing to do, i.e., that are good for patient care. In this case, that means that performance measures have to be based on good, sound medical evidence. The second thing is that we need to make the practicing physician's life easier if at all possible. A good example in this case would be reducing the amount of paperwork that would be necessary. For example, if we had standardized performance measures that were uniform, this would go a long ways toward making life easier for those on the frontline. Third, use rewards and incentives that are meaningful to the physician. In most cases those rewards and incentives will be financial, but there are certainly other settings where those might relate to time to do research or teaching or other things that are important to the physician that is involved. I would also note that in my experience, and I think in that of others, physicians generally respond much more favorably to positive rewards than to negative or punitive incentives.

The other lens that I would look through in sharing these comments is simply that there are three especially effective change levers that can be used to affect physician behavior today. One of those is performance measurement and public reporting. Second has to do with modernization of information management, and the use of IT. The third is the alignment of financial incentives with desired improvements in quality and efficiency. Dr. Rich has com-

mented on some specific examples in that regard. From my experience at Veteran's Affairs (VA), I can attest to how powerful performance measurement and public reporting are as change levers for physicians. As I believe the Committee is aware, the veterans health care system underwent a major transformation in the latter half of the nineties and today, when comparison is made on standardized quality indicators, VA outperforms Medicare on essentially all indicators of quality. Much of that change was accomplished by implementing a performance measurement system in which standardized measures of quality were regularly assessed and the results were made available for everyone to see. In this case there were no changes in payment that went along with performance measurement. It was simply making performance data available for everyone to see. Physicians respond quite dramatically to having that information made available. I have provided some additional comments regarding IT and payment incentives in my written testimony, and in the interest of time, I will not repeat those now.

I would just conclude these comments by making an observation about Medicare's potential to drive improved quality and efficiency of care. I think the Committee is well aware of the very robust documentation in recent years of the human and financial costs of medical error and deficiencies of quality in our health care system. I would commend CMS for the steps that it has taken so far in moving forward on a quality agenda, including things that are based on performance measurement and linking payment to performance. While applauding these things, if we compare the magnitude of the problem against the efforts that have been launched, I think that we would have to say that it is a very modest beginning. My recommendation to the Subcommittee is that payment for performance should become a top national priority and that Medicare should lead in this area, greatly expanding payment for performance programs for both hospitals and physicians. Not only would this have a positive effect in driving quality improvement in the Medicare Program, but it would also stimulate similar efforts and be encourage the private sector, just as Medicare's adoption of prospective payment for hospitals did 20 years ago. With that, Madam Chair, I conclude these comments. Thank you for the opportunity to be here.

[The prepared statement of Dr. Kizer follows:]

Statement of Kenneth Kizer, M.D., President and Chief Executive Officer, National Quality Forum

Good morning. I am pleased to appear before you today to comment on measuring physician quality and efficiency of care for Medicare beneficiaries. I commend Chairwoman Johnson for holding this hearing; the subject is most timely.

In the time that I have this morning I would like to do three things. First, I would like to briefly describe the role of the National Quality Forum as it relates to the subject of this hearing. Second, I would like to recount some lessons that I have learned over the years regarding physician behavior and improving physician quality of care. And third, I would like to offer some personal thoughts about Medicare's potential to drive improved quality and efficiency of care.

First, on behalf of the approximately 260 organizations that belong to the National Quality Forum (see attached member list), I am happy to tell you that we currently have underway a major project to identify performance measures that can be used to assess physician quality and efficiency of care. I expect the first set of

these measures will be ready for implementation by October of this year, if not sooner.

Before saying more about this particular effort directed toward identifying physician-related quality indicators, I should take a moment to make sure that the Committee understands the role that the National Quality Forum (NQF) plays today in healthcare quality improvement.

The National Quality Forum (NQF) is a not-for-profit membership organization created in 1999 to standardize national performance measures and quality indicators for healthcare; to develop a national strategy for healthcare quality measurement and reporting; to serve as an "honest broker" for convening multidisciplinary, multi-stakeholder groups to work on healthcare quality issues; and to do other things, as needed, to drive healthcare quality improvement. It was established pursuant to a recommendation of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The Commission recommended that such a Forum needed to exist where both the private and public sectors and all healthcare stakeholders (i.e., consumers, purchasers, providers, researchers and manufacturers, etc.) could come together to achieve accord about a coherent way to improve the quality of American healthcare.

The NQF is a voluntary consensus standards setting body as specified by the National Technology and Transfer Advancement Act of 1995 and OMB Circular A–119 (1998). The NQF use a formal Consensus Development Process (copy attached) that resembles federal rulemaking in a number of ways, and is more explicit than many other consensus processes used by voluntary consensus standards setting bodies—e.g., that used by the American National Standards Institute (ANSI). The performance measures endorsed via the CDP can be used for both public reporting and accountability purposes or for internal quality improvement activities.

Among the work the NQF has done to date has been to endorse performance measures in the areas of acute hospital care, nursing homes, home health, diabetes, nursing-sensitive care, and cardiac surgery. Other projects are underway to address cancer, deep vein thrombosis, and ambulatory care. In addition, we have endorsed a set of Serious Reportable Events in Healthcare, which serves as the basis of state-based mandatory adverse event reporting initiatives, and Safe Practices for Better Healthcare, a set of 30 practices that, if universally utilized in all applicable settings, would substantially reduce the risk of medical error. These 30 practices provide a clear roadmap for what needs to be done now to improve the safety of healthcare.

Of probable particular interest to the Subcommittee is our project on ambulatory care performance measures—i.e., performance measures for physician offices. The NQF is currently engaged in Phase II of the ambulatory care performance measures project.

Phase I consisted of a Robert Wood Johnson Foundation-funded effort to identify 10 priority areas for which standardized performance measures for outpatient care should be sought. These areas are: patient experience with care, coordination of care, asthma, prevention (primary and secondary, including immunization), medication management, heart disease, diabetes, hypertension, depression, and obesity.

In Phase II, the NQF seeks consensus on ambulatory care performance measures in these priority areas by expedited consideration of an existing array of more than 100 performance measures that have been developed by the American Medical Association's Physician Consortium for Performance Improvement, the Centers for Medicare and Medicaid Services' Doctor's Office Quality Project, and the National Committee on Quality Assurance. This work is funded by the Robert Wood Johnson Foundation and CMS. We expect to achieve consensus on an initial set of physician office performance measures later this year. We will then embark on Phase III of the project, during which we will endorse a more complete set of ambulatory care measures.

The second topic I want to comment on this morning is changing physician behavior and, in particular, improving the quality and efficiency of physician-related care. I base my comments on my personal experience as a practicing physician, my experience as the director of the largest Medicaid program in the nation, and my experience being the CEO of the largest healthcare system in the United States, in which capacity I oversaw the care provided by more than 20,000 physicians and during which time I engaged them in a major quality improvement effort that is often used today as an example of radical organizational change.

I would make two sets of observations regarding changing physician behavior.

First, to be successful at changing physician behavior the prescription for change should entail three elements: (1) a change that is clinically the right thing to do—i.e., it is good for patient care; (2) a way to make the practicing physician's life easier; and (3) rewards or incentives that are meaningful to the physician. In most

cases, rewards and incentives will be financial, but in some settings they may be time to do research or time to do teaching or other such activity. Today, one of the most effective ways to make the practicing physician's life easier is to reduce the amount of paperwork that he or she has to complete in order to get paid. It is also worth noting that, in general, physicians respond much more favorably to positive rewards than to negative or punitive incentives.

Second, similar to the above but viewed through a somewhat different lens, the three most powerful change levers for effecting physician behavior today are: (1) performance measurement and public reporting; (2) modernization of information management; and (3) alignment of financial incentives with desired improvements in quality and efficiency—what is often called payment for performance.

From my experience at the VA I can attest to how powerful is performance measurement and public reporting as a change lever for physicians. As I believe the Committee is aware, the veterans health care system underwent a major transformation in the latter half of the 1990s, and today the VA outperforms Medicare on essentially all standardized quality indicators. Much of that change was accomplished by implementing a performance measurement system in which standardized measures of quality were regularly assessed and the results made available for everyone to see. In this case, no changes in physician payment were associated with performance measurement.

Modernization of information management, and especially use of an electronic health record, is an important change lever in so far as it is a critical enabler or facilitator of quality improvement. Basically, it provides an easy and reliable means to document and assess performance

And lastly in this triad, while pay for performance is still in its infancy as a common method of payment for healthcare, conceptually it makes sense—as opposed to the current payment system in which one gets paid for the number of units of service delivered regardless of whether the service is truly needed or whether it is provided in a quality manner. Quite simply, if you want higher quality and more efficient physician services, then payment needs to be aligned in a predictable way with this goal.

Finally, I would like to conclude these comments with a few personal reflections about Medicare's potential to drive improved quality and efficiency of care. I would preface these comments by noting that the human and financial costs of medical error and substandard care have been exhaustively documented in recent years, and American healthcare truly faces a quality crisis today. At the same time, a robust inventory of performance measures and standards for quality improvement have been developed, and the repertoire continues to grow. The main problem is getting these performance measures and quality standards used. In this regard, the two most important players are physicians and payers, with Medicare being the single largest payer. Medicare has a unique opportunity to address the crisis of quality through its payment mechanisms.

The Centers for Medicare and Medicaid Services has taken significant steps toward operationalizing a quality strategy based on performance measurement and incentives. The agency's publication of performance data on nursing homes and home health agencies has heightened public awareness of the value of information on quality and has alerted the provider community that it has a critically important role to play in adopting best practices and improving patient safety. While information on hospital and physician performance may be more difficult to collect and organize, the CMS plans to extend the consumer information campaign to hospitals and in the meantime has launched a breakthrough demonstration project with Premier, Inc., a national alliance of nonprofit hospitals, to pay quality improvement incentive bonuses for Medicare patients at participating institutions. CMS has more recently announced plans for applying this concept to a number of large physician group practices. While applauding these milestones, when measured against the magnitude of the problem, these efforts have barely begun to achieve critical mass and momentum.

The performance measures available today may not be perfect and do not address all the areas needed; however, they are more than good enough to be used to accelerate the drive for quality improvement. My recommendation to the Committee is that payment for performance should become a top national priority and that Medicare should lead in this area, greatly expanding payment for performance programs for both hospitals and physicians. Not only would this have a positive effect in driving quality improvement, but it would also stimulate similar efforts by private payers, just as Medicare's adoption of prospective payment for hospitals did 20 years ago.

That, Madam Chair, concludes my comments this morning. Thank you for the opportunity to share my views with the Committee. I would be happy to answer any questions or clarify any of the points made here this morning.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Dr. Kizer. I do look forward to the discussion amongst all the panelists and the Committee Members. Mr. Lee.

STATEMENT OF PETER LEE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PACIFIC BUSINESS GROUP ON HEALTH, SAN FRANCISCO, CALIFORNIA

Mr. LEE. Thank you very much, Madam Chairman, Mr. Stark, distinguished Subcommittee Members. I am Peter Lee, the President and Chief Executive Officer (CEO) of the Pacific Business Group on Health, and I appreciate the opportunity to be with you today to talk about how leading purchasers are joining with labor, consumers and providers to measure and reward quality and cost efficiency to foster improvements in a very troubled health care system. In my remarks, I will seek to provide concrete examples of efforts currently under way to promote higher quality and more cost efficient care, highlight some principles that should apply to the expansion of these strategies and describe how Medicare can lead these important efforts. The variation of care and the quality of care that Americans receive has been well documented, as Dr. Kizer noted, but this is also true for the cost efficiency with which care is delivered to Americans.

In this slide I have before you and is attached to your material, this show actual data from a health plan in Washington that portrays the performance distribution of hundreds of individual physicians based on the quality of care and their cost efficiency. The vertical axis reflects their adherence to evidence-based quality of care process measures. The horizontal axis reflects cost-efficiency of the care they deliver, meaning it captures the total cost of care provided by each physician. This graph demonstrates that patients today are as likely to be seen by physicians who are providing lower quality care and less cost efficient—the lower left quadrant—as they are to be seen by high quality, more cost efficient doctors, the upper right quadrant. Today the vast majority of physicians do not know where they stand in terms of the quality and cost efficiency of their care. They are not rewarded through payments for doing a better job and patients to do not have information to make better choices. Both research and practical experience have demonstrated that significant cost savings are achievable while improving the quality of care, and we have heard some examples of that already today from STS.

Actuarial modeling—Medicare has demonstrated that slight movement upward and right—could generate 3 to 4 percent savings in Medicare alone. Other estimates show those savings could be far greater. Over the past 5 years there have been a growing array of programs that seek to measure provider performance, make that information available to providers for improvement, and reward better performers with payments or by public recognition. These programs are touching the lives of tens of millions of Americans

today, and thousands of physicians and thousands of hospitals. They provide lessons for Medicare and chart the way for changing our payment system into one that actually rewards better performance. Many of the Nation's leading health plans have programs that promote high performing physicians and hospitals, such as Aetna, Blue Shield of California, Pacific Care, Humana and United Health. Health plans are developing these products in direct response to the call by purchasers and the evident gaps in the current payment and delivery system. We have also seen employers and labor institute collaborative projects to reward and measure performance.

The three examples I would like to highlight briefly are, first, a program from the UNITE–HERE Labor Management Trust in Las Vegas. UNITE–HERE is a labor group that represents 120,000 hotel workers and their families in Las Vegas, Nevada. After many years of double-digit cost increases the trust decided to focus on the variation in quality and cost efficiency of the physicians serving its members. It measured the physicians using industry standard cost efficiency tools, and measured the quality of care based on analyzing administrative data and looking at the extent physicians were meeting evidence-based guidelines.

In 2003, after using cost efficiency analysis as a screening tool and applying other criteria to ensure fairness and maintenance of adequate access to all kinds of care, the Trust excluded 50 of 1,800 physicians from their network. The Trust at the same time identified physicians as gold star based on their quality of care. These gold star physicians were highlighted in the physician directory for their beneficiaries. In addition, these physicians were eligible for performance bonuses of up to 10 percent of their compensation weighted three-quarters by quality and one-quarter by cost efficiency. The results were dramatic, as you can see from the second slide. What you have is an experience where trend was reduced over 10 percentage points from what had occurred the prior year at a 12-percent rate increase. The vast majority of those savings, 70 percent, was due to changes in the physician network, and the ripple sentinel effect on the physicians in the network. For these low-wage hotel and restaurant workers and their families, the result of the savings generated has met that they were able to see salary increases for the first time in 3 years.

The next program I would like to reference is the Bridges to Excellence Program, a multi-stakeholder approach to rewarding quality. Through Bridges to Excellence, quality is measured uniformly by three national Committees for quality assurance developed physician recognition programs. These programs look at physician practice connections which look at the extent to which physicians practices have implemented IT systems that have been proven to show that they can improve the quality of care. A version of these measures is currently being used by CMS as part of their pilot programs. The second recognition program is for diabetes care and the third for heart and stroke. Physicians elect to participate in these programs and go through a submission of data. The employers that participate use this data to reward higher performers who can receive bonuses of up to $20,000 depending on how many patients are in their panel. This program has been launched in four commu-

nities by employers such as Ford Motor, Verizon, General Electric and Hannaford Brothers. To date over $1 million has been paid out, and Bridges to Excellence, beyond paying the physicians, is seeking to engage consumers by supporting them in care management tools for diabetes and cardiac care and providing incentives for patients to participate in programs to enable them to manage their illnesses. The program is now being expanded to over a dozen additional areas.

The third program I would like to reference is the Integrated Healthcare Association's initiative in California, my home State. The Integrated Healthcare Association (IHA) initiative has brought together the seven leading health plans in California with over 200 medical groups, with purchasers, with consumer advocates, to launch a program that reaches physician groups in California's Health Maintenance Organization (HMO) market. The drivers of IHA's initiative are similar to the three we have heard from the prior programs. They are about common measures. It is about public reporting and payment, in this case from health plans. The seven health plans and over 200 physician groups encompass over 7 million HMO enrollees in California and 25,000 physicians. In 2004, using these common metrics, over $50 million was paid out by the health plans of these medical groups and $100 million in total with some of the health plans using other performance measures as part of their rewards. Many physician groups report these bonus payments are key drivers in terms of their making more rapid investments in IT, and at the same time these common measures are used by the State of California's Report Card on Medical Groups and by health plans in doing benefit designs.

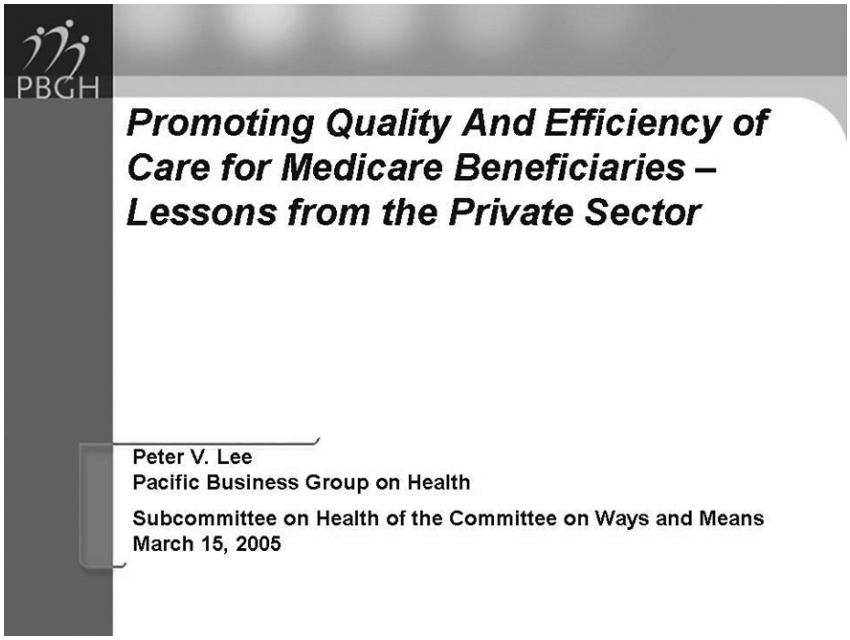
These three initiatives provide concrete examples of programs that share a common goal of encouraging improvements in quality and cost efficiency by linking payments to better performance and by engaging consumers. As a nation we need to move forward with a standard set of performance measures for physicians and hospitals as rapidly as possible. As other speakers have said, we need to avoid a tower of Babel of conflicting measures by getting a full set of physician and hospital measures endorsed by the NQF, and, through that process, assuring that these measures are valid, reliable and transparent. In addition to the clinical quality and patient experience measures that we need to have, we have to have a similar rapid review by the NQF for cost efficiency measures. We need cost efficiency measures that are feasible to implement by health plans and by CMS, credible and reliable for consumers, and fair, equitable and actionable by providers. In my written testimony I highlight some of the challenges for doing this right, but also underscore that we have to do this now.

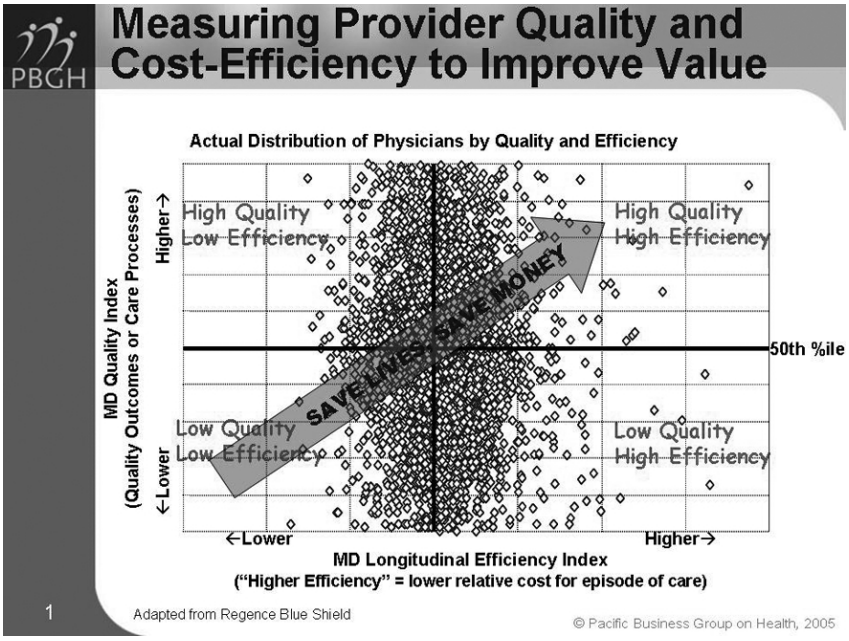
Finally, I would like to remark briefly on CMS. The CMS, as we have heard, has increasingly embraced performance measurement and rewards through demonstration projects, and I want to applaud CMS Administrator Mark McClellan's leadership in this area. We strongly support the recent recommendations of MedPAC that CMS go beyond demonstrations to phase in an increasing percentage of performance based payments for hospitals, physicians and home health care. We need to move to making performance-based payment a substantial portion of our payments to physicians

and hospitals. Likely, I think we need to be in the range of the 20 percent that is currently being paid in the United Kingdom. The many private sector efforts need the leadership and partnership of Medicare to foster improvements that will ripple through the entire health care system.

In addition to the MedPAC recommendations to phase in performance rewards for providers, we also need to move in parallel to phase in transparency in reporting, to allow consumers and the private market to make this information available for making better choices. Beyond its own use, CMS should make routinely available to the private sector the patient-identify encrypted version of the full Medicare claims database, so private plans can more precisely measure hospital and physician performance. Medicare must reward better performance and provide consumers with tools to make better choices. We have to take deliberate steps to increase the portion of payments made to providers that are based on performance and the extent to which this information is shared with the public. We must move beyond a system that currently is performance blind. Thank you very much for this opportunity to be with you, and I look forward to your questions.

[The exhibits follow:]




PBGH
Measuring Provider Quality and Cost-Efficiency to Improve Value
Actual Distribution of Physicians by Quality and Efficiency
MD Quality Index
(Quality Outcomes or Care Processes)
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High Quality
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High Quality
High Efficiency
SAVE LIVES
SAVE MONEY
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Low Quality
Low Efficiency
Low Quality
High Efficiency
←Lower
Higher→
MD Longitudinal Efficiency Index
("Higher Efficiency" = lower relative cost for episode of care)
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Adapted from Regence Blue Shield
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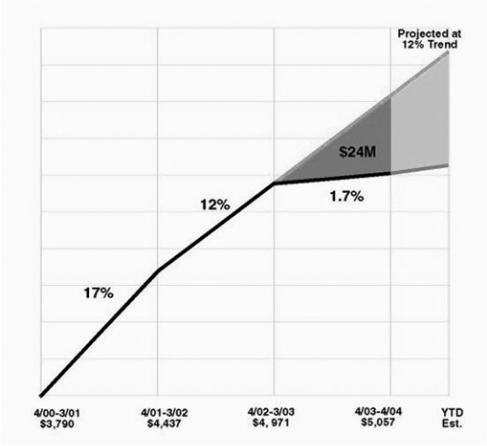
PBGH

Real Savings from Early Steps to Rewarding Higher Value Physicians



UNITE-HERE Labor Management Trust Fund Program (Hotel workers union representing 120,000 members in Las Vegas, NV)

- **Savings from network design using admin data to profile on quality and cost-efficiency**
- **Substantial physician engagement -- all engaged, but only 50 of 1,800+ excluded**
- **One year savings of 10.3%**
- **70% of saving from network design (balance from benefit design)**
- **P4P for quality and affordability by physicians**

Courtesy of Elizabeth B. Gilbertson, UNITE-HERE Labor Management Trust Fund, 2005

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[The prepared statement of Mr. Lee follows:]

Statement of Peter Lee, President and Chief Executive Officer, Pacific Business Group on Health, San Francisco, California

Chairman Johnson, Congressman Stark, distinguished Subcommittee members, I am Peter Lee, the President and CEO of the Pacific Business Group on Health. I appreciate the opportunity to be with you this morning to talk about how leading purchasers are working with labor, consumers and providers to measure and reward quality and cost-efficiency to foster improvements in a very troubled health care system. In my remarks I will provide concrete examples of efforts underway to promote higher quality and more cost-efficient care through measurement and reward programs, highlight some principles that should apply to the expansion of these strategies, and describe the how Medicare can join and even lead these important efforts.

The Pacific Business Group on Health is a nonprofit association of many of the nation's largest purchasers of health care, based in California. PBGH represents both public and private purchasers who cover over 3 million Americans, seeking to improve the quality of health care while moderating costs. The members of PBGH range from large public and private purchasers such as Bank of America, CalPERS, FedEx, Target, the University of California and Wells-Fargo, to thousands of small businesses in California that we serve through our small employer purchasing pool—PacAdvantage. For fifteen years, PBGH has been a catalyst promoting performance measurement and public reporting at every level of the health care system to improve performance and to help consumers to make better choices.

Current Performance Gaps—Wide Variation and Significant Room for Improvement

Health care cost is one benchmark against which both employers and employees measure health care. By that measure, with costs nearly doubling over the last five years, we should be getting more and better health care. While it's true that there have been important advances in technology and new services, it is also sadly true that there is a huge value disconnect in our health care system. Recent research by RAND found that an American's likelihood of getting the right care at the right time was about 50 percent. This work only serves to underscore reports from the Institute of Medicine and others that document the chasm between what clinicians know works and the care actually provided. These deficits persist despite many initiatives by both the federal government and private health care delivery systems to improve care. Key findings of the RAND work include:

- Overall, adults received about 55 percent of recommended care;
- The level of performance was similar for chronic, acute, and preventive care;
- Quality of care varied substantially across conditions. For example, people with cataracts received about 79 percent of recommended care; those with hip fractures received about 23 percent.

The variation in care is also true for the cost-efficiency with which care is delivered to Americans. In Slide 1 of the material accompanying this testimony we show data from a health plan in Washington that portrays a performance distribution of hundreds of individual physicians based on the quality of the care and their cost-efficiency. The vertical axis reflects adherence to evidence-based quality of care process measures. The horizontal axis reflects the cost-efficiency of the care they deliver (measuring "longitudinal efficiency" which captures the "total cost of care provided by each physician"—adjusting for the mix of illnesses among their patients and including all physician, lab, hospitalizations, pharmacy, imaging and ALL other costs related to an entire episode of acute care or a year of chronic illness and preventive care).

This graph demonstrates that patients today are as likely to be seen by physicians who are both lower quality and less cost-efficient (the bottom-left quadrant) as they are by high quality, more cost-efficient doctors (the upper-right quadrant). Today, the vast majority of providers do not know where they stand in terms of the quality and cost-efficiency of their care; they are not rewarded through payments for doing a better job; and patients do not have information to make better choices. Some of the lessons from this reality are:

- While we have an obligation to give patients better information to choose doctors—and let them know where their doctors stand with regards to quality and cost-efficiency—it is just as critical that we provide information and incentives to providers to move "up and right." Consumer AND provider information and incentives must be about fostering performance improvement by physicians.

- Both research and practical experience have demonstrated that significant cost savings are achievable—while improving better quality care. The "Breakthrough Competency" assessment of health plans conducted by PBGH reported on research finding that up to 17 percent of premium could be saved by better provider selection, while actuarial modeling in Medicare identified savings of 3–4% with relatively little movement "up and right." (The full details of the evaluation of potential Medicare savings conducted by the Consumer-Purchaser Disclosure Project are attached to my testimony.) Both of these figures are likely low estimates. Since we have never had a health care system that rewarded better cost-efficiency and quality, we have no idea how large the savings could be or how quickly quality would improve if we harnessed market forces to continuously motivate better performance.

Over the past five years there have been a growing array of programs that seek to measure provider performance, make that information available to providers for improvement, and reward better performers with payments or by public recognition programs. The Leapfrog Group recently published a compendium of 90 incentive and reward programs sponsored by health plans, private purchasers, CMS and others. These programs are touching the lives of tens of millions of Americans, and thousands of physicians and hospitals. They provide lessons for Medicare and chart the way for changing our payment system into one that actually rewards better performance.

Performance-Based Provider Programs

Many of the nation's leading health plans are instituting programs that promote high performing physicians or hospitals. Examples include:

- Aetna's Aexcel Network, through a set of multi-tiered options, promotes higher-performing physicians in 12 specialties based on clinical quality and cost-efficiency;
- Blue Shield of California's hospital tiering, which includes consumer information on hospital performance, is based on cost-efficiency and quality;
- PacifiCare's medical group and hospital tiering also combines quality and relative cost-efficiency;
- Humana promotes better consumer choice through its use of a "Hospital Value Index;" and
- United Health Plan's Performance Program identifies more efficient and higher quality physicians, and offers a Centers of Excellence program for hospitals.

Health plans are developing these products in direct response to the call by purchasers and the evident gaps in the current payment and delivery of health care. We have also seen employers and labor institute collaborative projects to measure and reward higher performance. Three examples I would like to describe are a program sponsored by the UNITE–HERE Labor Management Trust in Las Vegas, Nevada to create a more cost-efficient network of physicians and reward better performers, the Bridges to Excellence program rewarding individual physicians, and California's Integrated Healthcare Association initiative for medical groups.

UNITE–HERE Labor Management Trust Fund, Las Vegas

The UNITE–HERE Labor Management Trust Fund is a Taft-Hartley trust providing health care to 120,000 hotel workers and their families in Las Vegas, Nevada. Faced with years of double digit medical cost increases, the Trust decided to focus on the variation in quality and cost-efficiency of physicians serving its members. The Trust measured all of its physicians using an industry standard "cost-efficiency tool" that assesses the longitudinal efficiency of care provided, and also measured the quality of care provided based on analyzing administrative data to determine the extent to which physicians were meeting evidence-based guidelines. In 2003, after using cost-efficiency analysis as a screening tool and applying a variety of other criteria to ensure fairness and maintenance of adequate access to all kinds of care, the Trust excluded 50 of the 1,800 physicians that had been providing care as network providers. The rationale given by the Trust for its program was that multiple factors, of which cost-efficiency screening was one, were taken into account in deciding who was included in its restructured physician network. At the same time, the Trust identified "Gold Star" physicians based on their quality of care. These Gold Star physicians were highlighted in the physician directory for Trust beneficiaries. In addition, these physicians were eligible for performance bonuses of up to 10% of their compensation based on a calculation that gave ¾ weight to quality and ¼ weight to cost-efficiency.

The results have been dramatic (as can be seen in Slide 2)—with medical trend reduction of over ten percentage points from the trend that would have occurred if

the 12% rate from the previous year had continued. The vast majority of the savings (70%) was due to the changes in the physician network and the ripple sentinel effect on all the network physicians. (At the same time, the Trust instituted changes to its formulary, added a pharmacy benefit that provided some generics at no cost and made other benefit design changes that accounted for the remainder of the savings.) For these low-wage hotel and restaurant workers and their families, the result of the savings generated has meant they are seeing salary increases for the first time in three years, making possible a 30 cents per hour wage increase that would have otherwise been unaffordable.

Bridges to Excellence

Bridges to Excellence (BTE) is a multi-stakeholder approach to creating rewards for quality. The mission of BTE is to improve quality of care through incentives that encourage providers to deliver optimal care and encourage patients to seek evidence-based care and self-manage their conditions. By recognizing and rewarding providers who demonstrate they have implemented comprehensive solutions in the management of patients, BTE seeks to create significant leaps in the quality of care. Quality is measured uniformly using one of three NCQA-developed physician recognition programs. These programs focus on areas where there is a clear link between quality improvement performance criteria and actuarially estimated financial returns for payers and for providers in a fee-for-service environment. The three NCQA recognition programs that serve as the basis for payments (summary information provided in Slide 3 attached) are:

- **Physician Practice Connections** measures the extent to which a practice has implemented information technology (IT) systems that leverage available data to track and educate patients, maintain medical records, prescribe medicines and ensure appropriate follow up. These are all IT systems that have been shown to dramatically improve patient care and prevent mistakes. A version of these same measures is in development to be used by CMS as part of its efforts to pilot reward programs with the DOQ–IT project, the Medicare Care Management Program Demonstration project, and the upcoming 8th Scope of Work for Quality Improvement Organizations.
- **Diabetes Provider Recognition Program,** developed with the American Diabetes Association, covers an array of measures for effective care to diabetics. The measures assess care for diabetics in a physician's practice including the measurement and control of cholesterol, blood pressure and blood sugar (HbA1C) levels, and whether critical eye, foot and kidney function exams are conducted; and
- **Heart Stroke Recognition Program** has six measures of effective care for people with cardiac disease, developed in collaboration with the American Heart Association. The measures assess physicians' care of patients with cardiac disease and include the measurement and control of cholesterol and blood pressure levels, use of aspirin and smoking cessation advice.

Physicians elect to apply for recognition with NCQA and submit data documenting their performance. The sponsoring employers then assess the extent to which their employees are being seen by participating doctors. Those that are recognized as high performers can receive "bonus payments," which could earn a physician practice an additional $20,000 from BTE.

The program has been launched in four communities in Ohio, Kentucky, Massachusetts and New York by employers such as Ford Motor, Verizon, General Electric and Hannaford Brothers with a half dozen health plans (as described in Slide 4 attached). While nationally these employers sponsor health care for millions of Americans, in the four named communities alone they are providing incentives for services provided to over 300,000 employees and dependents. BTE has paid out more than $1 million to date, out of an available pool of $8 million. Payments to physicians are geared to reflect higher standards over time.

In addition, the participants in BTE seek to engage consumers by supporting them with care management tools for diabetes and cardiac care and providing information on physicians that have completed the recognition program to inform the consumers' selection of provider. The patients in physician practices recognized by BTE are more likely to get the right care at the right time, such as increased early testing for diabetes, for heart disease, or learning how to better manage their chronic illnesses. BTE also provides incentives to patients who participate in programs to enable them to better manage their illnesses.

The program is now being expanded to over a dozen additional areas by United Health Care, multiple Blue Cross/Blue Shield plans, including CareFirst here in the Washington, DC area, and employers and purchaser coalitions. While BTE has

learned that physician certification processes are resource intensive, they have also seen how important this route can be to engage physicians.

California's Integrated Healthcare Association's Medical Group Pay-for-Performance

Over the past four years, the Integrated Healthcare Association in California has brought together a collaboration of purchasers, seven of California's largest health plans, physician groups, consumer advocates and researchers to launch a pay for performance program to reward physician groups in California's HMO market. The goal of the IHA program is to create compelling incentives to drive breakthrough improvements in clinical quality and patient experience. The drivers of IHA's initiative are common measures, public reporting and payment from health plans. The use of standard measures creates economies of scale for data collection and enables a common platform for statewide public performance reporting (a full description of this program is attached to my testimony).

The common metrics that are the basis of the IHA initiative are:

Clinical Quality *(50% weighting)*

- 10 HEDIS-based measures for preventive care (cancer screening and childhood immunizations) and chronic disease care (for asthma, diabetes and cholesterol management) reported with administrative data

Patient Experience *(30% weighting)*

- 5 measures that reflect overall ratings of care, access, specialty care, and communication between physician and patient, collected through common statewide CAHPS-like survey

Investment and Adoption of IT *(20% weighting)*

- Measuring extent of data integration (e.g., combining pharmacy and inpatient data) and clinical decision support at the point of care, with capacity collected through web-based survey plus audit

The seven health plans (Aetna, Blue Cross of California, Blue Shield of California, CIGNA, Health Net, PacifiCare, Western Health Advantage) and over 200 physician groups participate in this initiative, encompassing 7 million HMO enrollees and 25,000 physicians. In 2004, more than $100 million in bonus payments were made to participating medical groups, with half of the pay-out, $50 million, based on common quality measures established by IHA. There is every indication that the 2005 payout will be even larger.

A range of stakeholders—including health plans, physician groups, purchasers and consumers—selected the measures. In an effort to minimize burden on the participating physician groups, the clinical measures are all based on administrative data and the patient experience survey on a statewide standard. PBGH, together with the National Committee for Quality Assurance (NCQA), and the California HealthCare Foundation, have spearheaded the development of measures for this program. Many physician groups report these bonus payments as key drivers in making more rapid investments in information technologies. We are also seeing marked improvement in performance areas that we can track over time—such as for patients' reported experience of care.

The program also gives credit for physician groups' efforts to measure individual physician performance on clinical effectiveness and patient experience, provide regular feedback to those physicians and offer rewards based on performance. Many of California's physician groups are taking this next step of measuring and rewarding individual doctors. One demonstration of the growing interest can be seen in the participation of 18 physician groups in physician-level patient experience surveying which is sponsored by PBGH and which seeks to align individual physician survey efforts with those at the group and health plan level.

In addition to the common metrics being the basis of payments, the IHA initiative has helped provide a common picture of physician group performance for consumers, thereby providing a consistent picture of medical group performance. This information is now being used by the State of California's Office of Patient Advocate and PBGH's HealthScope consumer websites, as well as by the participating health plans. In addition, it is being used by health plans such as PacifiCare and Health Net to inform their design of higher value networks that deliver both higher quality care and relative premium savings.

Building on Lessons Learned

These three initiatives provide concrete examples of programs that share the common goal of encouraging improvements in quality and cost-efficiency by linking payments to better performance, and by engaging consumers. In each case, the sponsors recognized that they needed to constructively engage both providers and consumers. In addition, they all recognize that the measures each is using are a work in progress. As a nation, we need to move to a standard set of performance measures for physicians and hospitals as rapidly as possible. The Consumer-Purchaser Disclosure Project, a coalition of employers, labor, and consumer groups, has endorsed a set of guidelines to encourage alignment of the many efforts in effect today. We need to also avoid having a Tower of Babel of conflicting measures by:

- Getting a full set of physician and hospital measures endorsed by the National Quality Forum ("NQF"), and through that process we are assured of their validity, reliability and transparency.
- Assuring that measures are not "black boxes"—those conducting measurement and reward programs should be fully transparent and those being measured must have an active role in shaping the measures and understanding their component parts.

In the case of physicians, within the next two years there should be an NQF-endorsed standard ambulatory patient-experience survey. On the technical quality of care front, while there are proven measures that use administrative data—none have yet been subject to the National Quality Forum's endorsement process. The NQF, however, is embarking on an Ambulatory Care measurement process, This process should result in a "starter set" of measures, but will need to be rapidly expanded to reach the full array of specialists through increasingly expanded administrative data reporting.

We need to have a similarly rapid review and NQF-endorsement process for cost-efficiency measures. As detailed in a recent multi-stakeholder effort describing working standards for measuring provider cost-efficiency, sponsored by the Leapfrog Group and Bridges to Excellence, we need cost-efficiency measures that are feasible to implement by health plans and CMS, credible and reliable for consumers and fair, equitable and actionable for providers. The need for efficient and timely data collection necessitates use of administrative data for reporting. In doing so, however, a number of key factors need to be considered, including:

- Using existing administrative data, but building on that data to include pharmacy and laboratory results data where it is not already present—these are key additions in the case of Medicare, and were recently recommended by MedPAC;
- Assuring that for physician measurement there are enough patient encounters combined to make reliable reports and enough physicians to make valid comparisons;
- Applying appropriate attribution rules for when to assign the cost of services to a particular physician and/or physician group;
- Determining the best balance between reporting physician performance via a few aggregate performance measures versus a complement of narrow performance measures;
- Applying appropriate case-mix and severity adjustment to account for different populations seen by physicians, and
- Assuring interoperability in health IT and data exchange systems to foster efficient data access and aggregation.

These challenges have been and are being addressed in the dozens of programs that are up and running around the country. Our challenge as a nation is to make sure they are addressed consistently, fairly and soon to create truly national standards. Though there will always be ongoing opportunities to improve the precision and validity of provider performance measures, there is clear consensus among consumer organizations, purchasers and many providers that current measures are sufficient starting point and the time for universal performance transparency is now.

Medicare—The Opportunity and Necessity to Lead

CMS has increasingly embraced performance measurement and rewards through demonstration projects. And we applaud CMS Administrator Mark McClellan's leadership in this area. We strongly support the recent recommendations of MedPAC that CMS go beyond demonstrations to phase in an increasing percentage of performance-based payments for hospitals, physicians and home health care. Though it remains unknown what level of performance-based payment will best accelerate our crossing the quality chasm, many researchers have observed that the small percentages tested to-date are woefully inadequate. We need to move to making per-

formance-based payment a substantial portion of our payments to physicians and hospitals—likely in the range of the 20% currently being paid in the United Kingdom. The many private sector efforts need the leadership and partnership of Medicare to foster improvements that will ripple through the entire health care system. In contrast to the 90 programs currently operating across the country, Medicare not only has a national geographic reach, but it has the service density in virtually every community to provide a robust picture of the performance of most providers.

The programs I have described reinforce the rationale behind the MedPAC proposal to start with rewarding information technology capacity and then phase in performance rewards for quality, patient-experience and cost-efficiency as measures for these areas are endorsed by NQF. In addition to the MedPAC recommendations to phase in performance rewards for all providers in Medicare, we also need to move in parallel to phase in transparency in reporting to allow consumers and the private market to use the information to make better choices. Medicare itself should build on its important efforts at public quality reporting in the hospital and nursing home arenas to show publicly the relative performance of physicians and add measures of cost-efficiency.

Beyond its own use, CMS should make routinely available to the private sector, the patient identity-encrypted version of the full Medicare claims data base, so private health plans can more precisely measure hospital and physician performance over longitudinal periods of illness (which most private sector plans do not have sufficient data with which to do on their own with precision).

Medicare must reward better performance and provide consumers with tools to make better choices. While these steps should be taken with all due deliberation and consideration for the complexities—we need to keep in the forefront of our minds that employers, consumers and taxpayers are being faced with untenable options by a health care system that delivers inconsistent quality at a staggering cost relative to other countries with which our companies and workers compete. The National Health System in the United Kingdom has embarked on a program to have 20% of family practice payments be performance based. While I believe that we should move to a system that has a similar portion of payments based on performance, we need to move in that direction by taking deliberate and considered steps. Taking deliberate steps, for example, means that physicians and hospitals should see their results before they are publicly released. But deliberate steps must be taken to increase the portion of payments made to providers that are based on performance and the extent to which this information is shared with the public. We must move beyond a system that is performance blind.

Most patients today are not receiving the care we know they should be. Most providers are paid the same whether they deliver the high quality or low quality care, irrespective of their cost-efficiency. Wasted spending that buys no incremental health likely exceeds 25% of current spending. We must change these dynamics—consumers must have the performance measurements and incentives to make the best choices; and providers must be rewarded for doing a better job. Thank you for the opportunity to be with you today.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, and I thank all the members of the panel. I want to raise the issues, more specifically, of technology. Dr. Lee, in your written testimony you say we must start with rewarding IT capacity and then phase in performance awards for quality patient experience, cost efficiency and so on. Mr. Kuhn, on the contrary, you note the potential of technology. How can we possibly do this? Dr. Rich, you certainly point to the 15 years it took to develop the clinical database that you need. What is the relationship of our incentivizing the adoption of technology, particularly in the physicians' offices out there? Most of the hospitals are pretty well on their way,but how far can we go, without the technology to collect the relevant clinical data, to make this realistic and fair, and make these steps a clinical advance in the delivery of quality care?

Mr. KUHN. The technology is going to be key in all of this because through the technology you are going to be able to draw the picture, connect the dots—whatever you want to say—of the entire

patient experience. It is an opportunity, at least in the physicians' offices for them to look at their patient cohort as a whole; to understand which ones have special needs and deal with those folks accordingly. It can set up the opportunities to trigger follow-up visits. Through technology, physicians can look for drug interactions. It includes all of the different things in the tool kit that physicians can use.

We think technology is important and it creates some real value propositions to them on a go-forward basis, not only for the physician but also in this whole area of trying to drive better performance. We are excited that one of the demonstration authorities we have in the Medicare Modernization Act, Section 649, is an opportunity to reach out to both smaller and medium size physician offices to begin to look at opportunities to deploy technology in those settings. We are moving in that area now. We also have, through our quality improvement organizations, a program called doctors office quality information technology (DOQ–IT). We are engaging physicians on a one-by-one basis across the country in an upcoming scope of work to try to drive better opportunities. It is an important piece that helps us knit together the picture. So, I agree it is an important anchor as we go forward in this whole effort.

Chairman JOHNSON OF CONNECTICUT. Anyone else want to comment?

Mr. LEE. If I could. I think that it is an important step, and I actually did hear the doctor from STS, and it is an important first step in terms of recognition of having IT systems in place and using those systems. I think that the work STS has done has been so important as a national model. However, it is a model that we can't wait 12 years to have ripple through every other specialty. The issue of having IT systems in place is about making sure we can collect data efficiently so we can use administrative data in a valid way to make sure we are able to report more broadly across all specialties.

Chairman JOHNSON OF CONNECTICUT. I should have added to my question, we don't have interoperable standards yet and that is an impediment to any government mandate. Dr. Rich, you guys have been at it a long time; is the technology you are using so standard? Dr. Kizer, in the VA, was the technology so standard that we would assume that any standards of interoperability would address the kind of technology that you are using in this instance? Dr. Rich?

Dr. RICH. I don't think that it will take 12 years for any other specialists to develop what we have developed. We have been using it for 12 years. We have developed a very robust database with 200 data elements. I think that there are light versions of the database that can drive quality improvement far quicker and can be implemented within a 12-month timeframe. We are addressing this issue in the State of Virginia with the other specialists. We are working with Anthem of Virginia to develop the software that will allow others to develop specialty-specific versions of this STS database that will collect the important data for their practices. We are helping them develop the important outcomes and process measures that are necessary to promote quality improvement in their specialists. I do not think it will take 12 years and $15 million.

Dr. KIZER. I would just add that while technology is certainly needed and a big part of this, it doesn't mean that we shouldn't take small steps and move in the right direction first. There is a lot that can be done prior to having those interoperability standards. Of course we need to make the commitment to develop interoperability standards, and that is just a matter of tasking someone with the responsibility and doing it. It is something that certainly can be achieved in a reasonable amount of time.

Chairman JOHNSON OF CONNECTICUT. I am going to ask a second question, and I will be kind of flexible to 5 minutes, but I hope we will be able to get two rounds of questions in. You may be familiar with the Johns Hopkins American Health Ways Project, where they call in the doctors from their system every year and talk about something, and this year they called in their many practicing physicians and the issue was outcome-based compensation. One of the vignettes in that report—and they came to many of the same conclusions that you have come to—was about a 38-year-old male patient that this doctor saw who had very serious diabetes. He did all the counseling, made all the referrals, everything. That first office visit took 42 minutes of face-to-face time. Then in spite of multiple efforts by telephone and mail, "Mr. I" did not return for follow up until 13 months later. He never went for monitoring, laboratories, the dilated retina exam, diabetic education or medical nutrition therapy. He had long since run out of medications and was no longer monitoring his plasma glucose.

We had a long talk about the importance of forming a therapeutic patient-physician relationship, adherence with prescribed therapies and follow up in addition to the importance of controlling his multiple risk factors quickly and passably. He goes on at considerable length. This office visit required 23 minutes of face-to-face time. The fear is that this kind of patient who takes a lot of time, who requires a lot of education, and then doesn't cooperate, will be counted against this physician in terms of whether or not he is performing by quality. Dr. Kizer, who many years ago was the head of the VA Hospital in North Haven came to each one of us in the congressional delegation and said, "Look, I have to take the post traumatic stress syndrome cases that no one else will take, and there are going to be some suicides, there are going to be some problems. Now people are avoiding those patients so they won't look bad and they have no place to go." So, this is the fear with going down the path that you are suggesting. You all have had some experience in it, and we talk smartly about risk adjustment, but risk adjustment is worrisome when it gets down to the individual patient, and if you get to be known as sympathetic, you get to attract that kind of patient. So, your comments.

Dr. KIZER. Two things I would say in response to that. First of all, that is a very real world situation, and it may be an exceptional case, but those are the ones that always stick in the minds of the doctors; those are the cases that everyone worries about. In setting up measures, you have to have a panoply of measures, and physicians should be judged according to those things that are under their control. So, while we like to talk about outcome measures, often it is more important to have process measures that relate to what the physician is doing as opposed to something that requires

both the physician and the patient or other factors that may affect the outcome. This also relates to your comment about risk adjustment, which is much more relevant to outcome measures than it would be to processor or structural measures. So, you need to have that mix of measures upon which physicians would be judged.

The other comment is that many of the types of situations that you described can be appropriately dealt with in how the measures are constructed and in what is often called the specifications or the micro specifications, for the measures. In many cases these exceptional patients would drop out; they would not be counted in the final tabulation of the physician performance. So, while it is a real world issue, it is something that can be relatively easily dealt with.

Mr. KUHN. Madam Chairman, if I might add to that. Last week at CMS we had our quarterly meeting of our Practicing Physician Advisory Committee. As we talked to these practicing physicians around the country about the issues of payment for performance, this very issue came forward; that is, what do you do with a noncompliant patient, and would that be scored against a physician as you went forward? As the physicians thought about it and reacted to it, I think they came to the same conclusion that Dr. Kizer was referring to. That is, you don't put one set of measures out there and you don't say everything is based on outcome. You look at process measures and you have a mixed bag to give the total picture of the patient experience. The total picture of the efforts of the physician or other clinicians to try to intervene on behalf of the patient gives you more of a balanced scorecard. As we had that conversation with them, I think it made a lot of sense and I think the practical experience that Dr. Kizer is describing here makes sense because you are going to have these noncompliant patients. They are going to try their best to be of assistance to them, but we need to help them understand, so that the measures are real and meaningful to the clinicians, and they don't get penalized by them either.

Chairman JOHNSON OF CONNECTICUT. Dr. Rich?

Dr. RICH. I would like to expand on that, and just as a point of clarification, not all physicians are created equal. There are some of us who practice in hospitals and some of us who practice in the outpatient setting, and we have very different worlds in which we practice. We don't deal and grapple with these issues. What I deal and grapple with is that patient who continued to smoke, who comes in with a blood pressure of 240 in the midst of a massive heart attack. Then my quality and my performance is measured on the entry of that patient into the system, the episode of care that I care for. So, hospital based physicians can be monitored and can develop performance measures, outcomes measures with the risk adjusted in a very real and different way than in the outpatient setting.

Mr. LEE. The one thing that I would add is the consumer side of this. Some of the programs that we have seen out there increasingly in the market are also having employers or others trying to get tools to that consumer. So, I agree with all the remarks made about the physician measurement side, but also we need to get better tools to consumers, because it is not just with the physician that they interact, and they need to be given tools and incentives

to engage in care management, and so forth. So, that is the one thing I just want to underscore.

Chairman JOHNSON OF CONNECTICUT. Thank you. Mr. Stark.

Mr. STARK. Thank you, Madam Chair. I want to thank the panelists, fascinating. I notice some disagreement basically between all of you on the question of positive rewards or negative or punitive incentives. I just make a couple of observations that I could get from your testimony or events, as Mr. Leno is in California. We have vast differences in this country. Minnesota I think is perhaps the lowest cost State as opposed to California, and I doubt if anybody would think that the Mayo Clinic is all that shabby as opposed to University of California. Costa Rica spends $500 a year on medical care for their citizens. We spend about $6,000 or $7,000 per head, and a baby born in Costa Rica today has the same life expectancy as a baby born in the United States. They may take more babies to term here, so you have a little bit difference, but still, 15 times necessarily infant mortality.

Two cardiologists, Dr. Rich, conspiring with a tenant hospital, killed 167 people in Reading, California and nobody caught them. Other cardiologists practicing in Reading said, "Oh my, something is wrong there." So, what I see here is, we do have a system in which I am going to suggest, one, we must punish substandard performance, that kind of substandard performance either with jail or defrocking. There has to be a penalty. That is not to suggest that we build a whole system on it, but there has to be some kind of retribution for reckless behavior.

Second, Dr. Kizer suggests that he favors positive rewards, right, Ken, that is what you said in your testimony. However—and most of that will be financial, you suggested. Part of it is pride in your work and recognition in other ways, but nonetheless financial, a pretty nice reward. Then in the VA, I suspect everybody is on salary. Yet your success there was accomplished without, I would imagine, huge payment differentials. I don't know how you want to resolve that.

Then I go back and I wonder if in medical school, where those of you who are physicians all start—I will bet you that all of the incentive in medical school is don't screw up or you don't make it. I don't think they rank the way they do in law school. Maybe they do. Maybe you get ranked by how you get residencies, but I don't think they go, one, two, three, four, five down the list. You either make it or you don't. Somehow if you are going to suggest that you don't want punitive incentives, maybe you have to start in medical school then, ranking, paying, getting this done.

So, the Stark program—and I am going to ask you all to comment on this—would punish substandard. We are going to have to go to uniform standards which physicians are going to hate. They are all sure they are the best, they are the best artist and they do not like what this guy at Dartmouth is doing, so that we get the same thing in Minnesota that we get in California. Pay uniform standards across the country. Demand uniform procedures, whether it is C-sections or how you treat breast cancer, whatever kinds of—prostate cancer, they are treated differently different areas. Reoperations, if it is the doc's fault, they have to be done free, just

like my mechanic if he doesn't fix the tune-up right, he does the second one free. Not so in health care. Now, if it is just because I want to go back and I like being operated on, I got to pay for the same one, but it should be that if the doctor messes up, the second one should be free. Ask President Clinton about that.

Lastly, if somebody is really outstanding, there is major rewards, develops a new procedure, leads something, breakthrough procedures, is a leader among his or her peers in developing new systems. Can we have that kind of a system, Mr. Lee? I don't care, anybody—that is just how I see it.

Mr. LEE. We certainly don't have a system like that. A couple things that I would note though, I don't think anyone would disagree that for the real extreme outliers that are committing malpractice, we need a system that addresses them in a punitive way, but that is not the vast majority of physicians. The other thing that I think we all agree with is the primary driver needs to be about improvement, about motivating improvement of physicians to get better in terms of their quality and in terms of their cost efficiency, and I think that many of the elements you noted are incredibly important as we have huge variation that has no good reason for it. I think the incentives, physicians and hospitals respond to public reporting. That is a major incentive. A second major incentive——

Mr. STARK. They hide from it. They don't like it, do they? Is that right, Ken? They don't like it?

Mr. LEE. They absolutely generally don't like it, and some of the reasons are technical, make sure the measures are right. We do have to make sure the measures are right. Right now we have Americans driving blind. About 1 out of 10 Americans this last year made a choice of hospital in America based on what they thought was quality information. We don't have good enough quality information for Americans to make informed choices. We need to improve that. The other thing that I would note about salary is Kaiser Permanente in California pays their docs a salary, but they also have bonuses that are based on performance. So, even where you have a salary system, we should have some financial amount at play. So, thank you.

Dr. KIZER. Mr. Stark, you raise a lot of complex issues and I would certainly echo Mr. Lee's comments, that I think the majority of physicians are trying to do the right thing. I think certainly there has to be mechanisms to deal with those exceptions such as the one you cited at Reading.

Mr. STARK. At both ends.

Dr. KIZER. At both ends.

Mr. STARK. Real rewards and real—yes.

Dr. KIZER. By the way, I think if I recall correctly, in one of the reports I read on the Redding situation, the physician wasn't even a cardiologist, and it may not have even been board certified in internal medicine; as I recall he was basically a general practitioner, but that is neither here nor there at this moment. The reason I cited the VA was simply to underscore the point that you are making, that in that system where there was not a financial incentive, simple performance measurement and reporting of performance, was, in and of itself, a very strong change lever. So, I want to make that clear, that public reporting of performance can very much af-

fect behavior. Now, if you add some financial incentives to it that are aligned in the right direction, I think that can be even more powerful, and I guess that is the point that I was making.

Dr. RICH. I think I alluded to quality improvement in the face of a decade of declining reimbursements for cardiac surgeons. They actually did the right thing, for the right reason, at the right time, with mortality decreasing by 40 percent and their reimbursements decreasing. So, there was no reward for them. I do think the issue in Redding is real, and it is extreme. We discussed this at the NQF within our measure——

Mr. STARK. You have guys in your profession who come up with new procedures that are outstanding, right?

Dr. RICH. Correct.

Mr. STARK. They are still getting the same fee for whatever. That end of the scale I think should be rewarded as well. How you determine that? My experience has been that doctors don't like to rank each other.

Dr. RICH. They don't.

Mr. STARK. They resist that somehow.

Dr. RICH. One of the real issues that has been brought up is the validity of data. What are we collecting, what are we reporting, and what are we being judged on? We find administrative data to be very weak. We like to have peer-reviewed databases. We believe it is our professional responsibility to collect and report the data. We have used it. The STS does support public reporting, and we would like to see more of it.

Mr. STARK. So, the answer is, Mr. Kuhn is going to do it for you through CMS, right?

Dr. RICH. No, the answer is we have to do it by ourselves. Physicians and their specialty societies need to pull up their bootstraps.

Mr. STARK. I notice a little problem here, but go ahead.

Dr. RICH. However, he will help us by providing incentives to do it.

Mr. KUHN. There certainly is a partnership here. Speaking to the incentives issue, you raise a good point about hospitals. A couple of years ago, when we were conducting a voluntary effort under the Hospital Quality Improvement Program, hospitals were signing up, but not in great numbers. Then, the Medicare Modernization Act came along and said, "We will pay you a 0.4-percent differential if you sign up for this." Virtually, every hospital in the country is now participating. I think what that tells us is incentives do work. I think it gives us a signal that it doesn't necessarily have to be a terrific or a great incentive, but incentives do work, and if they are deployed appropriately, we can change behavior. We can change how we deliver care.

Mr. STARK. Thank you. Thank you, again, Madam Chair, for tackling this problem. In spite of my opening remarks, it is important, and you are to be commended. You won't get any more money, but you are to be commended anyway for going into this.

[Laughter.]

Chairman JOHNSON OF CONNECTICUT. Listen, if you don't shoot for the stars, you never get even half way. Just let me interrupt for 1 minute. There is one 15-minute vote, with a possible second vote. I am going to go and vote immediately. Maybe Mr. Stark

will join me. I am going to recognize Mr. Johnson for his 5 minutes, and then Mr. Thompson would have time. I am going to come back, so we will be sure to get some more of your advice on the record, and I am going to ask my colleague, Mr. McCrery, to take over while I am gone, and then the two of them will get a chance to ask questions, too. Thank you. Mr. Johnson?

Mr. JOHNSON OF TEXAS. Thank you, Madam Chairman. I have to agree with Mr. Stark that one size fits all is not a very good approach, but I have to tell him that we need to stop comparing the U.S. medical to any other country. I would ask the question would anybody go to Costa Rica for their medical care?

Mr. STARK. In the winter?

[Laughter.]

Mr. JOHNSON OF TEXAS. No way. No way. You mentioned in your testimony, Dr. Kizer, that the best way to help physicians is to reduce the paper workload. I agree with you. It makes a lot of sense to me because every time I go home to the district that is all the doctors talk about again, and again, and again. I wonder, you talk a little bit about standardizing, but I don't see how that would help in that instance. Could you tell me a little bit more about what you mean, and what has worked so far, and what Medicare can do to help solve that problem.

Dr. KIZER. Sure. Thank you. Today, physicians will often see patients for multiple different insurers. This notion of performance measurement, many insurers have put in play. However, they don't use standardized performance measures. So, at the end of the day, a practitioner may have to sit down and fill out 15, 20, 25, 30 different forms that are substantially the same information, but they are different enough that each one has to be filled out differently for whoever the payer is for that particular patient.

Mr. JOHNSON OF TEXAS. Yes, and he doesn't do it. He hires two extra people to do that stuff for him, doesn't he?

Dr. KIZER. Often that is the case, yes.

Mr. JOHNSON OF TEXAS. Which costs money.

Dr. KIZER. Which costs money, and the point is, if there were standardized measures that all of the payers were using, then one wouldn't have to hire those two additional people to fill out all of those paper forms.

Mr. JOHNSON OF TEXAS. Well, why can't CMS do something about that? You guys have been dragging your feet forever on those issues.

Mr. KUHN. Congressman, you make a good point there. In the area of trying to just get better improvement for the office clinical setting, there was a major initiative that the Secretary launched a couple of years ago where we began that process, and it is ongoing. It is called the Physician Regulatory Issues Team. We have dedicated physicians within the Agency who are contacting practicing physicians around the country, finding their issues, trying to solve those problems, and eliminate the bureaucracy and the redundancies that are in the system. That is an ongoing improvement program.

When it comes to the payment for performance here, what we hope to be able to do is find ways that we can capture this information in an easy and seamless way. I couldn't agree with you more.

For example, if we do chart reviews or look at the billing records, things that they are already doing, is there a way that we can pull that information from that system instead of them having to go out and erect a new system? The only way this is going to work is that people believe in these measures, they have confidence in the measures, and we make it simple for them to use. That is what we are trying to look at.

Mr. JOHNSON OF TEXAS. You have got too many numbers for them to mess with. If they make one number mistake, the next thing you know the paperwork is shoved back at them, and they go through the whole process, again. Isn't that true, Dr. Kizer?

Dr. KIZER. Certainly, if the forms aren't filled out correctly, they tend to be rejected.

Mr. JOHNSON OF TEXAS. How many times do you have to send them back before CMS or the Medicare process approves them? You guys have got to streamline things over there and make it work. You're not hitting the problem on the head, I don't think, and test programs don't work. You need to fix it.

Let me ask you another question, Mr. Kuhn. Medicare pays for hospital services under part A and physician services under part B. So, Medicare, also, prohibits hospitals from rewarding physicians who reduce admissions under the Stark law. How big of a problem is it, and what is CMS doing with your demonstrations to help that problem?

Mr. KUHN. We don't have any demonstrations that look at those kind of joint opportunities for rewards because, as you may recall, Congressman, back in 1999, the Inspector General looked at this issue called "gain sharing" and said that it violated the civil monetary penalties in the Social Security Act. However, this year, as you may know, MedPAC, in one of their recommendations, urged the Agency to begin looking at gains sharing again and see if there were opportunities to create relationships between hospitals and physicians and put up the appropriate safeguards to prevent inappropriate inducements. That is something we are looking at now. We are going to begin working with the Inspector General. So, it is an issue. I think MedPAC gave us some good recommendations, and we will continue to work with them.

Mr. JOHNSON OF TEXAS. You guys are focusing on it.

Mr. KUHN. We are looking at it. That is correct.

Mr. JOHNSON OF TEXAS. God bless you. Yield back. Thank you.

Mr. MCCRERY. [Presiding.] Thank you, Mr. Johnson. Dr. Rich, we have heard that a primary obstacle to getting quality measurement standards in place is cost. Can you describe how the thoracic surgeons paid for your quality measurement standards.

Dr. RICH. It is self-funded, basically, by practices shared somewhat with the hospitals. It depends on how much collaborative effort and data collection is at the hospital level and at the practice level. Just to personalize it, at our institution, we are doing 2,000 cases a year. There are 10 cardiac surgeons in our practice, and our costs are about $118,000 a year to participate in the database, collect the data and to donate our time in supporting the effort. As I said, it can be divided among providers, but there are some incre-

mental costs that are involved, and currently it is borne by the physicians and the hospitals.

Mr. MCCRERY. Given the experience of the thoracic surgeons, do you think that other specialty groups should be expected to do the same thing?

Dr. RICH. I do. Again, I will go back to the comment I made that there are lighter versions of what we do. This is a very scientifically robust database, with over 200 data elements. It is used for quality improvement, and it is used for research as well. So, you don't need as much infrastructure to begin at a lower level of involvement. I do believe that physicians in other specialties can do this quicker and less costly.

Mr. MCCRERY. Any other panel members want to comment on that question of cost and how to handle it?

Mr. KUHN. We continue, during our demonstrations, to look at the issues of cost and see what kind of barriers that might create. Also, we are hoping to be able to harvest information that will tell us what the return on the investment is from making these improvements, whether it is IT systems or performance improvement systems. I think as we talk to all providers, quality should be a central business strategy for all providers that are out there, and I think all of them are taking that as a central business strategy. We just need to get more information to understand what those costs are and how we can help providers manage those costs. Whether it is through differentiation and payment,education materials, or standardization, we can help the providers move forward in this area.

Dr. KIZER. I would add that in putting forward any of these performance measurement sets, it has to be understood that there are ongoing costs associated with them. There is the initial cost of doing the big search through the data and coming up with that initial set of measures, but then those measures have to be maintained. As medical science continues to change, and as new technology becomes available, those measures quickly become outdated. New drugs become available that will then change the practices. So, whatever measure set is good today, 2 years from now or 3 years from now, several of those are likely to be out of date. The ongoing measures maintenance cost has to be factored into the expense of any of these systems.

Mr. LEE. Congressman, the only thing that I would add to that is, we have heard a good bit about some of the concerns around administrative data. While some of those concerns are real, I think adding pharmacy and laboratory results data is a critical element, and that is one of the recommendations of MedPAC, to add those elements for CMS, to use administrative data in a more robust way. I would agree, though, that some specialties you may have trouble doing effective quality process outcomes profiling with the administrative data, and so building on models like STS's would be important. I am also optimistic that these specialty societies could do this in 1 year instead of 12, which I applaud and strongly agree with.

Mr. MCCRERY. Dr. Rich?

Dr. RICH. Again, there is division of labor and intent on the administrative versus the clinical data. In the outpatient setting,

some process measures using administrative databases may work and work very well and be less burdensome. On the inpatient side, the administrative data that we see, when we compare it to the STS database, is terribly flawed. It will not lead you down the road of quality improvement nor reward the right people at the right time for doing the right things.

Mr. LEE. The one note that I would add, though, is flawed data will get a lot better when payment is being made based on it. The issues of these bounce-back of coding forms that Dr. Kizer noted are cutting down the deforestation, there are problems in charts as well. We have had a lot of looking at some of those issues, but the issue of getting good data used correctly is something we all want to do because we only want to be using valid results to report on physicians.

Mr. MCCRERY. Well, gentlemen, I am going to have to recess the Committee. I have got to go vote. Mrs. Johnson should be back in just a couple of minutes. If the staff would tell Mrs. Johnson that Dr. Rich wants to make another comment on that, she will get to that. The Committee will be in recess subject to the call of the Chair.

[Recess.]

Chairman JOHNSON OF CONNECTICUT. [Presiding.] The seventh inning stretch is over, and the Committee will reconvene, having recessed for a vote. I would like to turn to the issue of data issues. I would like to hear all of your opinions on this issue of what can be done through analysis of current claims data versus clinical data and can we move forward in this area without clinical data and to what extent, and so on. So, if you will, please, comment on that issue, I would appreciate it. He is deferring to the government.

Mr. KUHN. There we go. I am happy to take that. The issue for us at CMS, as we continue to look at the demonstrations, is our internal development of performance monitoring systems; we need to capture the information and make sure that it is functional to get the results and be able to pay the rewards accordingly. Part of that performance monitoring is not only the data management, but the opportunity to provide ongoing feedback to the clinicians so they can understand the information——

Chairman JOHNSON OF CONNECTICUT. Excuse me. It wasn't my turn, and I didn't realize it. Also, I was supposed to let Dr. Rich add his comment to the preceding discussion. I will come back to that data issue when it is my turn, but I am going to recognize Dr. Rich, and then I am going to recognize my colleague, Mr. Thompson.

Mr. THOMPSON. Thank you, Madam Chair. I thought maybe I was being punished, I had done something wrong. Thank you. It wouldn't be the first time.

Chairman JOHNSON OF CONNECTICUT. That could happen.

Mr. THOMPSON. Thank you for having the hearing, and I want to thank all of the panel members for being here. I just have a couple of questions, and one goes back to I think where Mr. Stark started, and that is the idea of some sort of standard of treatment and making sure everyone complies with that to get us where we need to be rather than trying to rethink the system, when it seems

to me there are so many underlying problems, everything from 45 million people without any access to health care. There is a real void in the area of preventive health care. Reimbursement rates right now are just a real problem. I have a clip from one of my local newspapers, where a local physician is quoted. She says, "My own practice has reached the point where it cannot take any more Medicare patients."

As this starts to happen, this is over in Sonoma County, in large part because of reimbursement rates, where Sonoma County is reimbursed at a rate that is different from the surrounding counties, most specifically Marin and San Francisco County, and it is about a $32 million problem. This particular physician is stating that it has hit her, but down the road it is going to start hitting other people. When she is having to turn people away, it creates big problems for other folks, and they come very, very suddenly. We have malpractice liability fears. There are all kinds of—and the cost of the IT, which I think everyone has stated that they think is a good idea. I am just wondering what these underlying problems that we have not been able to address, and we know they are there, but we haven't been able to deal with those and how this is impacting the issue that we are meeting on today, if you have any comments on that.

Then I will just ask my last question, and then you can answer both of them. Someone mentioned, I think Mr. Lee mentioned that there have been some great examples of how docs have improved both quality or procedures. I am just wondering, to what extent have we brought the doc community into this, and how are we getting out to the physician community any improvements or any new procedural gains that we have made, to make sure we bring everybody into the same—so we have some sort of level playingfield in the way that we deliver health care?

Mr. LEE. I will take a shot. I am not going to try to say how we can address all of these underlying problems, but I think one of the core underlying problems——

Mr. THOMPSON. Not the way you address it, but how much of these core underlying problems are emblematic of the issue that brings us here today?

Mr. LEE. I think that many of those core underlying problems would be addressed, in part, by having a valid performance measurement that cuts across. A lot of the issues that consumers don't know where to choose, we have medical trends that are going up because there aren't market incentives to reward more cost-efficient care, higher quality care. I think a lot of these underlying problems really are related to the fact that we are performance blind. I think that a lot of what we are talking about today will address those underlying issues in significant part. In terms of engaging the physician community——

Mr. THOMPSON. So, if I could interrupt you, then, does that mean that our standard of treatment is lower because of the lack of resources to address these underlying problems today?

Mr. LEE. I would go back to the chart that I noted about the distribution of where physicians fall. It is not necessarily, there are some physicians that are providing very high-quality and cost-efficient care. There are others that aren't. So, where you get care,

how we are providing care, is throwing a dart at that dartboard. Without having good performance measurement and rewards, we aren't going to be, overall, for the entire system, getting more cost-efficient care and better-quality care.

Mr. THOMPSON. Who is forced out of the game, given the procedures that we are following now? For instance, this doc who can no longer provide or take Medicare patients, she is a good doc—I know that—so she is out of the game because of the existing rules. Who is forced out—the good ones or the bad ones? Are we left with a few folks who are providing a good level of care or a few people who are providing sub-level of care?

Dr. KIZER. I think all kinds of folks are forced out of the system, both practitioners, and patients and others. A couple of years ago, the Juran Institute did a study looking at the cost of poor quality of care. The Midwest Business Coalition on Health had asked them to do the study. They put the price tag of poor quality care at $585 billion a year, an enormous amount of money that could more than pay for all of the uninsured and go a long ways toward addressing many of the other systemic problems if we would just focus on improving the quality of care.

Dr. RICH. I think you have just reiterated what I showed on my slides. In terms of who is left out and who is not, and why this is happening, if you look now, going forward, at the sustainable growth rate formula, with physician declines in reimbursements of 5.4 percent for the next decade, that scenario will happen more, and more, and more again. I don't want my comments misinterpreted from when I had said that physician specialty societies should be responsible for the IT development and the database development. I think from a financial standpoint, that it is impractical to think that in an era of a decade of declining reimbursements, that you will get these societies and physicians to invest in IT; that there has to be some other way that we can come up with that can provide incentives for us to invest in IT, so that we can do what Dr. Kizer just said—focus on quality and contain costs.

Mr. THOMPSON. Madam Chair, if I could just clarify one thing. Just so you know, the Sonoma problem is not a problem of declining reimbursements, they are just not getting what they are supposed to be receiving.

Dr. RICH. Right. Thank you.

Chairman JOHNSON OF CONNECTICUT. You may have understood that last comment, but I didn't, so I will talk to you about that later. It is also true that, under the formula, in spite of the fact that we spent $54 billion the first year and many billions thereafter, to allow just a 1.5-percent increase at a time of significantly rising costs explains why your doctors don't want to add more Medicare patients. In some parts of the country, we are the best payer, but in other parts we are not. The contrast between Marin and Sonoma is a perfect example of the really systemic problems the system has. In facing the responsibility to actually repeal the Sustainable Growth Rate, which I see as the only possibility, we have to be able to, also, replace it with another system of payments. That is why this issue of how much we could integrate the new thinking on rewarding quality, and focusing on quality into a new payment structure, is so critical. It is unfortunate we have to

do this about 2 years in advance of the technology curve, but those are the things we need to think out in the next weeks. I appreciate your comments in terms of helping us think out not only what has to be done, but how we interweave technology adoption and pay for quality care and so on.

Let me go back to my question—and then we are going to go another round—that I had asked earlier. What can claims data do for us versus what clinical data can do for us? Would you see a way that just using claims data, we could start this process, with a certain year at which clinical basis which we would build between now and then, would then take over. Now, what is that kind of hybrid that we need to do to get from here to there?

Mr. KUHN. Madam Chairman, we were talking earlier. As we look at this, we are looking at our performance monitoring systems and what we can erect and put in place in order to capture this information. So, we can not only validate the quality improvement we see, but, also, performance and efficiency as we go forward. Performance monitoring data management, the ability to provide ongoing feedback to the clinicians to see how they are performing, and to see how they are changing their behavior so they can do benchmarking with one another is important. As we look at that, we are looking, really, at two items here. We are looking at the claims data, which we think is a pretty good indicator. It might not be the perfect one, but we think it is a pretty good indicator. We are, also, looking at the chart audits and the extraction from the charts in order to capture that information so that we can use both in order to get, again, a broad picture of the patient experience and what is going on in the physician's office. So, we think claims data are a good start, and we think that is a good place to begin to start to capture this information as we move forward.

Chairman JOHNSON OF CONNECTICUT. Dr. Rich?

Dr. RICH. I think, again, it depends on what your expectations are for claims data, whether you want to create a claims database that looks at structural measures or process measures or outcomes measures. I think that we have looked very closely at the outcomes measures to——

Chairman JOHNSON OF CONNECTICUT. Don't tell me what I need to think. Our thinking is too embryonic. What would you think? In other words, are there process indicators that claims data could help with? What are the pairings here?

Dr. RICH. In your absence, I made the comment that on the outpatient side, in an ambulatory setting, there may be some process measures that claims data would track accurately. On the inpatient side, there is clearly not a lot of tracking and correlation between process or outcomes measures that can be generated from claims data. Since my world lives on the inpatient side and much of specialty medicine works on the inpatient side, we would find claims data to be the wrong route to take at this point in time; we should be supporting clinically driven database development, with incentives for specialty societies to develop those on their own and to integrate those, as the STS has done, with the NQF. The CMS, I have to applaud, is taking many of the measure sets from the NQF and integrating them into their hospital measure set.

So, there seems to be some synergy developing in the country, and we can develop the necessary components out there for good data collection. A minute ago you stated that we are about 2 years out on electronic medical record (EMR). We don't need an EMR right now. We can take our database, and we can have all the specialties develop databases, which can be integrated into a larger system once it is ready for prime time.

Chairman JOHNSON OF CONNECTICUT. So, you are saying that within 12 months, using the light databases that you could identify, that we could begin to move in this direction.

Dr. RICH. With clinical data, yes.

Chairman JOHNSON OF CONNECTICUT. With clinical data.

Dr. RICH. Yes.

Dr. KIZER. Mrs. Johnson, I agree with what Dr. Rich has said, but I would say it a little bit differently. The bottom line is that you need both, and you need them for somewhat different purposes, and both are currently being utilized. The other thing I would add to that is, certainly the experience with performance measurement systems is that nothing makes the measures better than being used. So, what we have to do is to start using the ones that we have, make them better as the systems evolve and as we add more to it.

Chairman JOHNSON OF CONNECTICUT. Mr. Lee?

Mr. LEE. I would absolutely agree with that and note that it does depend very much on the specialties. There is a very wide range of specialties and conditions for which administrative data—in particular when we include laboratory results and pharmacy—can provide a very solid picture of physician performance—not in all specialties. So, I would agree with Dr. Rich. When we look at asthma, breast cancer, depression, pneumonia, preventive care, hip fracture, there are a number of areas where there are vendors that are out there that have physicians getting feedback based on these measures. We can use administrative data, but it is not going to be the only source. The other data point that I would underscore, and I believe this is going to be going through the NQF process, is patient experience. One of the core elements of quality is how patients experience the care they get, and we look forward to having in the next 2 years a national standard for a patient experience survey at the physician level, and that is going to be a core element of having what we look to be a full dashboard of performance for physician care.

Chairman JOHNSON OF CONNECTICUT. That patient experience stuff worries me. I have been to many new, freestanding ambulatory clinics. They are pink. They are beige. They are aqua. They are very pleasant. They have parking. I could get the same procedure done in my downtown hospital. It is not pink. We don't reimburse it to modernize its facilities, but it has brand-new operating rooms and brand-new equipment. Now, the patient is going to be happier going to the outlying clinic, but is that relevant, and who is going to pay? So, this is an issue that the surgery centers brought up first, now the boutique hospitals bring up. So, patient satisfaction is very dependent on the sort of pleasure of the experience. Well, at what cost to the taxpayers? I don't know why you are so hot on patient satisfaction. I agree that patient satisfaction

with the doctor-patient relationship. I look at these forms they fill out or I fill out, and they aren't really talking about that.

[Interruption.]

Mr. JOHNSON OF TEXAS. That means the other Members won't be back. I will let you talk about this, and then I will have to go vote, but we will be back in touch with you. I want you to keep thinking about this because we are going to need a lot of help in how you step this out. We have really appreciated Mr. Kuhn's help on it, but we need the practical world involved, and we want you to stay involved. Yes, Dr. Rich?

Dr. RICH. I am sorry. I did want to make that one comment that you alluded to when you came back. In your absence, there was a comment made about hospitals and physicians and hospitals rewarding physicians for improved quality of care and declining readmissions. Mr. Kuhn made some comments about that. This is a very real issue and sore point for me because we had worked with CMS for three years on a demonstration project that involved global payments for cardiac surgical care within the State of Virginia that followed exactly that model.

Mr. JOHNSON OF TEXAS. You mean Medicare Parts A and B merged?

Dr. RICH. The merger of part A and part B payments, where we took risk, the adverse risk for patient care. We assumed risk. We had patient beneficiaries who were receiving one bill and, at the local level, hospitals were to redistribute the payments based on performance measures, the same performance measures we spoke about here—outcomes and process measures. That was widely approved by CMS and supported by Secretary Thompson. It was approved at OMB. At OIG and the Department of Justice, it was termed to be in violation of Stark rules and regulations. Here we had a project that seemed to have all of the right stuff, that did all of the right things at the right time for patient care and, also, addressed cost, and it addressed efficiencies of care, yet the current system prohibited it from moving forward.

Chairman JOHNSON OF CONNECTICUT. I am glad you did get into that because the relationship between what we need to do and current law barriers is very important. The current law, also, looked at Medicare as an illness treatment program, with tubes of payments flowing to people who took actions to cure illness. If we are going to move toward a preventive health, disease management model, we can't have those same narrow pipes through which stuff flows. So, I would be interested, and my staff probably has a copy of the OIG decision in your regard, in regard to this particular project, but if you are ready to go, we are just dumb not to provide an exemption so you can go ahead and try that. We can see what the consequences are. We will look at that.

Dr. RICH. Thank you.

Chairman JOHNSON OF CONNECTICUT. Any further comment on this issue of staging claims data and payment structures? I guess that and the Stark barriers are things that we will need to work on more in the future. So, thanks a lot for your participation in this hearing. Thanks for all of you listening, for being here. This is an arcane subject, but in the end it is going to play a major role in how America does health care not just in Medicare, but for

people of all ages throughout all systems. Thank you for your help. We look forward to working with you. The hearing is adjourned.

[Whereupon, at 11:57 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of Jack Ebeler, Alliance of Community Health Plans

The Alliance of Community Health Plans (ACHP) applauds the Health Subcommittee for convening a hearing on Medicare Physician Quality and Efficiency of Care for Medicare Beneficiaries. We are pleased to have the opportunity to share our perspective on opportunities to improve health care quality.

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 count among our membership seven of the National Committee for Quality Assurance's top-ten highest quality Medicare plans.

ACHP has a proud legacy of leadership on quality improvement and was formed more than twenty years ago to help health plan leaders share best practices, learn and innovate. 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—which today manages and updates the HEDIS® measurement process—employers, Medicare, Medicaid and other payers regularly monitor and evaluate health plan quality. 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.

Having led the way in establishing health plan performance measures, ACHP remains focused on how to use what is learned from these measures to improve health care quality. This work takes two forms. First, ACHP members regularly review their clinical quality and customer satisfaction performance to identify areas for improvement and, through ACHP-sponsored learning sessions, help each other address key issues. Second, ACHP assesses the ways in which public policy can support high-quality care and advocates for policies that encourage quality improvement. Our learning sessions have included explorations of how and when plans can use pay-for-performance incentives to help drive quality improvements in specific health care settings and across multiple settings. Our policy agenda includes a commitment to helping Medicare link quality improvement and payment by promoting rigorous public reporting of quality measures by all Medicare Advantage plans and the creation of pay-for-performance incentives for Medicare Advantage.

MedPAC and Pay-for-Performance

As the Subcommittee and MedPAC have noted, Medicare payment is at best neutral towards quality and at times even pays more for poorer quality, such as when medical errors produce complications. Having spent considerable time examining how Medicare could help beneficiaries receive higher quality health care, MedPAC has recommended that Medicare reform its payment policy by building quality incentives into its payment system. MedPAC's assessment of where and how to begin pay-for-performance in Medicare, detailed in its June 2003 Report to Congress, identified health plans as a likely starting point, noting that: "Medicare+Choice plans may be prime candidates for applying incentives because they meet, in whole or part, all of the criteria for successful implementation." Among the indicators of plans' ripeness for pay-for-performance are the following.

- Standardized, credible measures of health plan performance and customer satisfaction already exist and are reported annually to CMS; Health plans have data collection capacity and mechanisms to report on quality measures already in place;
- Plans have leverage to improve performance across the variety of settings with which they contract; and
- Plans can improve coordination of care across settings in a way that is "not possible through provider-specific efforts."

ACHP and Pay-for-Performance

MedPAC's 2003 discussion of the opportunities for performance incentives to promote health plan quality includes a summary of a pay-for-performance proposal ACHP developed in partnership with our member plans. ACHP's proposal would

create performance incentives that recognize both high quality health plans and those demonstrating marked improvement, and award incentive payments both at the national and regional levels. This proposal became the basis for legislation, the Medicare Equity and Access Act, introduced in the last Congress by former Health Subcommittee member Representative Jennifer Dunn.

ACHP's work on pay-for-performance for Medicare Advantage plans is informed by our key principles for pay-for-performance. They include the following:

- Payment-for-performance incentives should eventually apply to all Medicare providers, including fee-for-service and Medicare Advantage. Given health plans long record of reporting on standardized measures of quality, it is reasonable to begin with Medicare Advantage plans, including HMOs and PPOs.
- Pay-for-performance incentives should be based upon standards of excellence and improvement.
- Measures to evaluate both fee-for-service Medicare and Medicare Advantage plans should be developed. In the interim, incentives should be based on existing measures and should emphasize clinical effectiveness.
- To ensure successful implementation and sustainability, pay-for-performance incentives should be financed with a new, dedicated stream of funding.

ACHP believes that pay-for-performance incentives are an essential means of raising the quality not just of Medicare Advantage plans, but of all sectors of Medicare. We applaud the Subcommittee for its ongoing efforts to examine pay-for-performance models for physicians. We share MedPAC's assessment that health plans may be among the most logical places to begin using quality incentives, but that Medicare should be aggressively working to develop quality measures for other sectors, including fee-for-service settings such as physician offices. We believe that adopting pay-for-performance for Medicare Advantage plans would be an important initial step in moving Medicare toward a more performance-driven system, while also helping to inform the development of measures and mechanisms for using incentives with physicians, hospitals and the other health care sectors.

Thank you for the opportunity to share our views. We look forward to working with the Subcommittee in the year ahead on this important issue.

Statement of the Alliance of Specialty Medicine

The Alliance of Specialty Medicine is a coalition of 13 physician specialty societies representing over 200,000 specialty physicians. The Alliance's member specialty physician organizations are continually striving to offer the highest specialized quality care to all Medicare beneficiaries. However, with our physicians facing over 30 percent reductions in Medicare reimbursement from 2006 through 2013 compounded by exorbitant liability premium increases, many of these specialty physicians are reconsidering their Medicare participation status. Therefore, the Alliance believes that if Congress is to begin to explore alternative payment requirements—such as pay for performance—then the current unsustainable Medicare physician payment system needs to be fixed.

The Alliance represents 13 physician specialties which are all at varying stages of sophistication regarding pay for performance initiatives; therefore, we believe that the following points need to be considered:

- Any type of system that rewards providers by improving patient care and outcomes should not be subject to budget neutrality or be used as a physician volume control.
- The reporting of quality or efficiency indicators and health outcomes data could be administratively prohibitive to many physicians, especially those in small practices that do not have electronic medical records. It could be difficult to link payment to performance without an interoperable health information technology infrastructure.
- Pay for performance programs must not be punitive.
- Measures will need to be specialty specific. Some measures may be appropriate for some specialties, and not others. In some areas, particularly surgery—it can be difficult to keep quality measures up-to-date enough to be perceived as relevant.
- Any measures would have to be developed by the physician community.
- In order to be effective, collecting data must be reliable and easy for physicians to record and report based on a clinical data set and in a manner that is acceptable to the physician community. The collection of such data must be timely and

easily submitted and should not create a burden on practices. Furthermore, the data collected must allow for physicians to comply with Medicare HIPAA requirements.

- Given the limitations on the current status of specialty performance measures, the Alliance believes that incentives should be placed on optimizing quality of care and physician participation, not on performance of specific quality measurements.
- If a pay for performance requirement is implemented, it should be phased-in and pilot tested on a voluntary basis first.

Currently, through the use of demonstration projects, CMS is testing various aspects of pay-for-performance programs. However, there must be a transition time to address challenges and questions before pay-for-performance is incorporated fully into the Medicare physician fee schedule, as many physicians are simply not ready for this step. This transition should involve stabilization of the physician payment system first, before any pay for performance initiatives are implemented. Also, pay for performance initiatives can not be a replacement for the current physician payment system, or used as a physician volume control.

MedPAC recommendations

We would also like to address the Medicare Payment Advisory Commission's (MedPAC) March 2005 recommendations on pay for performance in its Report to the Congress. Without addressing the significant flaws with the SGR and the predicted cuts of 31 percent over the next seven consecutive years, MedPAC instead recommends the implementation of quality improvement measures to encourage individual physicians to control unnecessary volume; for example, implementation of "resource use measurement", pay-for-performance programs, and the rapid adoption of health information technology (HIT) systems.

MedPAC recommends that these measures be implemented in a *budget neutral* scenario; specifically, by taking 1–2% from the physician payment pool and re-distributing those monies to those providers who participate in these quality improvement programs. Those who do not or can not participate in these programs will fund the "bonus" payments for those who can. MedPAC believes that *"all physicians are ready"* to participate in these pay for performance programs.

According to the report, MedPAC suggests that two types of measures are ready to be collected; 1) quality-enhancing functions and outcomes associated with information technology (IT) use, and 2) claims-based process measures. The report notes that CMS should begin collecting both structural and process measures—but only base rewards on the IT structural measures. **The Alliance is *very* concerned with these recommendations, including MedPAC's perception that *"all physicians are ready"* to participate in these programs. We strongly disagree with this perception and maintain the position that all physicians are *not* ready.**

According to the National Center for Health Statistics (2005), about 17 percent of physicians are using electronic health records in their practices, and the majority of these are group practices. However, more than 50 percent of America's physicians are small practices with 5 or fewer physicians. With physicians facing steep reductions of 31 percent over the next seven years, it is totally unrealistic to expect that physicians would be able to invest in these expensive IT systems—especially small practices with one or two physicians. Further, without documented national standards for HIT systems in place yet, how can physicians reasonably invest in something that may become obsolete in only a few years?

In terms of claims-based process measures, the Alliance is concerned as to how physicians will be able to report the use of "claims-based process measures" on a CMS–1500 form or the electronic equivalent. What "coding system" exists that would allow providers to report these claims-based process measures? The only available "performance measures" set that are currently available for reporting on the CMS 1500 form are the American Medical Association's (AMA) Current Procedural Terminology (CPT) Category II codes "which include a little over a dozen performance measures" most of which do not cross all specialties.

Conclusion

Thank you for the opportunity to submit a statement for this hearing. Congress must rationally implement physician quality initiatives involving pay-for-performance and other untested programs, and the Alliance of Specialty Medicine looks forward to working with you to develop a transition plan that will insure fair reim-

bursement for physicians and continued beneficiary access to quality specialty healthcare.

Submitted by,

American Academy of Dermatology Association
American Association of Neurological Surgeons
American Association of Orthopedic Surgeons
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society for Therapeutic Radiology and Oncology
American Urological Association
Congress of Neurological Surgeons

Statement of Behrends Foster, America's Health Insurance Plans

Introduction

AHIP is the national trade association representing nearly 1,300 private sector companies providing health insurance coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

For more than 20 years, our member companies have been working to meet the health care needs of Medicare beneficiaries. Our broad-based membership includes Medicare Advantage organizations and Medicare cost contractors that cover almost 5 million beneficiaries and Medigap carriers that cover 10 million beneficiaries.

All segments of our membership, regardless of which products they offer, are committed to providing beneficiaries with affordable protection against high out-of-pocket health care costs. By covering more than the Medicare fee-for-service (FFS) program, our members serve as a crucial health care safety net for many minority beneficiaries with chronic diseases and for many low-income beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare FFS program.

As we begin the 21st Century, the U.S. health care system faces a number of significant challenges, including sub-optimal care in varying parts of the country, racial disparities in access to care and quality of care, and skyrocketing health care costs. For the last 40 years, Medicare has helped introduce innovative changes into our nation's health care system by leveraging its power as one of the largest purchasers of care. Our member companies enthusiastically support the work by the Centers for Medicare & Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC) to promote pay-for-performance initiatives that pay providers based on the quality of services delivered to beneficiaries.

Importance of Pay-for-Performance

Through its landmark reports released in 1999, *To Err is Human*, and in 2001, *Crossing the Quality Chasm*, the Institute of Medicine (IOM) focused the nation on the critical need to improve health care quality and patient safety, coordinate chronic care, and support evidence-based medicine. Variation in medical decision-making has led to disparities in the quality and safety of care delivered to Americans. The 1999 IOM report found that medical errors could result in as many as 98,000 deaths annually, and a 2003 RAND study found that patients received only 55 percent of recommended care for their medical conditions.[1]

Part of the problem is that in general, payment systems have not historically paid for quality, including improved clinical outcomes and patient satisfaction; improvements in processes; or investments in infrastructures, such as information systems. Instead, traditional payments to providers, particularly in Medicare's fee-for-service program, have been based on the volume and technical complexity of services—rewarding over-utilization and misuse of services, health care complications, and poor quality. Moreover, in many instances, the current financing system actually creates disincentives to improve quality and efficiency. For example, more efficient hospital

[1] "To Err is Human," Institute of Medicine, 1999; "The Quality of Health Care Delivered to Adults in the United States.," Elizabeth A. McGlynn, RAND, June 25, 2003.

care leads to shorter lengths of stay, which unfortunately produces less income for those providers who are most effective in keeping patients healthy.

Critically, physicians have expressed concerns about the quality challenges within our current system, and the lack of recognition and reward for providing high quality care. According to a 2004 survey of 400 primary care and specialty physicians across the country conducted by Ayres, McHenry & Associates, a large majority of physicians (86 percent) are concerned that the current payment system does not reward practitioners for providing high quality medical care. Seventy-one percent of physicians favor paying physicians, in part, based on the quality of care they provide.

All of us in the health care industry must be held accountable for the quality of care delivered to Americans. Ensuring nothing less than high-quality care must be the nation's commitment, and moving toward a system that rewards providers based on performance is necessary to accomplishing that goal. While changing the payment system is admittedly a difficult task, it's the right thing to do because it's in the best interest of patients.

Paving the Way

Paying for quality is a promising strategy for improving overall wellness and advancing evidence-based medicine, thereby reducing unnecessary follow up care and improving efficiency—which in turn will lead to better health outcomes and greater value. Health insurance plans have long been at the forefront of developing innovative payment arrangements that have promoted population—based health care, improved care for the chronically ill, and more systematic investment in prevention. Many plans currently are offering financial awards to physicians in the form of increased per-member-per-month payments or non-financial rewards in the form of public recognition, preferential marketing or a reduction in administrative requirements. Additionally, some plans are beginning to tier provider networks and offer consumers reduced co-payments, deductibles, and/or premiums for using providers deemed to be of higher quality (based on select performance measures). Based on recent interviews with select health insurance plans, the most common categories of performance measures reported include clinical quality, utilization/efficiency, patient satisfaction, and information technology infrastructure.

Appendix I highlights several examples of health insurance plans that have achieved measurable results by changing their payment mechanisms to recognize and reward quality performance.

Collaboration Between Providers and Plans

Our member plans are committed to working with stakeholders across the health care community, particularly the health care professionals working on the frontlines everyday, to develop a strategy that accounts for the quality of care delivered to patients. To demonstrate this commitment, the AHIP Board of Directors in November 2004 released fundamental principles to maximize the effectiveness and value of health care services (see Appendix II). Entitled, "Promoting an Effective and Efficient Health Care System Through Rewarding Quality Performance," these principles provide a vision for the future of pay-for-performance programs based on first-hand experience by health care plans as they work to ensure higher-quality care for members. Highlights of these principles include:

- Incentive programs should be designed to give providers the opportunity to receive rewards for achieving agreed-upon quality goals.
- The involvement of physicians, hospitals, and other health care professionals in the design and implementation of programs that reward quality performance is essential to their feasibility and sustainability.
- Incentives must be sufficient enough in size to attract participation and alter provider behavior.
- Stakeholders should collaborate to develop standardized measures to ease the administrative burden of data collection and reporting.

Health insurance plans remain committed to working with providers and other stakeholders to further improve programs that better measure and reward quality performance, as well as other initiatives that promote health care effectiveness and efficiency.

Conclusion

We applaud the subcommittee for recognizing the value of pay-for-performance systems. We also commend CMS and MedPAC for their strong commitment to improving the quality of care delivered to Medicare beneficiaries by evaluating performance and efficiency. While this is not an easy task, it is a critical one. We look

forward to working with policymakers and medical professionals as we chart this new course for health care in America.

Thank you.

Promoting an Effective and Efficient Health Care System through Rewarding Quality Performance

Through its landmark reports released in 1999, *To Err is Human,* and in 2001, *Crossing the Quality Chasm,* the Institute of Medicine (10M) focused the nation on the critical need to improve health care quality and patient safety, coordinate chronic care, and support evidence-based medicine. These quality challenges are further heightened by rising medical costs, the growing gap between evidence and practice, and significant expenditures for sub-optimal care.

Taken together, these factors create an urgency for stakeholders to work collaboratively to improve the quality, safety and efficiency of the health care system. A key element of this strategy should include alignment in payment mechanisms. Health insurance plans have long been in the forefront of developing innovative payment arrangements that have promoted population-based health care, encouraging better care for the chronically ill and more systematic investment in prevention.

These payment arrangements as well as new efforts to re-align payment policies in accord with safe and effective care: (1) encourage higher-quality clinical performance; (2) provide purchasers and consumers with greater value for their health care expenditures; and (3) support consumers in making more appropriate health care decisions.

Physicians as well as health insurance plans express concern about the quality challenges within our current system, and the lack of recognition and reward for providing high quality care. According to a new survey of 400 primary care and specialty physicians across the country, a large majority of physicians (86%) are concerned that the current payment system does not reward practitioners for providing high quality medical care. Seventy-one percent of physicians favor paying physicians, in part, based on the quality of care they provide.

Finally, there is a growing interest by other stakeholders to better align reimbursement with enhanced quality, and a variety of initiatives that include benefit redesign, tiered provider networks and a range of other financial and non-financial rewards are emerging. To facilitate this movement to a quality-based payment system, our community expresses its commitment to work together and with other stakeholders, consistent with federal and state laws, to advance the following fundamental principles.

FUNDAMENTAL PRINCIPLES THAT MAXIMIZE THE EFFECTIVENESS AND VALUE OF HEALTH CARE SERVICES

- Programs that align payment methods with the goal of improving quality of care for acute and chronic conditions will play an integral role in encouraging the transition to a health care system that achieves optimal health care quality.
- Programs that reward quality performance should promote medical practice that is based on scientific evidence and aligned with the six aims of the 10M for advancing quality (safe, beneficial, timely, patient-centered, efficient, and equitable).
- Research is urgently needed to inform clinical practice in priority areas currently lacking a sufficient evidence-based foundation.
- The involvement of physicians, hospitals and other health care professionals in the design and implementation of programs that reward quality performance is essential to their feasibility and sustainability.
- Collaboration with key stakeholders, including consumers, public and private purchasers, providers, and nationally recognized organizations, to develop a common set of performance measures-process, outcome and efficiency measures-and a strategy for implementing those measures will drive improvement in clinically relevant priority areas that yield the greatest impact across the health care system.
- Reporting of reliable, aggregated performance information will promote accountability for all stakeholders and facilitate informed consumer decision-making.
- The establishment of an infrastructure and appropriate processes to aggregate-across public and private payers-performance information obtained through evidencebased measures will facilitate the reporting of meaningful quality information for physicians, hospitals, other health care professionals, and consumers.

- Disclosure of the methodologies used in programs that reward quality performance will engage physicians, hospitals, and other health care professionals so they can continue to improve health care delivery.
- Rewards, based upon reliable performance assessment, should be sufficient to produce a measurable impact on clinical practice and consumer behavior, and result in improved quality and more efficient use of health care resources.

Rewarding Quality Performance: Health Insurance Plan Examples

Blue Cross of California
Woodland Hills, California

In October 2002, Blue Cross of California introduced its PPO Physician Quality and Incentive Program (PQIP). This program includes: (1) an online PPO Physician Report Card that allows physicians to benchmark their performance compared to their peers; (2) a Physician Recognition Program that provides rewards for superior performance on clinical, administrative and pharmacy indicators, and (3) information resources provided to the PPO physician network to support quality improvement. The Report Cards and information resources are available statewide; the payment rewards are currently limited to six counties in the San Francisco area.

This program is in addition to the quality efforts offered under Blue Cross of California's HMO products. Blue Cross of California collects information from PPO physicians on their performance in various areas, such as clinical care, access, affordability, and physician status. In the first year of the PQIP, over 12,000 Blue Cross PPO physicians statewide will have access to the PQIP Scorecard, permitting these physicians to access information about their own performance, and compare data on their performance to that of other physicians by specialty and geographic area. Over 4,000 physicians located in six counties in the San Francisco area are eligible to participate in the Physician Recognition Program and receive a financial bonus for superior performance on **clinical quality (e.g., breast cancer screening, childhood immunizations, and eye exams/Hemoglobin A1C testing for diabetes), service quality (e.g., enrollee complaints) and pharmacy measures (e.g., generic substitutions) in the PQIP Scorecard**. Nearly $3 million in bonuses were distributed to close to 2,000 physicians in Spring 2004 based on first year PQIP performance. **Going forward, PPO physicians could be eligible for a fee schedule increase up to 14 percent above the plan's standard PPO fee schedules.**

HealthPartners
Minneapolis, Minnesota

HealthPartners' Outcomes Recognition Program (ORP) offers annual bonuses 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 performance targets. Measures focus on important clinical issues, such as diabetes, coronary artery disease, tobacco cessation, generic prescribing, and consumer satisfaction. ORP bonus awards are an addition to the standard provider payment for primary care provider groups. In 2004, eligible clinics were able to earn financial rewards ranging from $90,000 to $290,000, depending on the size of their HealthPartners' enrolled populations and the number of measurable targets reached. In 2004, 19 of the 26 eligible primary care groups received a total of $656,250 in ORP bonus awards. Since 1997, ORP bonus awards have totaled over $3.95 million.

Highmark Blue Cross Blue Shield
Pittsburgh, Pennsylvania

Highmark Blue Cross Blue Shield's Quality Incentive Payment System (QIPS) rewards physicians for improvements in measures based, in part, on the Health Plan Employer Data and Information Set (HEDIS) for preventive screenings and treatment for chronic conditions. Additional quality and service performance measures include generic versus brand prescribing patterns, electronic submission of claims, use of Highmark's provider portal, and enrollee access. Highmark's QIPS rewards are for Primary Care Physicians (PCP's) as a bonus in addition to capitation. Scoring is based on meeting or exceeding the Highmark network average for each indicator. In the tenth year of the program (2003), primary care physicians were reimbursed $12.3 million for 12.6 million member months or approximately $0.98 per member per month.

Independent Health
Buffalo, New York

The goal of Independent Health's Quality Management Incentive Award (QMIA) program is to improve enrollee health through improved access/timeliness of care, preventive screening, and adherence to evidence-based guidelines for the treatment of chronic conditions. A physician advisory group helps to develop "performance targets" in key areas, such as patient satisfaction, emergency room utilization/access, access/office visits, breast and colorectal screening, immunizations, and treatment for diabetes and asthma. Physicians then earn an award based on their level of performance: high, average and below average. Payment is based on additional per member per month reimbursement for the level of performance achieved. Certain primary care physicians, for example, can earn up to $2 PMPM for high-level performance in all five areas. Independent Health's QMIA program is already meeting success, as significant improvements in clinical care have been documented.

PacifiCare Health Systems
Cypress, California

PacifiCare's semi-annual Quality Index® profile uses clinical, service, and data indicators to rank medical groups. The measures are sorted into five categories: *Staying Healthy* (e.g., includes cervical and breast cancer screening, chlamydia screening and childhood immunizations); *Appropriate Care* (e.g., appropriate care for diabetes care and coronary artery disease); *Patient Safety* (appropriate use of antibiotics and cholesterol-lowering drugs); *Service & Satisfaction* (e.g., satisfaction with medical groups or primary care physicians, and Primary Care Physician communication); and *Affordability*. PacifiCare profiles the medical groups and then posts the results as "report cards" on its Web site and includes a summary in its provider directory to members.

Enrollees who select physicians from PacifiCare's "value network" of higher quality, lower cost providers, also may pay $10 per visit for their primary care physician and $20 per visit for a specialist, whereas co-payments for office visits using physicians and specialists in the "standard network" may be double those amounts. Furthermore, PacifiCare's Quality Incentive Program (pay for performance) incorporates a subset of the Quality Index® profile and has demonstrated an average improvement of 20 percent in 17 of 20 measures, with rewards exceeding $15 million in the past three years to better-performing providers.

Submission by Dawn J. Lipthrott, Ethical Health Partnerships, Winter Park, Florida

This Committee is faced with the unenviable task of trying to meet the current proposed budget requirements while not compromising healthcare quality or accessibility. The task is especially challenging since accessibility, quality and cost reduction each commonly raise costs initially rather than reduce them. Savings are gained over the long-term as improvements occur. Because of budget pressures, such as those you currently face, immediate and short-term measures are most often explored, rather than the more difficult longer-term efforts to solve those things that most significantly increase health costs. In fact, physician care has historically been the slowest growing category of health care spending and has increased very little in recent years. (Source: Tracking Health Care Costs, Strunk, BC and Ginsburg, PB, Center for Studying Health system Change, December 2004.)

Since this hearing is specifically about pay-for-performance, I will present recommendations, concerns and potential modifications in the proposed pay-for-performance approach you are currently considering.

As you and I and others look at this issue, some of the questions are:

a) How can you and we as patients and healthcare professionals realize the positives and avoid the negatives, both in a pay-for-performance approach and in quality improvements beyond or in addition to pay-for-performance

b) How do we co-create a more ethical system—to patients, to physicians, to other healthcare partners, including our government agencies?

c) How do we address quality and cost in ways that strengthen the patient/physician relationship rather than weaken it?

d) How do we challenge each contributor to healthcare (patients, physicians, insurance, government, pharmaceuticals, the legal profession, the

media and others) to take responsibility for their own contributions to both problems and solutions?

Most patients and physicians want continued and increasing quality and time and cost effectiveness. Pay-for-performance may not be the only, or even the most effective way to obtain those goals, especially if presented primarily as an immediate way to balance the budget. At the same time, while I think all physicians should be compensated fairly, I do believe that those physicians who provide superior care, should be rewarded in some way. The problem with that is that sometimes, though not always, the higher quality care is more expensive care.

Recommendations for A Pay-for-Performance Approach:

1. Link Pay-for-Performance with Improved Patient Safety:

Ethical Health Partnerships is designed to educate and challenge all individuals and groups that impact healthcare to take personal responsibility for creating more ethical health partnerships with patients, physicians and other partners in the system of relationships that is healthcare.

As part of that, our group is beginning to challenge each national specialty association of physicians, nurses, other healthcare providers, in collaboration with its members, to identify the top 3 most common serious errors that occur in that specialty and then to create and implement plans to reduce those identified errors. The errors may be due to physician/provider, procedural, equipment, or systemic error. The goal is to increase patient safety in systematic and effective ways, designed by physicians, nurses and hospitals themselves——the ones who know first-hand the real factors that lead to avoidable injuries and negative outcomes.

Once the 3 areas of highest error have been identified, the specialty association would create a committee for each error in order to develop plans and procedures to eliminate that error or effectively and efficiently reduce avoidable serious injuries. The committee would receive suggestions and information from the association membership to help develop the plan. In addition, the association would post the 3 primary errors identified, committee information (including contact information), plans and progress on the association website, available not only to the membership, but also to patients and other specialties. They could invite input to help view the problems from a variety of perspectives, all of which are important in developing effective plans. They would then develop a timeline for information and implementing actions that will lead to the elimination of the error.

Medicare Can Lead the Way and Expand the Challenge While Rewarding Progress:

Medicare can become a leader in issuing that challenge to improve quality and cost effectiveness in healthcare by improving patient safety. In addition to protecting patients and physicians themselves, medical errors raise the cost of healthcare. For example, the challenge could become to annually identify and address one area of avoidable serious area, the highest area of waste/duplication, and the highest area of patient non-compliance (in each specialty)——all of which affect patient safety, quality of care, and health costs. We also believe that even addressing those errors systemically will create policies and procedures which ultimately will become more cost-effective.

You could challenge the associations to design ways to effectively improve those areas, with incentives and tax credits for those physicians working to test or implement the recommendations of their respective associations.

This challenge could become an ongoing process, with additional areas needing improvement continually identified and addressed as progress is made.

2. Pay-for-Performance Program Standards Should be Designed by Physicians' Associations, and Where Appropriate, Nurses Associations and Hospital Associations:

Physicians with experience in each area of medicine are the ones who should be challenged to create any standards of more efficient and higher quality care for pay-for-performance standards. Government officials, insurance company executives, patients, or outside consultants can and should be encouraged to provide input, but the standards must come from the physician organizations to fully protect the patient and to address clinical issues. I believe that our physicians and nurses are deeply committed to quality care and patient well-being. They have knowledge, experience, awareness of most of the factors impacting care and should be challenged to use that creatively to further their commitment to quality care for their patients.

3. Initiatives Should Be Encouraged to Reduce the Largest Drivers of Healthcare Costs:

The rate of physician reimbursement is not a large driver of increasing cost. There has to be the distinction between RATE of reimbursement as a health cost factor versus VOLUME and utilization rates as factors increasing the amount of money that goes to physician reimbursement. Reimbursement has already been regularly reduced over the past 10 years. Therefore to focus on that is an ineffective approach to addressing rising cost.

Some of the highest drivers of healthcare costs are obesity, chronic illnesses, patient non-compliance (especially with medication), pharmaceutical cost and defensive medicine (which you cannot expect doctors to change without addressing medical liability issues, including alternatives to the current tort system.) However, because many of the biggest drivers are seen more by some specialties than by others, it could create unequal situations between specialties.

Offering bonuses for initiatives, programs, procedures to reduce these areas should be part of a pay-for-performance approach. Offering grants to develop programs would also contribute to quality and cost effectiveness in the long term.

- **Therefore, we also recommend that your committee make recommendations to appropriate departments to address those high cost factors that directly impact the Medicare budget.** When you look at these factors and remember that the amount spent for Medicare reimbursement of physician services was an estimated $54.2 billion for 2005, it is clear that addressing the biggest drivers of increasing costs makes more sense than penny-pinching and placing undue burden on the providers of healthcare. (Source: MEDICARE PHYSICIAN PAYMENTS Information on Spending Trends and Targets—May 5, 2004 Testimony Statement of A. Bruce Steinwald Director, Health Care—Economic and Payment Issues, Testimony Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives www.gao.gov/cgi-bin/getrpt?GAO–04–751T)

Some of these high cost factors include:

- **Increasing prevalence of obesity in adults and children:** The rapidly rising prevalence of obesity puts people at greater risk for numerous serious illnesses such as certain forms of cancer (including breast and colorectal, kidney among others), diabetes, high blood pressure, arthritis, cardiovascular disease and more. The combined prevalence of both overweight and obesity averages 53.6% across all categories and is largest for those enrolled in Medicare (56.1%) Obesity-attributable expenditures totalled $75,051, 000,000 from 1998–2000. We urge Medicare to work in partnership with private insurance to develop national and local campaigns to prevent and reduce obesity. (Sources: *Estimated Adult Obesity-attributable Percentages and Expenditures by State (BRFSS 1998 to 2000).* http://www.naaso.org/statistics/obesity—exp—state.asp. Also: National Medical Spending Attributable to Overweight and Obesity. Finkelstein, EA et al, Health Affairs. May 14, 2003.)
- **Patient non-compliance with treatment for chronic conditions** such as diabetes, high blood pressure and others; In 1992, the cost of medication non-compliance alone was $100 billion ($45 billion in direct medical costs). $31.3 billion was spent on nursing home admission due to noncompliance, $15 billion was spent on hospital admissions due to noncompliance, $1000 was spent per year per non-compliant patients versus $250 dollars spent per compliant patient. No doubt these costs have gone up considerably in 10 years since little has been done to address them. (Source: Compliance in Elderly Patients, University of Arkansas College of Pharmacy http://www.uams.edu/compliance/; Also, Schering Report IX: The Forgetful Patient: The High Cost of Improper Patient Compliance. Also Standberg, LR, Drugs as a Reason for Nursing Home Admissions, American Healthcare Association Journal 10, 20, 1984))
- **Defensive medicine:** Explore meaningful alternatives to the current tort system for handling complaints and patient injury to reduce cost, improve patient safety, and avoid unnecessary tests and procedures. If reasonable limits were placed on non-economic damages to reduce defensive medicine, it would reduce the amount of taxpayers' money the Federal Government spends by $23.6–42.5 billion per year (Source: Confronting the New Health Care Crisis, U.S. Department of Health and Human Services, July, 2002.)
- **Rising drug costs,** especially for Medicare beneficiaries: Marketing and research companies such as Delta Marketing Dynamics of New York and PriceAlert show that 31 of the top 50 drug companies raised prices from November 2004–January 2005. The year before, 22 of those companies increased

prices. Analysts believe that this is part of the preparation to take advantage of the prescription drug benefits through Medicare. We recommend that Congress change the law recently passed that prohibits Medicare from negotiating prices with pharmaceutical companies. Veteran Affairs already negotiates their prices. Even under the best of reimbursement systems, you negotiate physician services. Negotiating with pharmaceutical companies is the sensible choice of action

4. Change in SGR Formula Must Take Place Apart from any Pay-for-Performance or Other Incentive Programs;

One of my deep concerns is that pay-for-performance will be used simply as an attempt simply to save money, given the challenges facing Medicare and this committee. And once again, physician reimbursement is the easiest to control. I cannot say strongly enough, as a patient, not as a physician, that continuing declines in physician reimbursement harms both physicians and patients. It reduces quality and ultimately adds to costs. Pay-for-performance cannot become a way of side-stepping the fundamental flaw in the current payment system OR a way to avoid reimbursing physicians in a more just manner. Payment must be adjusted in light of cost of living increases and physician practice expenses. Since most physicians have had to work hard to cut expenses, this is the ideal time for Medicare to start with a less inflated base.

It is imperative that physicians are not penalized further by withholding money from them to pay some additional amounts. MedPAC's approach of withholding 1–2% and then using that to pay bonuses continues, and adds to, the injustice of the current system. It is like saying "we will continue to penalize you, but then some of you can benefit from what we take away from others who also have increasing expenses and decreasing income." As a patient, I oppose this. The trend has been to penalize physicians rather than tackle the bigger issues. I strongly encourage you to stop that trend. A just system for physician payment, relative to practice expenses and other indices, must be created.

5. Pay-for-Performance Cannot Be One More 'Cookbook' Approach to Healthcare:

Another concern is that pay-for-performance standards will become another attempt at insurance or government to create a cookbook of their definition of 'efficient and quality' care. We have gone that route with managed care and it has contributed to the decline in patient and physician satisfaction and in quality of care. It has also compromised patient safety in many instances.

Any proposals must strengthen the patient/physician relationship and use the knowledge and skill of the physician. There is no government or private substitution for the clinical judgment of a competent physician. As a patient, I want treatment decisions made by me and my physician based on my situation and physician-created standards rather than checklist of what insurance or Medicare or even a physician association has decided is the correct procedure, amount of tests or visits. To have basic standards of care is a good thing, as long as they are used as a basic guideline, realizing that quality and efficient care for the same disease can be very different for different patients. Any attempt at pay-for-performance must be wary of the 'one size fits all' approach.

6. Pay-for-Performance Needs to be Fair and Effective:

The American College of Physicians issued a position paper in April, 2004 on pay for performance that listed recommendations for the approach to be fair and effective. Some of their recommendations are:

- To create voluntary demonstration programs of performance measurement before implementing system-wide change.
- To use widely accepted, evidence-based measures that "provide valid and reliable comparative assessment across populations"
- To avoid rating physicians on factors that they cannot control (like compliance)To use incentives that are positive, not punitive
- To use pay for performance to foster quality improvement, not just competition.
- To ensure that any data collection needed to demonstrate performance will protect patient privacy and avoid adding to the paperwork burden or additional costs of data collection.

It is also important to note that some specialties, like surgery, are very different than monitoring patients with chronic illnesses like diabetes. So even process-oriented standards need to be specialty specific and not imposed uniformly across specialties.

Other Factors to Consider:

A March, 2005 article in the *Journal of the American Medical Association* points out that a healthcare 'report card' approach evaluating services provided by hospitals, physicians and health insurers is "largely undemonstrated" and "may have unintended and negative consequences on health care." It can encourage physician practices to avoid sicker patients in order to achieve target rates for outcomes or process. Another study reported in the Archives of Internal Medicine in January, 2005 said that such reporting can influence physicians to withhold procedures from patients at higher risk, even when the physician believes that the procedure might be beneficial. (Source: The unintended consequences of publicly reporting quality information. JAMA. 2005 Mar 9;293(10):1239–44. See also: The influence of public reporting of outcome data on medical decision making by physicians. Narins CR, Dozier AM, Ling FS, Zareba W. Arch Intern Med. 2005 Jan 10;165(1):83–7.)

One of the leaders of the quality improvement and pay-for-performance approaches has changed his view in the past year. Donald Berwick, president and chief executive officer of the Institute for Healthcare Improvement (IHI) in Boston, Massachusetts, and one of the leaders, has recently changed his long-held position on pay-for-performance on an individual physician or physician group level.

He states that:

"It (pay-for-performance) certainly will drive expensive consultancies, and lots of money will change hands. But will care get better? I think that care will get better much more quickly with a national commitment to learning, putting knowledge about improvement in the public domain, and developing appropriate information infrastructures. I don't think that the market will be sufficient to support the kind of national learning we need about what care has to become. I just don't trust it enough. I think we'll end up with gaming. When we got DRGs [diagnosis-related groups] into place, we didn't get this wave of learning about how to manage cases better. We got a wave of learning about how to bill properly. I want to induce real improvement, not games—that's all. And I don't trust the market to do that the way you do. I think that improvement should be regarded as a property of knowledge for the common good, somehow. We don't have a national policy that really does that.

With respect to your first point about pay-for-performance, I would first draw a very dark line between the incentives that apply to organizations, boards, executives, and the bottom line of a company, where I do want incentives in place. I want it to be good for an organization to be safe, and I want it to be good for an organization to manage chronic illness carefully or to put patients in control.

As far as organizational incentive structures—I want the kind of reforms you're after, to the extent that we possibly can. At the individual level, I don't trust incentives at all. I do not think it's true that the way to get better doctoring and better nursing is to put money on the table in front of doctors and nurses. I think that's a fundamental misunderstanding of human motivation. I think people respond to joy and work and love and achievement and learning and appreciation and gratitude—and a sense of a job well done. I think that it feels good to be a good doctor and better to be a better doctor. When we begin to attach dollar amounts to throughputs and to individual pay, we are playing with fire. The first and most important effect of that may be to begin to dissociate people from their work. That's really where we've come to, and we've done it by pay-for-performance in terms of throughput measurements and manipulating payment schemes.

I think we need a national agenda to restore joy in work, and I don't see that as the direction we're moving in right now. Ninety-nine out of a hundred people would think that's a naïve comment. But they don't think it's naïve when they go to work. Because they know when someone shows up and says, I'll pay you ten bucks more to do a good job, they feel not helped out, not incentivized. They feel insulted. And they ought to feel insulted. When we have garbage—bad doctors, bad nurses, bad hospitals—we ought to nail them, shut them down, throw them out, fire them. That will make the system a tiny bit better. But I don't think we're going to get to the heart of the problem in American medicine by paying doctors to try harder.

Mr. Berwick continues:

"Pay-for-performance at the entity level would be probably a pretty good idea. It would be better for organizations that are safer and more effective and more patient centered to find that that's good for their wallets. It is always a little bit troublesome to me, though, that we have to dangle money before the system before it does the thing it was created to do. There's something a little off-center about pay-for-performance as a fundamental strategy, and I think we should talk more about that. But it's probably going to be helpful.

It's really crucial that anything we do with pay-for-performance and incentives be linked strongly with a capability-building agenda. The average hospital, the average doctor, cannot improve what they do, because they don't know how. That's a big, big gap, and that part of the strategy has got to be completed."

(Source: "A Deficiency Of Will And Ambition": A Conversation With Donald Berwick by Robert Galvin. Health Affairs 12 January 2005.

I encourage you to make choices that protect and support patient care and the physician/patient relationship, that are ethical and just to both, and that are truly focused on quality and not just saving money in the short term. To truly improve quality and affordability of healthcare, we need to invest in programs that will reap benefits in the long-term. I hope that Medicare, in their efforts to provide quality care while addressing the very real concerns of costs, will become leaders in promoting patient safety and programs that address those drivers of healthcare costs that are more complicated and more difficult to effectively impact, but that could save significantly more money in the long run.

Thank you for continuing to struggle with the questions.

National Business Coalition on Health
Washington, DC 20036
3/23/05

Dear Chairwoman Johnson,

It is an honor for the National Business Coalition on Health (NBCH) to provide a submission for the Congressional Record relative to the Committee on Ways and Means Health Subcommittee March 15, 2005 hearing, Measuring Physician Quality and Efficiency of Care for Medicare Beneficiaries.

NBCH is a national, non-profit, membership association of business health coalitions committed to reforming the health care system and improving community health through value-based purchasing. NBCH's membership consists of nearly 80 employer-based health care coalitions dedicated to value-based purchasing of health care services. Representing more than 10,000 employers and approximately 20 million employees and their dependents, NBCH's member business coalitions are composed of mostly mid- and large-sized employers in both the private and public sectors across the United States.

As the catalyst for value-based purchasing, for over a decade NBCH has been focused on a clear set of principles:

- Value-based health care purchasing—obtaining the highest quality care at the most reasonable cost
- Measuring the comparative quality and efficiency of hospitals, physicians, and health plans in the community to identify the best value
- Creating incentives to provide higher-value care through integrated delivery systems and continuous quality improvement
- Improving the overall health of the community

To move value-based physician pay for performance incentive programs forward, late in 2004 NBCH selected four of its member organizations as Bridges to Excellence demonstration sites. The sites are part of an overall NBCH physician incentive program implemented through a partnership with the Bridges to Excellence coalition, a group of large employers supporting physician pay-for-performance efforts around the country.

Bridges to Excellence creates market incentives for physicians to follow best practices, which will yield better outcomes and reduced costs. The NBCH Bridges to Excellence initiative was launched in July 2004 to assists local business coalitions in taking a leadership role in recognizing and rewarding health care providers who demonstrate that they deliver performance-based, efficient and effective care.

Business coalitions were selected for this grassroots effort because they can coordinate the action of many employers, which is a key component to creating market incentives for improved health care quality and value. Business coalitions can have a strong impact in their markets and, in turn, can be instrumental in restructuring the health care reimbursement system that rewards performance-focused activities.

The four business coalitions selected as demonstration sites are:

- Employers' Health Coalition, Fort Smith, Arkansas
- Tri-State Health Care Coalition, Quincy, Illinois
- Heartland Healthcare Coalition, Peoria, Illinois
- Colorado Business Group on Health, Denver, Colorado

With the addition of these new markets, Bridges to Excellence has become one of the largest national pay for performance programs. Working with these four coalitions, NBCH is developing and implement strategies to promote the adoption of Bridges to Excellence tenets by both local employers and physicians. The lessons learned and experience gained in these markets will assist other business coalitions, purchasers and providers in implementing future physician incentive programs.

NBCH strongly believes that the key to the success of value-based purchasing is the commitment to continuous quality improvement, standardized assessment of performance, and the delivery of evidenced-based care.

In providing a knowledge base for employers to improve health care quality and make the most of their health care spending, over the past four years NBCH has developed a tool known as eValue8. This is a Web-based health plan procurement system enabling health care purchasers and coalitions to focus on plan performance management and improvement while reducing the time involved and associated expense.

eValue8 is conducted annually and is driven specifically by NBCH coalitions and members, focusing and uniting purchaser voices informed by public health and clinical experts. The tool includes information on hundreds of benchmarks on critical issues such as plan administration, provider performance, pharmacy management, disease management, patient safety, and member and provider communication. It also complements the National Committee for Quality Assurance (NCQA) accreditation process, an essential foundation without which eValue8 would need to be vastly more extensive.

NBCH and our members commend Medicare for taking a leadership role in provider pay for performance. As the nation's largest health care purchaser, Medicare has an opportunity to set an example to the private sector, and is in a very unique position to have the most influence on building the business case for quality. Additionally, to the degree possible, Medicare and private sector pay for performance activities need to be coordinated. A fine example of such collaboration is a Medicare pilot program in Arkansas in which physicians will be paid a bonus for investing and using health information technology (HIT). Similarly, NBCH's member coalition in Arkansas is participating in a pay for performance project that comprises a bonus for physicians investing in HIT who have been certified through NCQA's physician recognition program.

Finally, key to the success of a performance-based health care provider payment system is a standardized set of national consensus measures. Consistency and reliability are vital to the success of performance-based health care. These measures should be used as a platform for all private and public sector performance programs, with preference given to measures endorsed by the National Quality Forum (NQF), and independent and national accreditation entities.

NBCH and its members are dedicated to value-based purchasing of health care services through the collective action of public and private purchasers. In developing, identifying and disseminating best practices in value-based purchasing strategies; NBCH seeks to accelerate the nation's progress towards safe, efficient, high quality health care. NBCH is eager to provide more information to the Committee regarding our organization's efforts toward health care payment reform.

Sincerely,

Andrew Webber
President & CEO

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