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The Honorable Dave Camp, Chair
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20510

Dear Chairman Camp:

On behalf of the Pacific Business Group on Health (PBGH), I am writing in response to the request for comments on the second draft of the Sustainable Growth Rate (SGR) Repeal and Reform proposal being circulated by the Committee. For over twenty years, PBGH has helped purchasers nationwide to improve the quality of health care and to moderate health care cost increases. PBGH serves as a voice for purchasers, leveraging the strength of its 60 member companies which provide health care coverage to 10 million Americans.

PBGH supports repealing the Medicare SGR and transitioning to a payment system that bases physician reimbursement on the quality of care, thereby ensuring greater value for every health care dollar. For too long, our members have been paying for volume of services insensitive to the quality of care provided. To address this, we need a health care system transparent about the quality and cost of care, where providers are incentivized to offer more effective and affordable care and consumers are motivated to seek the right care at the right price.

To be truly effective, an improved physician payment system must ensure that the interests of patients and the nation in high quality care and long-term sustainability must come first, and that the particular interests of physicians and others in maximizing their own income come second. Any new, sustainable payment system will evolve over time and be constantly adapting to new care models, technologies, and requirements. As such, the payment system cannot be dominated by those being paid. **We strongly encourage you to develop a system and methodology that reflects the interests of patients, purchasers, and society at large.**

Our letter discusses some of the key issues in the SGR proposal which we believe need to be addressed as the Committee moves forward to ensure that those that pay for care get the value they deserve.

## Transitioning to a New Payment System

The proposal would establish a transition phase of predictable fees and updates before a quality incentive payment system is fully implemented. We support a period of stable payment in Medicare so that providers can prepare for the upcoming change. At the same time we urge the Committee to be specific about the length of the transition period. **We recommend a two-year transition period, to ensure**

**that the reform process actually moves forward expeditiously.** Otherwise the stable payment transition period could be extended indefinitely and the quality incentive system never fully realized. This would be to the detriment of beneficiaries who need the guarantee of better quality care and would hamper the potential for controlling health care costs.

## The Need for a Multi-Stakeholder Process for Measuring Quality

PBGH has been consistently engaged in, and sometimes leads, multi-stakeholder collaborative processes to develop, evaluate, endorse, and recommend performance measures for use in federal and California-based reporting and payment programs. We have worked collaboratively with providers, payers, consumers and other stakeholders to support efforts to improve health care quality and outcomes while at the same time getting better value for the health care dollar. We are extremely concerned that under the revised proposal physicians remain the primary stakeholders involved in establishing quality measures on which their own performance – and ultimately their reimbursement – would be based.

**Measures that are used in this program should include those that are relevant and meaningful to purchasers and consumers.** Specifically, that includes measures that assess appropriateness, clinical and patient-reported outcomes, patient safety, patient experience, coordination of care, and cost and resource use. These measures should also adhere to certain technical specifications, which we oftentimes find lacking in measures developed by provider organizations. For more information, refer to *Ten Criteria for Meaningful and Usable Measures of Performance*. Additionally, National Quality Forum endorsement is preferred in order to ensure that the measures meet national standards and have been approved through a nationally recognized multi-stakeholder consensus process. Involving these multiple stakeholders in the approval process helps assure the broad acceptance of the measures for use by both public and private payers and by consumers.

We strongly support the risk-adjustment of outcomes and resource use measures, for example, but not for process measures. Specifying the relevant population in a process measure obviates the need for risk adjustment (e.g., age and gender demographics are used to identify the appropriate population for NCQA's HEDIS® breast cancer screening measure). Additionally, we caution against adjusting away for all possible differences, which is feasibly challenging, and for certain population groups that would seriously hamper efforts to identify and address disparities in care. Typically, there are a group of variables that produce reasonably accurate risk-adjustment models.

We do not support physicians bearing sole responsibility for determining at what level assessment occurs. **This program will achieve the greatest improvements in care if it promotes both individual and shared accountability.** Individual physician accountability reinforces professional motivation for quality improvement, identifies variation that is masked by higher levels of aggregation, and in some instances is more appropriate (e.g., proceduralists). Shared accountability supports team-based care, coordination across providers, and progress toward a genuine system of care.

## Update Incentive Program (UIP)

As we have noted previously, PBGH strongly supports tying payment incentives to measurable improvements in performance. But how these incentives are determined is critical. Under the proposal the Secretary would convene an "expert" panel to advise on the establishment and maintenance of the UIP. It is important that this panel includes members who do not directly benefit from changes to Medicare's payment rates. Furthermore, we believe the majority of the panel should include not only experts who do not have a vested interest (e.g., medical economists, technology experts) but also those who are paying for and receiving health care (e.g., patients and purchasers).

Once up and running, the proposed UIP would base physician payment on 1) a base payment rate and 2) the variable performance rate. The performance rate would be based on one of three components: 1) the physician's score on quality measures relative to peers; 2) significant improvement in quality scores from previous years; or 3) executing clinical improvement activities. We think it is reasonable to base physician payments on achieving quality benchmarks or demonstrated improvement but **we strongly oppose clinical improvement activities as one of the criteria**. This can be subjective and easy to "game". Moreover, it does not tell us about the quality of care provided or its outcomes. Clinical improvement activities, however well-intentioned, are of interest to the government, private payers, and beneficiaries only when they lead to demonstrable improvements in health outcomes.

We strongly support the intention to align some program requirements with federal and non-federal programs. As representatives of purchasers of care, we see the devastating impact that uncontrolled health costs has on the tens of millions of people in our member organizations. Efficient care is a high priority to us, and the alignment of both public and private purchasing programs is important to achieving this. Alignment sends a consistent signal to the market, ensures we are rowing in the same direction to meet common goals, and reduces confusion and frustration among physicians. Utilizing of a core measure set that incorporates high-value, physician-level performance metrics is a key mechanism for achieving alignment. Not only should this apply to the UIP, but also the Alternative Payment Models discussed below.

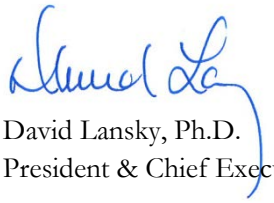
## Alternative Payment Models

The revised proposal would allow physicians to choose to participate in an alternate payment model at any time. Services provided in an approved alternate model would be exempt from UIP and reimbursed according to the arrangements of the particular model. While we see the logic in creating flexibility for the Secretary to recognize the emergence of new payment models – including those being tested through the Innovation Center – we urge the Committee to carefully craft the criteria for alternative payment models so that these models do not become a means of circumventing a payment model that ties reimbursement to quality. For physicians that choose to participate in alternative payment models, it is not clear if the alternative payment needs to apply to their entire Medicare patient population. If not, that leaves open the possibility of continued payments under a deeply flawed fee-for-service model.

**Conclusion**

Thank you again for the opportunity to comment on the proposed draft. Changing the way Medicare pays physicians is central to value-driven health care. We are very interested in talking with you further about the issues raised in our letter and look forward to working with you as the proposal continues to evolve.

Sincerely,



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