PBGH
PACIFIC BUSINESS GROUP ON HEALTH

221 MAIN STREET, SUITE 1500
SAN FRANCISCO, CA 94105
PBGH.ORG

OFFICE 415.281.8660
FACSIMILE 415.520.0927

November 12, 2013

The Honorable Max Baucus,
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Dave Camp
Chairman
Committee on Ways & Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways & Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Baucus, Ranking Member Hatch, Chairman Camp, and Ranking Member Levin:

The Pacific Business Group on Health (PBGH) applauds the Senate Finance and House Ways and Means Committees' bi-partisan efforts to reform the way physicians are paid under Medicare. We support the basic elements of the proposal that would move away from the current volume-based, fee-for-service model, and reward physicians for providing high quality, efficient and appropriate care.

For over twenty years, PBGH has helped large employers to improve the quality of health care and to moderate health care cost increases. For decades, large employers have been frustrated by the rising costs and inconsistent quality of health care, and they know we need to change the way we pay providers. All purchasers – Medicare as well as private sector employers – must be assured they are paying for high-value care at the appropriate cost. In addition, high-performing physicians should be rewarded for the quality of the services they provide. Most importantly, patients have a fundamental right to know whether they are likely to receive good care from their doctors.

We greatly appreciate the work of the Committees to reform the Medicare physician payment program and support the approach taken by the Committees in the discussion draft published on October 31. In particular, PBGH supports the general direction of the following key elements of the proposal:

1. Rewarding physicians who meet high performance standards for quality, resource management and appropriateness
2. Encouraging the effective coordination of care for patients
3. Simplifying Medicare's physician payment program by consolidating multiple existing payment and incentive programs
4. A GAO review of the RUC process
5. Stronger performance measurement to support value-based payment for physicians and informed choice for consumers
6. Expanded use of Medicare claims data by qualified entities.

Our letter (see *Appendix A*) discusses some of the key issues in the discussion draft that we believe need to be addressed to ensure that those who receive and pay for care get the value they deserve.

Appendix A

Value-Based Performance (VBP) Payment Program

PBGH strongly supports simplifying Medicare's physician payment program by consolidating multiple existing payment and incentive programs into a single VBP Payment Program.

The proposal establishes four weighted performance assessment categories; quality, resource, clinical practice improvement activities, and EHR Meaningful Use, with a payment based on composite score of all four. We recommend that the Committees consider making the following improvements to the assessment categories listed in the proposal:

1) Quality Measures

We are pleased to see that quality measurement will be a key component of this program. We are also encouraged that the proposal states that a higher overall weight will be given to outcomes measures. Since the proposal will allow for the use of quality measures contained in the existing PQRS program, PBGH is concerned that this new program could contain many of the PQRS measures that merely assess basic competencies of care and often reflect processes that are not strongly linked to improved outcomes.

This proposal should ensure the creation of a core set of high-value measures that drive attention to areas of high impact and focus efforts on areas of greatest importance. The measure set should be limited to those measures that emphasize where physicians should focus to achieve the goals set forth in the National Quality Strategy. The core set should include measures applicable to any clinician to permit maximum participation in the program.

The proposal will include funding for the development of additional measures. PBGH supports additional funding for measure development however **this funding should be used for the development of high-value measures for use in the new Value-Based Performance Payment Program, as well as the proposed Alternative Payment Model program and other physician incentive programs.**

The Committees' proposal should require that a substantial majority of the measures available for the program be outcomes measures including appropriateness of care, clinical outcomes, and patient-reported outcomes, as well as measures of patient experience, care coordination, and total resource use with an emphasis on high cost, high volume services. The proposal should allow for the use of some process measures, as long as they are clearly correlated with improved outcomes, as a transitional step toward a program that eventually includes only high-value measures. Furthermore, Congress should set ambitious targets for the rapid development of high-value measures. For example, **CMS should be held accountable for developing meaningful and useful outcomes measures for the large majority of physicians by 2015.**

Many parties have a stake in the development and use of better measures for physician payment. While physician involvement is critical in this process, the ultimate stakeholders are those who receive and pay for medical care. **It is essential for the process to involve all stakeholders, with strong representation from consumers and purchasers.**

2) Resource Use

The proposal seeks to enhance the metrics used in the current law VBM program to identify resources associated with specific care episodes. PBGH recommends that, in order to the enhance current program, the proposal should include a **requirement for the use of robust resource use measures with accountability for total cost of care and the rate of increase in per capita spending.** Furthermore, since individual physicians make decisions that control the majority of personal health spending, the proposal should **allow for measuring resource use at the level of the individual physician** as well as at the practice and group levels. Given the importance of importance of comparing resource use to outcomes, we again stress the need for CMS accelerate its efforts to develop a solid and comprehensive set of outcome measures.

3) Clinical practice improvement activities:

PBGH supports the inclusion of clinical practice improvement activities in this proposal; however we believe that a lower weight should be given to this performance assessment category. We support the principle that physicians should be rewarded for results, not activities. The clinical practice improvement activities listed in the proposal are designed to prepare professionals to transition to an advanced APM structure and are only of interest to private and public payment programs when they lead to demonstrable improvement in health outcomes. **This category should be weighted at 5 percent of the overall composite score and a greater percentage weight should be given to the to the quality and resource use categories**.

4) EHR Meaningful Use

The EHR Incentive Program is a unique opportunity to advance the capabilities and uses of health IT in quality improvement. However, to date, health IT-enabled quality measurement has not produced the results expected, in part because time and money were expended on developing low-value measures.[1] The MU Program must create a functional health IT *system* for managing and improving health care, rather than a constellation of separate health IT programs working in parallel, but not in concert with, each other. We advise doing this through **targeted use of the best measures available and developing measures to fill gaps.**

The EHR Meaningful Use program should focus on using high-value measures already applicable to electronic use —such as biometrics data to support risk adjustment, increasing the capacity for capturing patient-reported outcomes (PROs), and measures that identify overuse of tests and procedures—and discarding low-value measures. The current program has too many clinical quality structure and process measures that will not make a significant difference in improving care (e.g., reflect basic competencies, mask outcomes, allow providers to simply check-the-box, etc.).

Individual and Group Participation

According to the discussion draft, eligible professionals can opt to be assessed at the group, hospital or facility level. **PBGH believes this program will achieve the greatest improvements in care if it**

[1] For example, efforts to build measures of patient-reported outcomes for orthopedic care resulted in check-the-box measures of whether the clinician "assessed" the patient's functional status before and after hip and knee replacement and failed to take advantage of more valuable measures and tools (e.g., Minnesota Community Measurement's patient-reported outcome measure for total knee replacement).

promotes both individual and shared accountability. Given the variations that occur within practice groups, we recommend that the VBP provide feedback on individual physician performance. Individual performance assessment is especially important for specialists, and for certain procedures such as surgery.

Making comparative information available on individual physician performance within a practice can be a powerful motivator for change in a team-based context. Although team-based care is often very effective, most patients are concerned about the performance of individual physicians. Furthermore, individual physicians greatly impact the care that a patient receives.

Encouraging Alternative Payment Model Participation

The proposal would permit professionals who receive a significant portion of their revenue from an APM that involves two-sided financial risk and a quality measurement component to receive a 5% bonus payment starting in 2016.

PBGH endorses this concept and believes that payment for physician services should move away from away fee for service model and toward alternative payments. **PBGH strongly supports greater amounts of upside incentives.**

Medicare has already begun to experiment with value-based payment strategies. When crafting alternative payment models, the proposal **should encourage the expansion of payment methods used in bundled payments, ACOs and patient-centered medical homes.** For example, a payment method being used in some patient-centered medical home demonstrations uses a blend of incentives to pay for non-face-to-face activities such as communicating by phone and email with patients and coordinating care, which help to reduce the frequency of preventable hospitalizations.

The design of this program is critical in encouraging providers to innovate and redesign care delivery. Bundled payments for care encourage providers and other stakeholders to work together on innovative strategies that reduce system inefficiencies, improve the quality of care, share savings, and initiate steps toward full system integration and global payments. **Ultimately, the replacement model should move toward global payments for groups of patients** where by a single per-member per-month payment is made for all services delivered to a patient, with payment adjustments based on measured performance and patient risk.

We urge the Committees to carefully craft the criteria for alternative payment models so that these models use robust quality and performance measures. Congress should be explicit that the same quality measures should be gathered from all physicians in the Medicare program, regardless of whether they participate in the VBP program or the Alternative Payment Program option.

These complex APMs will benefit **from advanced measurement strategies that support internal incentive and quality improvement models.** According to NQF-sponsored research conducted by the RAND corporation:

- Composite measures will be important, especially in assessing episodes of care;
- Efficiency-of-care measures will be useful in APMs that are not based on global or capitated payment; and,
- Blended payment models will rely on blended performance measurement strategies.[2]

[2] Eric C. Schneider, Peter S. Hussey, Christopher Schnyer. Payment Reform: Analysis of Models and Performance Measurement Implications.

Encouraging Care Coordination for Individuals with Complex Chronic Care Needs

The proposal seeks to encourage care management services for individuals with complex chronic care needs through the development of new payment codes for these services beginning in 2015. PBGH endorses complex care coordination as an integral part of improving patient care, which, if done effectively, can also have an impact on reducing costs.

PBGH supports efforts in this proposal to improve care coordination but believes that this goal cannot be achieved solely with the creation of new codes. This is especially true if the new codes center on certifying that a physician practice has the capacity to perform basic care coordination activities, rather than paying for the actual coordination and the delivery of high-value care.

Care coordination should be paid based on improved patient outcomes rather than certification of basic processes and standards, such as the use of certified EHR technology or the development of a plan of care. Furthermore, patients should be asked to report whether they perceived their care to have been appropriately coordinated among the various providers who served them.

Ensuring Accurate Valuation of Services Under the Physician Fee Schedule

The proposal directs CMS to systematically identify and revalue misvalued services. CMS would solicit information from selected physicians to support its valuation activities. The proposal also directs the Government Accountability Office (GAO) to study the AMA/Specialty Society Relative Value Scale Update Committee (RUC) processes for making recommendations on valuation of physician services.

PBGH strongly supports an independent GAO study of RUC processes. In the current system, relative value units are based entirely on the Physician Practice Information Survey (PPIS); a survey that it is conducted and paid for by the AMA. As a physician membership organization, the AMA has a direct conflict of interest in the survey results. The survey depends on physicians self-reporting how much of their time certain services require which introduces the potential for distortion in the fee schedule. **This survey process should be conducted by an independent entity that is not directly tied to the physician community, and PPIS should be revised with a more rigorous methodology.**

CMS has begun to gather data on physician independently of the American Medical Association and PBGH applauds this move. PBGH **strongly encourages the Committees to devote more resources to CMS to expand this data collection** with the goal of improving the accuracy of the practice and intensity of time expenses.

Recognizing Appropriate Use Criteria

The proposal would implement a program that would require professionals who order advanced imaging and electrocardiogram services to consult with appropriate use criteria. **PBGH supports implementing a policy that ties payments to criteria that take into account the benefits and risks of performing imaging and supports appropriate clinical decisions.**

Currently, clinical measures reported in Medicare payment programs for certain conditions, like low back pain, do not effectively address the important area of overuse. If clinically-tested appropriateness criteria

are integrated into physicians' practices, the use of unnecessary EKG and imaging can be significantly reduced while still ensuring patients have access to the services they need.

The proposal calls for the Secretary, in consultation with stakeholders, to specify appropriate use criteria from among those developed or endorsed by medical specialty societies or other entities. **The consulted stakeholders referenced in the proposal should include those who receive and pay for care – consumers and purchasers.** Patients have a fundamental right to know whether they are likely to receive good care from a doctor they are considering. Similarly, purchasers must be assured they are paying for high-value care at the appropriate cost.

Expanding the Use of Medicare Data for Performance Improvement

The proposal will allow qualified entities (QEs) to provide or sell non-public data analyses to physicians and professionals, health insurers, and employers who meet specific requirements, in order to assist them in their quality improvement activities. PBGH supports the expanded use of Medicare data by qualified entities. However, we have we have some specific concerns with the language used in the proposal.

PBGH is concerned that the proposal as drafted will not allow QEs to provide subscribers with comprehensive data sets, but rather will restrict QEs to selling just "analyses" of that data. **We urge the Committees to either expand the proposal to explicitly allow QEs to sell the processed data itself**, or provide a broad definition of "analyses" that would include claims data sets that has been prepared by a QE.

While PBGH does support the proposal to limit permissible subscribers to certain stakeholders, we are a concerned that the list of permissible users and subscribers may be too narrow, and that the language used in the proposal will preclude certain organizations, that have an important interest in the data, from accessing it. The **language regarding "physicians and professionals" should be broad enough to include non-physician professionals, hospitals and hospital systems, and others that provide reimbursable services to patients.** The list should also be expanded to include research organizations that study trends in health care utilization and spending, as well as public health authorities and government agencies.

PBGH is also concerned that the proposal specifies that the data should be used for "quality improvement activities." **This language should be broadened so that subscribers are not prevented from using data for other important purposes such as process improvement, cost reduction, accountability, transparency and innovation**. Other important uses of the data may be precluded if the scope of this provision is too narrowly defined.

PBGH would support the inclusion of **stringent requirements and closer oversight of data use agreements (DUA) in this proposal**, in order to ensure that data is only used for purposes consistent with the goal of improving the way health care is delivered and paid for. QEs should limit how their members and subscribers use and share the data with DUA and through licensing agreements, which require subscribers to protect the privacy and security of the data, protect confidentiality of data contributed by other members, and limit subsequent use of the data. PBGH would also support whistleblower protections and financial incentives for employees of QEs and users who become aware of DUA violations.

Transparency of Physician Medicare Data

The Committees' proposal would require HHS to publish utilization and payment data for physician and other practitioners on the Physician Compare website. PBGH supports the release of physician-specific

Medicare data on utilization and payment so that consumers can gain a more complete picture of the care provided by individual physicians. However, this data would not be immediately useful to the public unless it is paired with other information to put it in context. **Cost and utilization data should be combined with quality data or presented to the public in a way that emphasizes the importance of considering quality in decisions about providers, treatments and health care services.**

The data that is posted on Physician Compare should be presented in a way that is consumer-oriented, easy to access and meaningful; therefore, it should be designed with significant input from consumers.

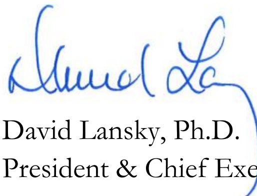
We also support the release of Medicare claims data through qualified entities that can analyze and "interpret" the data for the public.

Conclusion

Large employers want to see physician payment directly tied to the value of the services that are provided, including clinical quality, patient-reported outcomes, and total cost of care. To fix the existing problems of health care cost and quality, we must build a system based on innovation, value, and measuring what matters to consumers and purchasers. We need to replace Medicare's current fee-for-service system with payment based on performance, with the goal of achieving measureable improvements in quality and affordability. In other words – put patients first, help them identify the best doctors, and reward those doctors.

We applaud the work of the Committees to reform the Medicare physician payment program, and we would be happy to provide further information, analysis and perspectives on these issues.

Sincerely,



David Lansky, Ph.D.
President & Chief Executive Officer