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Policy Options to Promote Delivery System Reform

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This statement on policy options to promote delivery system reform comes with the sincere thanks and appreciation from the business community for the leadership shown by Senators Baucus and Grassley, and all of the members of the Senate Finance Committee. We are pleased that you are asking the right questions, including how to rein in the out of control health care costs while simultaneously fostering higher quality care. We also appreciate your understanding that reform cannot be just about expanding coverage. If we do not reform how we deliver and pay for care, the health care system will be an ever increasing weight dragging down the economy, America's business community and individual patients across the country.

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. Research tells us that quality varies, is often unsafe, and that we are providing far too much inappropriate and unnecessary care. Americans believe in value – most shop to get the best quality possible for their money. Yet, no one is getting good value for their health care dollar. Our health care system is broken:

- Quality of care varies dramatically between doctors and hospitals, but those differences are invisible to patients.
- Payments reward quantity over quality and fixing problems over prevention.
- Lack of standardized performance measures makes it impossible to know which providers are doing a good job, and those who are not.
- Consumers lack information to make the choices that are right for them.

Purchasers are not interested in dictating the form of health care delivery, but they do want better results. We live in a large and complex society, and one that expects continuous increases in knowledge and continuous innovation in how to apply that knowledge to achieve value. In most of our members' industries, they have seen dramatic and valuable innovations in how services are delivered and products are made. Now they want to see a health care environment where similar innovation and efficiency is facilitated and rewarded. They want a delivery system that succeeds when it achieves improved health through health promotion, prevention of illness, and effective treatment of disease and injury. The primary tests of delivery system reform should be

demonstrable improvements in health outcomes and efficient use of societal and personal resources. If we create the right incentives and metrics, the many thousands of highly trained and passionate professionals will be encouraged and enabled to deliver more effective, efficient care.

I would like to highlight five policy approaches that can help create the kind of environment that will encourage effective delivery system reform:

1. Transparency in provider performance and the comparative effectiveness of treatments, drugs and devices
2. An infrastructure to support the efficient collection and sharing of information
3. Payments that reward higher value and provide consistent incentives across both public and private sector payors
4. Effective ways to engage patients with information and incentives to make the best decisions
5. Policy and governance processes that incorporate the perspectives of those who receive and pay for care, as well as those who provide it

1. We need to know who's doing a better job and what works – promoting policies that foster transparency in provider performance and the comparative effectiveness of treatments, drugs and devices.

We know there is huge variation in the quality of health care, but we don't know who is or isn't delivering the right care at the right time. All too often we don't know which drugs, devices or treatments are the right ones. Without better information, providers cannot improve their performance, consumers cannot make better choices and payers cannot know who or what to reward. Continuous improvement will not occur based on top-down orders from Washington to "do the right thing." Health care professionals in every community in America want to provide the best quality care and to improve their performance – but can't get far if they don't know how they're doing. And, consumers and purchasers cannot identify and reward high quality efficient care without measures of what works and who's providing the right care. As part of charting out our gaps in performance, we know that people of color, limited English speakers and poor people often receive lower quality health care, even when they have the same health care coverage as other populations.

Improving quality requires sharing information about what is happening inside our health care system with everyone who gets, gives or pays for care. There are a range of concrete policy options that can foster better measurement – which is the foundation for all efforts to improve the value of our health care system:

- The recommendations of over 170 groups under the name "Stand for Quality" – representing an array of consumers, employers, clinicians and other providers, hospitals, health plans and more – called for dramatically increased federal leadership in aligning priorities, developing performance measures to fill gaps, and engaging stakeholders in how those measures are used by the public sector (information available at www.standforquality.org). These recommendations call for the development of robust, independent systems for collecting and reporting performance results on patients' outcomes, cost and patients' views of care, and whether the right processes of care are being delivered by doctors, medical groups, hospitals, nursing homes, and other providers. The breadth of support for doing measurement right – expanding our measurement of outcomes, patient-experience, disparities in care and resource use – is historic and charts a path for action.
- The American Reinvestment and Recovery Act's (ARRA) support for comparative effectiveness research is an important step, but we need to dramatically expand comparative effectiveness research so patients can have better information that they can use with their doctors to understand what's the right treatment for them. We need more than the studies being funded under ARRA, but an ongoing independent and robust comparative effectiveness process that will assure that decisions about care are driven by the evidence and what is in the patient's interest.
- CMS should routinely make available the Medicare claims database to qualified "Quality Reporting Organizations" via HIPAA-compliant agreements. This would enable employer-sponsored and individually sponsored health benefits plans to use aggregated public and private claims data to generate provider-specific health care performance results and ultimately lower premiums and raise quality of care.

2. There needs to be an infrastructure to support the efficient collection and sharing of information.

Health care is an information-dependent industry that has failed to keep up with the revolution in knowledge and information processing that has transformed the global economy. Patients, clinicians, and policymakers need reliable, real-time information to make sound decisions – whether about individual patient care or the allocation of societal resources. It is intolerable that we continue to "manage" a $2+ trillion industry that affects the well-being of every American with paper documentation and crude billing codes. As we enter the second decade of Google - with instant access to much of the world's knowledge - it is time to extend the network information model to US health care. We encourage you to consider several key principles:

1. The goals of health IT investments are to improve health care quality and affordability, stimulate innovation, and protect privacy – not the mere installation of software or hardware.

2. These goals can be achieved only through the effective use of information to support better decision-making and more effective processes that improve health outcomes and reduce unnecessary costs.
3. The definition of "meaningful use" should hinge on whether information is being used to deliver care and support processes that improve patient health status and outcomes.
4. It would be a strategic mistake to assume that only a highly integrated EHR system can achieve the goals of meaningful use. Public policy and incentive programs must allow for innovation in the architecture and technologies used to deliver information to clinicians and patients.
5. Consumers, patients, and their families should benefit from health IT through improved access to personal health information without sacrificing their privacy.

We also encourage you to recognize that every American is a user of the emerging health information network – it is not the preserve of researchers or doctors or institutions. Massive databases of valuable health information are already in digital form – medication histories, laboratory results, claims and billing data, imaging studies and, now, electronic health records – but we have not addressed the policy issues and the transport standards that would allow these data to be exchanged and aggregated under proper controls. To stimulate greater consumer engagement in their own care, and to encourage innovation in health care delivery, we need to establish the technical and policy framework that would open up the data networks to wider use.

3. Payments must be reformed to reward higher value and we need to be sure that these efforts align public and private sector efforts.

Our health care system pays providers for the number of treatments and procedures they provide and pays more for using expensive technology or surgical interventions. It is neither designed to reward better quality, care coordination or prevention nor to encourage patients to get the right care at the right time. While there are literally hundreds of efforts across the country to reform payments, without Medicare's leadership these efforts will be too small and run the risk of distracting instead of focusing health care providers on delivering better care. Recently a coalition of consumers, employers, labor and providers have come together because of their agreement on the need to transform the payment system. This group – the Center for Payment Reform – has established six core principles that should guide both public and private payment policies:

1. Reward the delivery of quality, cost-effective and affordable care
2. Encourage and reward patient-centered care that coordinates services across the spectrum of health care providers and care settings
3. Foster alignment between public and private health care sectors
4. Make decisions about payment using independent processes

5. Reduce expenditures on administrative and other processes
6. Balance urgency to implement changes against the need to have realistic goals and timelines

Using these principles as guidance, we must design payment systems to reward providers for giving the right care at the right time and encourage patients to be actively engaged in their care. Some policy options that should be taken include:

- Reward those who provide truly needed care – not care that is of unlikely benefit to patients. More health care is not always better care. In fact, too much care can harm people by subjecting them to unnecessary dangers and treatments. We need to stop giving and paying for care people do not need. In both the measurement arena and in payment, there is far too little discussion of overuse and whether care is appropriate. The fact that overuse is one of the priority areas identified by the National Priority Partnership effort being facilitated by the National Quality Forum is good news. We need to build on that identification to design payments that foster the right care and not overuse.
- Providers who deliver high-quality, cost effective care or who improve significantly should be rewarded. Medicare's efforts on both the clinician and facility fronts should be dramatically expanded.
- Fee-for-service payments should be modified to promote primary care, better coordination and more efficient care. We need to rebalance the payment equation to better compensate providers engaged in preventive care, time spent coaching patients and coordinating care for those with chronic conditions; and relatively decrease payments for procedures and testing. Not only does the current payment "get what we pay for" – large amounts of procedures, and consultations with uncertain benefit – we are generating a pipeline of specialist physicians who will see every patient as the "nail" for whom their "hammer" is the appropriate instrument. We need to begin signaling now for today's and tomorrow's physicians that we will reward primary care.
- Medicare, along with private payers, must embark on rapid cycle demonstrations to move away for the quality-blind fee-for-service "pay for quantity" approach. Substantial piloting of medical homes and bundled payments are examples of such efforts. We need to move to paying for episodes of care rather than discrete services. This means paying once for the total package of treatments necessary for a medical condition, rather than paying separately for each treatment. Congress, however, must balance the need for rapid cycle testing with the urgency which cries out for change. Launching demonstrations and pilots that allow for expansion are needed, but Congress should call on Medicare to move payments to reward coordination, quality and efficiency. Changing payments to promote quality cannot and should not happen overnight – but it can and must happen. Congress can foster this movement by requiring CMS to report on how Medicare spending is indeed patient-

centered and rewarding better performance. Potential reporting elements include:
    - Percentage of total Medicare payments that reward better care, participation in reporting programs or improvements in delivery (such as e-prescribing);
    - Percentage of total Medicare payments that specifically foster and reward care coordination;
    - Percentage of Medicare payments for care that is either of uncertain value because of gaps in evidence or for which there is no demonstration that the patients' values and preferences were incorporated in the decision process.
- Medicare should consider the circumstances it can and should reimburse providers for electronic consultations with patients.
- Allow providers such as physician assistants, nurses, pharmacists, nutritionists and dietitians to provide more care for which they are appropriately trained, such as working in settings like retail clinics.

4. There must be effective ways to engage patients with information and incentives to make the best decisions.

Health care consumers cannot compare the quality or efficiency of care offered by medical practitioners, clinics and hospitals or the various treatment options available to them to make good choices. Americans need tools to help them make good health care decisions. Some policy options that will foster better engagement of patients:

- The federal role must be first and foremost make sure that there is valid information consumers can use to compare quality and cost-efficiency of medical treatments and providers. Creating that information should allow for any users – public and private – to build on that information as long as patient privacy is protected.
- Medicare should explore providing information and incentives for wellness and the selection of higher value providers. Private health plans are increasingly offering not just tools, but incentives for their enrollees to improve their health and make better choices among providers. Medicare should follow the same path to investigate how beneficiaries can be given tools and incentives to make better choices. This could take the form of restructuring the standard Medicare Supplement plans to require that they offer information and tools to facilitate patient choice.
- Medicare should support shared decision making processes. This support can take the form of both providing incentives to patients to get coaching and reducing payments to providers in cases where preference sensitive care (i.e., care for which there is more than one medically reasonable choice, with choices that differ in risks and benefits – such as treating chest pain from coronary artery disease or early-stage prostate cancer) was delivered in the absence of patient participation in decision-making.

- Medicare should support information technology through which all of a patient's health records can be centrally stored electronically, allowing easy access to a patient's complete medical history by both providers and patients.

5. Policies must be made and revised in ways the incorporate the perspectives of those who receive and pay for care, as well as those who provide care.

Congress should assure that patient-centeredness and value are at the core of all the decisions made on an ongoing basis. There are many elements in health reform that will not mark the "end" of the discussion, but rather the beginning – the beginning of ongoing considerations on how to assess comparative effectiveness, determining what "meaningful use" is for health information technologies, assessing how payments should be adjusted to reflect higher value. Common to all of these areas is the fact that those who provide services or make products will always be "at the table" making sure their voices are heard (whether that is in the halls of Congress or in federal agencies). At every step along the way, Congress should look to create processes that assure that the voice of consumers – those who receive care – and employers and public purchasers – those who pay for care – is not only at the table, but there are structures to assure the policy making is particularly guided by their perspectives.

One example of this is the case of how Medicare reviews the relative value of its payments. Currently CMS seeks input from a range of sources, including the AMA/Specialty Society Relative Value Scale Update Committee (the "RUC") – through which evidence from and voting by the medical specialties themselves is garnered. As the AMA notes – "the RUC has created the best possible advocate for physician payment, the physician." We need to re-boot Medicare's process to have the regular review of the relative value of health care services framed not primarily by those who receive the payments, but by those who receive the care and pay the bills. We need new decision processes, potentially inside or above CMS, that should be structured so that a majority of its members represent public and private payers, consumers and patient advocates, along with the critical involvement of physicians and other clinicians assured in a way that is balanced such that a substantial portion of them should be from primary care specialties. This new, patient-centered value review process should certainly still look to specialty societies to inform their deliberations, but should actively go beyond those societies as it seeks evidence to review and revise relative value adjustments framed by what patients need and improving value. We need similar structures to shape other major reform decisions to assure that "delivery reform" is guided by those who are the intended beneficiaries.

Conclusion

Far too many patients today are not receiving the care we know they should. Far too many doctors and other clinicians are being paid to do more, not to provide care coordination or better care. Most providers are paid the same whether they deliver high quality or low quality care, irrespective of their cost-efficiency. Wasted spending that buys no incremental health likely exceeds 30% of current spending. The trends and current reality call on you to act with the urgency felt by employers and by all Americans. **We must change these dynamics – consumers must have the performance information and incentives to make the best choices; and providers must be given the tools to improve and be rewarded for doing a better job.**

Private purchasers are looking to Medicare to be their partner – but without Medicare working in parallel and taking major steps forward the actions of the private sector are bound to lose to the concerted opposition from industry. The federal government needs to promote markets – both directly as a purchaser and by supporting the information every American needs to get better care. As noted, there are key leadership steps that Medicare and the federal government must take, including (1) creating comparative performance information not just on providers, but for treatments and using it in payment and incentives; (2) rebalance Medicare payments to reward primary care and care coordination; and (3) establish a new CMS payment review process that is physician-informed, but patient-centered. These three steps, along with many others, will move us toward a health care system that is patient-centered and sustainable. Thank you for the opportunity to be with you today.