PBGH
Pacific Business
Group on Health

221 Main Street
Suite 1500
San Francisco
CA 94105

www.pbgh.org
Tel: 415.281.8660
Fax: 415.281.0960

Testimony of Peter V. Lee
Executive Director, National Health Policy
Pacific Business Group on Health

September 9, 2008
Senate Finance Committee

Promoting Quality and Value in Health Reform

Good morning Senators Baucus and Grassley and members of the committee. I am Peter Lee, the Executive Director for National Health Policy of the Pacific Business Group on Health. I appreciate the opportunity to be with you this morning to talk about how the federal government and Medicare can join with leading employers, labor groups, consumers and providers to measure and reward quality and cost-efficiency to foster improvements in a very troubled health care system.

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 – but we are simply unable to identify where those failures exist and either help clinicians understand when they are doing the right thing or help our employees be sure they are ONLY and ALWAYS getting the right care at the right time.

We realize that we cannot accomplish either goal without much better information about who is providing the right care – and toward that end, PBGH has invested in improving our ability to measure the performance of the health system and its various components. For almost twenty years, PBGH has been a national leader in promoting ways to measure the performance of health plans, hospitals, medical groups and doctors. Time and again we have gone beyond measurement, to foster ways those measures get used to help consumers to make better choices, used by plans to change payments and used by providers in quality improvement efforts. Besides representing many of America's largest public and private purchasers, PBGH is proud of its history of working closely with other employer groups, as well as consumer, labor and provider organizations to promote improvements in health care. One recent example of that collaboration is that through the California Cooperative Healthcare Reporting Initiative (CCHRI), which PBGH hosts, we are part of the California Chartered Value Exchange, a collaborative of collaboratives recently receiving designation by the Secretary of Health and Human Services. On the national front, another aspect of that history is reflected in our co-chairing the Consumer-Purchaser Disclosure Project.

As the debate on how best to reform our broken health care system continues, virtually all agree that the current system covers too few, costs too much, and does not deliver consistently high-quality care. Without ensuring quality, access to care may be meaningless. Without addressing costs, care will remain inaccessible for many Americans. More and more Americans will lose insurance and face financial hurdles to getting needed care if we are unable to control costs and create a system that uses resources intelligently.

By building health care value into reform measures, we can ensure that all Americans have not only the opportunity but the reality of getting the right care at the right time. These themes are ones that are shared by employers, consumer groups and labor. Our challenge is to go beyond themes to making performance measurement and payment changes that foster improvement actionable policies in both the public and private sectors.

As a nation we spend far more on health care per capita than any other country in the world -- $6,697 for every man, woman, and child in 2005. Yet, the United States ranks only 37th out of 191 countries in providing quality care, and we have the highest proportion of the population without health care coverage of all industrialized nations. For employers and for consumers – who have faced premium increases of over 125% in the last eight years alone – these costs have stark implications. For many small employers, they are being priced out of the market entirely. And, for large businesses, these costs put American businesses at a disadvantage compared to their foreign competition and add impetus to the last export we want to foster – American jobs.

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.

The good news is that across the political spectrum and the range of interest groups there is agreement that reform must look at coverage and financing, and also at improving the quality and cost-effectiveness of care. The good news is that there are solutions that we can work with. Our challenge, however, is to go beyond the aspirational goals of promoting prevention, better care for those with chronic illness, enhanced competition and improved technologies to concrete and actionable proposals that will improve quality and control costs.

What do we need to do?

First, we must reach for Universal Coverage

While promoting better quality and value is the focus of this hearing, we must keep on our radar the need to expand coverage and the related issue of assuring that coverage does not promote cost-shifting. One of the major implications of health care cost and premium increases is that working Americans are losing their insurance, adding to the ranks of 46 million who are already uninsured. The only reason the recent Census report did not show an increase in the uninsured was the growth in enrollment in public programs. But, the growth in many public programs actually may bode ill for the employers that are staying in the game – as an increasing cost of underfunded public programs and care for the uninsured and underinsured continues to be shifted onto the ever smaller portion of the population covered by employer-based insurance. A recent study that PBGH and CalPERS sponsored in California, found that almost 40% of the hospital costs born by private payers was not for costs of delivering services to those individuals, but rather it was paid to support the relative underpayment by Medicare and Medi-Cal (our Medicaid program). These trends are only getting worse.

Moving toward a Solution: Expand coverage to all. At the state and national level, stakeholders are discussing ways to increase coverage including expanding public programs, mandating individuals obtain insurance, requiring a payroll tax from employers, providing subsidies and providing other incentives for individuals. Whatever the solution, we should seek to cover all Americans. And we need to be sure that coverage includes fair and adequate payment so we are not just moving costs from one sector to the next.

Moving beyond coverage, we must have a health care system that (1) measures performance of providers and the comparative effectiveness of drugs, devices and treatments that gives providers the tools to improve; (2) uses that information to help patients and providers make better choices; (3) changes payments to providers and incentives for consumers to reward better quality; and (4) promote reengineering of care to deliver better quality. The only way to get to such a system is for Medicare – and other large federal purchasing programs such as the Federal Employee Health Benefit Program (FEHBP) and TRICARE – to play a leadership role, in partnership with private purchasers across the country.

The starting point for reforming health care to reward better care is that we must understand what works and who's doing the job right.

The Problem: 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 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 too often 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.

Toward a Solution: We must create a transparent health care system that will foster accountability, incentives for improvement and tools for consumers and providers. As I noted earlier, for almost twenty years PBGH has been active in initiatives to measure and report on provider performance. I'm sorry to say that we have not moved the quality needle nearly as much as we would want. The reason we haven't is that we need concrete steps to assure that robust performance information is public for all providers – which means allowing for the use of Medicare data – and we need to be sure that costs are part of the equation, with valid information about the relative cost-effectiveness of providers and treatments. While some interest groups may pressure members of Congress and state legislatures to keep cost and quality information hidden, protecting the health of Americans should come before protecting the commercial interests of any particular manufacturer or provider. Some examples include:

- CMS should routinely make available the Medicare claims data base to qualified "Quality Reporting Organizations" via HIPAA-compliant agreements. This would enable employer-sponsored and individually sponsored health benefits plans to lower premiums and raise quality of care by supporting private sector efforts through the single permitted use of the data of generating health care performance measurements, based on the aggregated claims of multiple beneficiaries.
- We need a major national initiative to measure and compare the effectiveness of drugs, devices and procedures – this must include formal economic analysis that can be trusted by all stakeholders by being transparent and rigorous. If we are going to improve the quality and value of health care, the results of these assessments must be used by public and private plans in benefit design, coverage, payment and in patient decision support.
- Develop 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.
- Assess quality of care in a standard way that allows for easy and fair comparisons. This means using national measures where they exist and developing measures that can become standards where they do not.

- Medicare and private plans collecting race and ethnicity information to enable the measurement and public reporting of health care quality information to ensure everyone benefits from improvements and allowing us to know where disparities exist so they can be addressed.

We must provide consumers with useful quality, price and treatment information

The Problem: 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.

Toward a Solution: Americans need tools to help them make good health care decisions. Some examples include:

- Tools will come in many flavors, from many sources – including federal and state governments, health plans, non-profit consumer groups and private vendors. The federal role must be first and foremost to make sure that there is valid information these groups can use to compare quality and cost-efficiency of medical treatments and 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.

Align payments to providers and incentives for patients to foster better quality care

The Problem: 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 not designed to reward better quality, to support care coordination or prevention or encourage patients to get the right care at the right time. While there are literally hundreds of efforts to reform payments occurring across the country, 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.

Toward a Solution: Design the payment system to reward providers for giving the right care at the right time and encourage patients to be actively engaged in their care. Some examples include:

- Public and private payers – health plans, Medicaid, and Medicare – should use common measures to assess provider performance.
- Reward those who provide truly needed care – not care that is of unlikely benefit to patients. 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. Beyond looking to the forthcoming recommendations from that group in November, one specific action Medicare can take is to 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.

- 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 expanded.
- 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. The recent MIPPA provision that related to the work-value weighting was a small step in this direction, but MedPAC's recommendation to establish a budget neutral payment adjustment is right on the mark. Why? Not only does the current payment "get what we pay for" – large amounts of procedures, many of which are of 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. Piloting the medical home is one example of such an effort. Others include paying for episodes of care rather than quantity of 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.
- Congress and CMS deserve credit for small steps taken to rectify the undervaluation of primary care and steps to reform payments to promote better quality and cost-effectiveness. Beyond the specific actions taken, Congress should assure that patient-centeredness and value are at the core of the assessment of the relative value of Medicare's 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 by those who receive the payments, but rather by those who receive the care and pay the bills. CMS should establish a formal advisory process that is structured so that a majority of its members represent public and private payers, patients and patient advocates, and the critical involvement of physicians and other clinicians is assured in a way that is balanced such that half 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.

Promote reengineering of health care to deliver higher quality

The Problem: Our current health care system uses outdated methods to deliver care and as a result all too often delivers unnecessary or poor quality care at a high-cost. Doctors, hospitals and other providers still rely on paper to record and transfer information, making care delivery slower, more error-prone and harder to measure and coordinate than it should be. Additionally, patients are not regularly given written information about their care and treatment, making it difficult for them to remember and manage their care effectively.

Toward a Solution: Encourage the rapid evolution to a health care system that is informed and information rich. We need to insist that doctors and consumers be rewarded for using both personal and scientific information when making treatment decisions. Just as Congress did with your recent move in providing incentives for e-prescribing, we need to create incentives to USE information in care. Examples include:

- Build on the recent payments for e-prescribing to assure that those systems are actually being used – call on CMS to assure that "using" e-prescribing means actually looking at your patients list of current medications before writing a new prescription.

- Medicare should consider the circumstances it can and should reimburse providers for electronic consultations with patients.
- Implement information technology, including where 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.
- 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.
- Medicare payment reforms should support care coordination and pay for episodes of care so providers have incentives to redesign care settings to encourage medical providers to work in teams.
- Payment changes such as the medical home and adjusting payments to support primary care are needed to compensate medical professionals for spending time with patients helping them learn to manage their own health and care.

In conclusion, I would remind the Committee that 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 25% of current spending. The trends and current reality calls on you to act with the urgency felt by employers and by all Americans. We must change these dynamics – consumers must have the performance measurements 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 I've noted, there are key leadership steps that Medicare and the federal government must take, including (1) creating comparative performance information not just for providers, but for treatments that will be used 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.