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RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

February 13, 2013

To: **Committee on Energy and Commerce Democratic Members and Staff**

Fr: **Committee on Energy and Commerce Democratic Staff**

Re: **Hearing on "SGR: Data, Measures and Models; Building a Future Medicare Physician Payment System"**

On Thursday, February 14, 2013, at 10:15 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Health of the Committee on Energy and Commerce will hold a hearing entitled, "SGR: Data, Measures and Models; Building a Future Medicare Physician Payment System."

This hearing will focus on a number of individual components essential for evaluating and reimbursing physician services under Medicare that policy makers must resolve when the Medicare sustainable growth rate (SGR) is replaced. While the SGR was intended to put the brakes on the incentives inherent in fee for service (FFS) medicine to increase utilization and volume to maximize revenue, there is broad consensus that it has been unsuccessful in doing so. Current thinking is that collaborative models of physician practice, which value cooperation, medical homes, and improved outcomes with more judicious management of resources should form the basis of not just a system to replace SGR, but our health care system as a whole.

The key question that remains unanswered is: how do we get there? Which models are worth investing in? How should success of these models be measured? What is the role and responsibility of physicians (beyond simply caring for patients) as careful stewards of Medicare resources? How should Medicare incentivize and reward good outcomes? Should bad outcomes be penalized? Who controls and develops the quality measurement infrastructure? Is it privately done by individual medical societies, or is it a public good better suited to national coordination and investment?

The witnesses at the hearing will bring their perspectives to these issues. At the heart of the issue (as the title suggests) is how quality is measured, what data are needed, and what models will deliver the best results.

I. WITNESS LIST

PANEL I

Glenn M. Hackbarth, J.D.
Chairman
Medicare Payment Advisory Commission

PANEL II

Harold D. Miller
President and CEO
Network for Regional Healthcare Improvement

Elizabeth Mitchell
CEO
Maine Health Management Coalition

Robert Berenson, M.D.
Institute Fellow
Urban Institute

Cheryl L. Damberg, Ph.D.
Senior Policy Researcher; Professor
Pardee RAND Graduate School

II. BACKGROUND

There is now broad consensus regarding the need to transform our current health care payment system from one that rewards volume to one that produces improved value by aligning quality, patient outcomes, and efficiency. Inherent in this transformation, is the need to move beyond SGR, the current system that calculates physician and provider fees in Medicare. The failure of SGR to provide a workable framework for controlling cost growth is reflected in the continual Congressional overrides, most recently, the American Taxpayer Relief Act of 2012. Because physician payments represent one of the largest categories of health care spending and decisions made by providers control the majority of health care costs, aligning and restructuring provider payment is critical to reforming the health care system. The Subcommittee most recently held a hearing July 17, 2012 on "Using Innovation to Reform Medicare Physician Payment." The Democratic Staff memo prepared at that time summarizes many of the payment and delivery system models referred to below (and will be circulated electronically).

The past three years have seen a dramatic slowing in the rate of increase of Medicare per beneficiary costs, estimated at 0.4% in 2012 and an average of 1.9% over the past three years.[1]

[1] R. Kronick and R. Po, *Growth in Medicare Spending Per Beneficiary Continues to Hit Historic Lows*, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (Jan. 7, 2013) (online at http://aspe.hhs.gov/health/reports/2013/medicarespendinggrowth/ib.pdf).

Despite this recent slowing in cost growth and the Congressional Budget Office's (CBO) revised 2013 Medicare baseline projections, changing demographics and aging of the population, projected to increase the number of Medicare beneficiaries from 50 million today to almost 90 million by 2040, necessitate strategies to control costs while not compromising patient outcomes or shifting additional burdens to beneficiaries. Even if per-capita beneficiary costs remain stable relative to GDP, the increase in the number of beneficiaries will drive cost growth. Based on CBO estimates, aging of the population is expected to account for 60 percent of the growth in federal health expenditures over the next 25 years.[2]

A number of recent reports have documented the challenges and opportunities provided by a transformed health care delivery system. The Institute of Medicine's (IOM) recent report, *Best Care at Lower Cost*,[3] acknowledges that our current system is falling short with regard to quality, outcomes, costs, and equity. Payment policies have a strong influence on how care is delivered and how well new knowledge and models of care are accepted. Implementing and ensuring high value care "requires restructuring incentives to reward the best outcomes for patients.[4]" The IOM estimates that poor quality and care inefficiencies account for 75,000 lost lives and $750 billion (30% of 2009 total health care costs) in wasted expenditures annually.

The necessity of realigning our health care delivery and payment systems around value over volume, including coordinated, evidence-based care that ensures quality and safety, the elimination of wasteful and inappropriate care, and an emphasis on primary and preventive care are common and recurrent themes across the policy and health care stakeholder landscape. The core questions that need to be answered are:

- What are the opportunities and challenges for leveraging federal policies and payment system reform to support delivery system transformation that leads to improved care at lower cost?
- How do we support transitions to more integrated models of care that reduce unnecessary care while at the same time ensuring access to high quality care for all beneficiaries (reducing waste, while ensuring equity)?
- How do we measure and incentivize improved quality and efficiency?
- What are the opportunities and challenges for leveraging payment and delivery system reform to emphasize prevention and primary care?

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[2] Congressional Budget Office, *The 2012 Long-Term Budget Outlook* (June 5, 2012) (online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term_Budget_Outlook_2.pdf).

[3] Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (Sept. 6, 2012) (online at http://www.iom.edu/~/media/Files/Report%20Files/2012/Best-Care/Best%20Care%20at%20Lower%20Cost_Recs.pdf).

[4] *Id.*

III. TRANSITIONING FROM VOLUME TO VALUE BASED SYSTEMS

While there is agreement regarding the need to move from the current fee for service (FFS) to value-based systems, there is less consensus regarding what those systems and a reasonable transition plan will look like. The Affordable Care Act (ACA)[5] provides a strong foundation for the kind of value-based models that are needed. Payment and delivery system reform is already incentivizing providers and health systems to move toward integrated models of care. We have a good framework on which to build in the context of replacing the current Medicare sustainable growth rate. Ideas suggested to replace the SGR include both restructuring FFS to support increased value and, at the same time, building on the new payment models (Accountable Care Organizations (ACOs) and value-based purchasing provisions) of the ACA.

Innovative delivery and payment system models are also being developed and implemented by physician groups, health systems, regional collaboratives, and private payers, in some cases as multi-payer initiatives with Medicare and Medicaid. While many of these share structural components with models being piloted by the Department of Health and Human Services (HHS), alternative models are also being introduced. Key questions moving forward include: how do we foster local and regional innovation, while at the same time ensuring that all models share needed standardization and oversight? What process needs to be put in place for timely assessment and authorization of new payment models? How do we leverage Medicare payment reform to stimulate and support local innovation?

At the same time Medicare is adopting new models of care, addressing imbalances and inequities in traditional fee for service is also needed. There are many opportunities to adjust reimbursement to support enhanced value. These include reassessing the value and reimbursement of primary care versus specialty services, assessing the volume and relative value of services, such as medical imaging and procedures, and revising reimbursement rates for overpriced services. The Medicare Payment Advisory Commission (MedPAC), in their October, 2011 letter, notes these and other potential options.[6] Ideally, any changes will reduce financial incentives in FFS for providing excessive and unnecessary services, while at the same time encouraging appropriate care.

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[5] ACA is comprised of two public laws, P.L. 111-148 and P.L. 111-152.

[6] Letter from MedPAC Chairman Glenn M. Hackbarth to Ranking Member Henry A. Waxman (Oct. 14, 2011) (online at http://www.medpac.gov/documents/10142011_medpac_sgr_letter.pdf).

IV. DATA IN DELIVERY SYSTEM REFORM

Innovative delivery system and payment models will need enhanced data to guide decision making in the health care system. In a recent review, the single most important factor found to either facilitate or impede the use of performance measures was the availability of data.[7] While the availability of data is increasing as a result of the wider use of electronic health records and other components of health information technology, there are still significant challenges at all levels (provider to health system) with the adequacy and availability of data. The same data challenges that limit quality improvement and care coordination at the provider level also create barriers to performance improvement and integration at the system level. HHS is working internally to bring more data to the public, but recent Congressional actions have also provided an additional push. The ACA included provisions which begin to change data sharing in Medicare. Included in this is the establishment of "Qualified Entities," both public and private, that are eligible to use claims data to evaluate provider performance on measures of quality and efficiency. The American Taxpayer Relief Act of 2012 also included additional provisions requiring the Secretary to develop a strategy for providing performance improvement data to Medicare providers in a timely manner. It is clear that as Medicare and policy makers move to demand increased accountability from providers, data will be critical. As reform moves forward, it is critical that we support both timely sharing of data and the capacity of providers and health systems to meaningfully use the information.

V. MEASURING AND PAYING FOR QUALITY AND PATIENT OUTCOMES

While data are needed to drive decision-making, there is a lack of agreement about which data and measures are most meaningful and useful. While population data, including indicators like mortality and rates of chronic diseases like diabetes and cardiovascular disease are critical to identifying areas for health system improvement, clinical process and outcomes measures like colon cancer screening rates and the percent of patients receiving appropriate monitoring and treatment goals for their chronic diseases are often more relevant to individual health care providers. While process measures, for example looking at whether clinical testing was appropriately performed, are important, what really matters is outcome measures. Outcome measures include whether blood pressure and diabetes are well-controlled and rates of heart attacks or cancer survival. To truly drive quality and hold providers accountable, what matters most is improving outcomes.

Developing consensus about which measures are most meaningful and how they should be used to align quality and efficiency with provider payment is one of the critical tasks for those piloting new models of care. In April 2012, HHS released the *National Strategy for Quality Improvement in Health Care*, a national framework for advancing quality and value, created with

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[7] C.L. Damberg et al., *An Evaluation of the Use of Performance Measures in Health Care*, RAND Corporation (2011) (online at http://www.rand.org/pubs/technical_reports/TR1148.html).

input from 52 multistakeholder organizations.[8] The National Quality Forum, National Committee for Quality Assurance, and others have also been engaged in the development of consensus measures. The Center for Medicare and Medicaid Innovation (CMMI) is also developing a core set of measures that can be used across pilots to allow for standardized assessment and comparison. To be both meaningful and useable, measures need to have a strong evidence base, impose a limited burden on providers for collection and reporting, and have a high degree of relevance (to improving quality and efficiency). Relevance is also directly related to who is using the measures and how they are being used.[9]

Another critical question related to performance measurement is who controls the development and revision of measures and how measurement is coordinated across providers and payers. While most people agree about the importance of having physicians and other providers engaged in the process, legitimate concerns have been raised about the inherent conflict of interest in asking providers who benefit financially from certain procedures and patterns of care to determine their own performance measures.[10] Ideally, panels should include representation from a broad cross-section of stakeholders including beneficiaries, with strict controls to limit financial conflicts of interest. MedPAC has repeatedly emphasized the importance of using measures that are endorsed by a credible, independent entity.[11]

As we move forward with delivery and payment system reform, it is important that quality and cost are meaningfully connected together. Historically, health care providers and other health care stakeholders have been very nimble at adjusting their business models to accommodate changes in payment systems. Capitated payment systems developed during the managed care boom of the 1990's were initially effective at slowing cost growth, but failed to adequately tie cost containment to quality improvement, thus creating financial incentives to limit access to both appropriate and unnecessary care. New payment and delivery system reform models must not only change the way we pay for services and ensure that we successfully

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[8] U.S. Department of Health and Human Services, *National Strategy for Quality Improvement in Health Care* (April 2012) (online at http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf).

[9] Performance measures are used for accreditation, certification, credentialing and licensure, public reporting, pay for reporting, pay for performance, performance-based contracting, tiering of provider networks, quality improvement, etc. See Damberg et al.

[10] P.S. Hussey et al., F*lattening the Trajectory of Health Care Spending Foster Efficient and Accountable Providers*, RAND Corporation (2012) (online at http://www.rand.org/pubs/research_briefs/RB9690z2.html).

[11] Letter from MedPAC Chairman Glenn Hackbarth to Medical Officer and Senior Advisor in the Center for Medicare Management (CMM) Dr. Thomas Valuck (Dec. 19, 2008) (online at http://www.medpac.gov/documents/Valuck%20Letter2.pdf).

measure quality, but explicitly link these together. There must also be safeguards to ensure that more challenging, traditionally higher cost populations who offer the greatest opportunities for cost savings are not excluded from participation. This includes having appropriate measures to ensure inclusion and access for high-risk and vulnerable populations and appropriate risk stratification and adjustment based on both clinical and socio-demographic factors.[12] Payment reform models must also be designed in a way that ensures the advancement of health equity and the Triple Aim[13] of improved care, better health, and lower costs for all populations.

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[12] E.C. Schneider et al., *Payment Reform Analysis of Models and Performance Measurement Implications*, RAND Corporation (2011) (online at http://www.rand.org/pubs/technical_reports/TR841.html).

[13] D. M. Berwick et al., *The Triple Aim: Care, Health, And Cost*, Health Affairs (2008) (online at http://content.healthaffairs.org/content/27/3/759.full.pdf).