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Congress of the United States

House of Representatives

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June 26, 2013

Dr. Cheryl L. Damberg
Senior Policy Researcher and Professor
Pardee RAND Graduate School
1776 Main Street
Santa Monica, CA 90401-3208

Dear Dr. Damberg:

Thank you for appearing before the Subcommittee on Health on Wednesday, June 5, 2013, to testify at the hearing entitled "Reforming SGR: Prioritizing Quality in a Modernized Physician Payment System."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests by the close of business on Friday, July 12, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov.**

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

Attachment 1—Additional Questions for the Record

The Honorable Joseph R. Pitts

1. In your testimony, you state that "value-based payment programs seek to incentivize providers to innovate and redesign care delivery to drive improvements in quality and how resources are used (i.e., costs)". Do you believe that payment reforms like those envisioned in the committee legislative framework hold the potential to improve the quality and value of the Medicare program for seniors?

2. Your testimony outlines the need for "meaningful" payments to help drive value-based payments. You also mention that incentives on the order of 5 or 10% would be needed to drive meaningful improvement in the system. However, right now the financing of the Medicare program is weak and I don't envision that Congress could pass a 10% increase for providers (or even a 5% increase) during these times. Are there other ways to structure incentive payments without having to rely on a 5 or 10% bonus to providers for practicing quality care?

3. You stated that many primary care providers have already been exposed to the kinds of performance measures outlined in the draft legislative framework. In your opinion, are the types of programs envisioned in the committee's legislative framework achievable goals for the Medicare program and providers? Also, do you believe they are goals that will improve the lives of seniors and taxpayers?

4. While primary care and some specialty groups have a long standing history of measure development and performance, others unfortunately lag behind. Do you believe that all provider groups adopting a system of quality measurement will be good for the provision of care in this country, and do you believe that provider specialties who are advanced in these areas might be able to help those who lag behind?

5. Your testimony touches on an important point. It is not whether we measure per se but really how meaningful the measure is and what it is measuring. In a system like that envisioned by the draft legislative framework, how do you believe Congress and CMS should ensure that measure development and application are meaningful both now and in the future?

6. The legislative draft puts a heavy emphasis on best practices as decided by medical specialties and primary care as the bed rock upon which measures should be founded. Your testimony also states that CMS should establish a process where measure development experts work with clinical specialties to identify performance gap areas and work to address those as measures. In your opinion, how important is this iterative relationship between CMS and medical providers around developing and maintaining a system of value-based performance?

7. Do you believe Medicare can benefit from thought leaders like Independent Health and others who are currently employing new models of care delivery in the marketplace?

8. How important is meaningful, timely feedback on performance for such a system to work?

The Honorable John Shimkus

1. Page 21 of the legislative framework released last week calls for the development of a "process by which physicians, medical societies, health care provider organizations, and other entities may propose" Alternative Payment Models for adoption and use in the Medicare program. Do you believe that model development from private payers and providers like those at Independent Health can lead to reforms that could benefit patients, providers, and taxpayers?

The Honorable Gus Bilirakis

1. In your testimony, you talk about a continuum of performance. Should we have a target percentage for performance of quality measures? For example, should the average of physicians meet 75% or 85% of performance measures? If we do use targets for performance measures and the averages are above the target percentage, should we recalibrate the metrics every five years or so, to adjust the metrics and increase the standards of care?

2. How much of these quality measures should be developed for the physician in general or should we have measures for specific diseases? How do we develop quality measures for rare diseases? These are hard to diagnose diseases with small populations. If we do develop metrics for specific conditions, how do we responsibly develop measurements for these conditions when research may be more limited?

3. How much input should patient groups have and what type of input into the process should they have when determining these measures?

4. Should the system evolve to allow a direct feedback loop to the doctor? For example, the physician would know that they were paid X because they did or did not do Y to patient Z. Do we want that granular a system, or should the information and payment be done on a more aggregate level?

5. Is it possible to use physician quality measures to encourage patients to better follow doctor's plan to manage diseases? For example, a newly diagnose diabetic getting a follow up call by the doctor reminding them to check their blood sugar or reminding them to schedule an appointment with a nutritionist. Should these metrics be limited to what is done inside the physician's office?

6. Should the quality measures be weighted? If there are 10 things that a doctor can do to increase their performance measure, should they be rated equally for payment bonuses or weighted to account for time or difficulty?

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested are provided below.

The Honorable John D. Dingell

1. During the hearing, you agreed that Congress should look at the innovations and changes being made in the private sector when considering reforms to SGR. Would you please list some suggestions of what you feel might be useful?