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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

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June 26, 2013

Mr. Bill Kramer
Executive Director for National Health Policy
Pacific Business Group on Health
221 Main Street, Suite 1500
San Francisco, CA 94105

Dear Mr. Kramer:

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

Responses from William E. Kramer,
Executive Director for National Health Policy
Pacific Business Group on Health
July 24, 2013

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. Tell me, 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?**

   Response: Yes. Private health plans, provider groups, employers and other organizations have developed a wide range of innovative provider payment models. The best of these provide appropriate incentives for improved quality, patient experience, appropriateness and efficiency of the services provided. These models benefit patients, purchasers and taxpayers by encouraging providers to deliver services that result in higher value – better quality and lower cost. The innovative payment models also reward physicians who are delivering superior medical care.

   Note: See response to the question from The Honorable John D. Dingell, Attachment 2, for more details regarding innovative private sector payment programs.

The Honorable Gus Bilirakis

1. **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?**

   Response: We need both general and specific measures.

   - General performance measures are needed to compare physicians regardless of their specialties and of the specific disease being treated. First, patients expect the same high quality of care from any doctor integrally involved in treating their condition. For example, a patient treated by a primary care physician for diabetes should expect to get the same care as a patient treated by a specialist. Otherwise, there is one standard for primary care physicians and another standard for pulmonologists. A patient-centered approach is to apply measures to all physicians that may be caring for patients with a particular condition. Otherwise, we are not getting a true picture of quality, and variation across peer groups is accepted. Second, general measures of performance are needed by patients and purchasers to evaluate the overall quality of care provided by an individual

physician or medical group. For example, patients choosing among competing ACOs want to know whether the ACO's physicians, as a group, are rated high for coordinating the care of their patients. This is important information regardless of the specific disease or condition, especially for patients who do not have an existing or chronic condition.

- Specific performance measures for certain conditions are also needed. For example, a prospective mother will want to know which obstetricians have the best clinical outcomes for deliveries. If the patient has had a previous C-section delivery, she will want to know whether the obstetrician is likely to recommend another C-section vs. a vaginal birth. Specific information like this would be masked by general performance measures.

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

   Response: Performance information is a public good, and it should be developed in order to meet the public interest. Measures that are used in this program should include those that are relevant and meaningful to purchasers and consumers. These types of measures are often lacking in measures developed solely by provider organizations. For more information, refer to *Ten Criteria for Meaningful and Usable Measures of Performance*. While physician involvement is critical in this process, the ultimate stakeholders are those who receive and pay for medical care.

   Patient representatives can bring the authentic voice of the patient into the process of defining and evaluating quality. Patients often make trade-offs that differ from those made by clinicians. Research shows, for example, that patients often choose more conservative treatment options when using shared decision-making tools and when considering end-of-life care. Excellent methods exist for scientific measurement of patient outcomes and preferences that should be included in the measurement development process. Patient organizations should be asked to help define "quality" for a given condition and to encourage patients to contribute their own data to the quality measurement process, through surveys and patient-reported outcome measures.

3. **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?**

   Response: In response to a question from the Committee during the June 5 hearing, I stated that, ideally, physicians would receive real-time feedback on their performance as well as real-time decision support tools. For example, a primary care physician would be able to see, every day, how many of her or his patients had acceptable blood pressure levels. The physician would also be able to see the expected costs of diagnostic and treatment options, e.g., lab tests, imaging and prescriptions, before making decisions in the best interests of the patient. Current reporting methods, however, often have a very long lag – sometimes as much as a year after services are delivered. Retrospective

reporting with long lags is not very useful to clinicians who are working every day to improve the care they provide.

Including the amount the physician would be paid for every decision is problematic. Physicians have an obligation to serve their patients, and information about the likely outcomes and potential risks – as well as costs and resource use – should be paramount when making decisions. We support frequent and convenient provision of aggregate cost and resource use data to physicians, but do not recommend patient-specific cost data that may influence physician judgment.

4. **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?**

   Response: Yes, quality measures should be used to encourage better follow-up care. For example, managing blood glucose levels is essential for diabetic patients. Measures should not be limited, however, to what is done in the physician's office. Managing a chronic condition like diabetes requires communication and an effective partnership between the physician and the patient, much of which happens outside the visit to the physician's office.

   Physicians should be rewarded for achieving superior outcomes -- e.g., do their diabetic patients have acceptable blood glucose levels -- not "process" measures such as follow-up calls or reminders. There are many ways to achieve good outcomes; overreliance on standardized process measures may deter important innovation, fail to recognize local health care market and populations differences, and lock in the care processes of today that may not be the most useful and effective tomorrow.

   Public reporting and payment programs should focus on outcomes and other patient-centered performance measures. Improvement will result from providers' efforts and innovative approaches to achieve superior outcomes.

5. **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?**

   Response: Yes, it is appropriate to consider different weights for performance measures. The relative weights, however, should be based on importance to patients, not the time or difficulty involved in achieving high levels of performance. The public interest should be paramount in selecting and using performance measures in Medicare physician payment programs.

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 information 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?**

   Response: Large employers have supported innovative approaches to physician payment, such as the Intensive Outpatient Care Program (IOCP) piloted by Boeing and adopted by other large employers.[i] The IOCP is a primary care-led, high intensity care management model for high-risk populations. The California HealthCare Foundation (CHCF) provided the funding to develop this groundbreaking model of delivering care as a strategy for reducing costs while maintaining or improving quality. The designs and financial projections underwent a peer review panel of subject matter experts and leaders of traditional and more innovative practices. Key features of the model include:

   - A focus on high-risk patients, i.e., the 5-20% who incur the highest costs.
   - Each site creating a new ambulatory intensivist practice.
   - Shared care plans, increased access, and proactively managed care.
   - Copays for the initial intake visit were waived; there were no other benefit changes.
   - Sites were paid a case rate per member per month (pmpm) to cover non-traditional services; otherwise, the sites continued to be paid based on traditional fee-for-service contracts.
   - The sites received a portion of the savings in total medical expenses.

   The Boeing Company initially implemented a pilot of this model in Seattle. Over a two-year period, Boeing achieved improved health outcomes (28% reduction in hospital admissions, 16% increase in mental functioning on the SF-36), 20% reduction in costs, and increased patient access to care.[ii] [iii]

   Following the success of the Boeing pilot, PBGH worked with CalPERS and Pacific Gas & Electric Company (PG&E) to replicate the model in rural Northern California with the Humboldt del Norte Foundation Medical Group. This program targets the top 20 percent of patients in terms of relative health risk. PBGH is now expanding the IOCP to the Medicare population. Under a grant from the CMMI, PBGH is rolling out this model to 17 medical groups in California, covering 23,000 Medicare patients, demonstrating commitment to public and private sector alignment.[iv]

   Other PBGH members are experimenting with models for accountable care organizations (ACO). For instance, CalPERS implemented an ACO-like pilot with Hill Physicians Medical Group, Dignity Health and Blue Shield of California that introduced a shared

savings model for improving care coordination and quality for 42,000 HMO beneficiaries in the greater Sacramento area. Early results showed a $15.5 million cost reduction annually due to a 17% reduction in patient readmissions and shorter lengths of stay.[v] Five months later, those results were updated to reflect $20 million cost reduction over the two years of the program, largely due to a 22% reduction in hospital readmissions.[vi] [vii]

Large employers know, however, that these innovations do not have the scale to drive system-wide change and improve health care across the nation. It is important to have the collaboration of the federal government - the nation's largest health care purchaser -- in transforming the way health care is delivered. Working together is also important to large employers to avoid the shifting of costs from the public to the private sector. In some markets, cost shifting from Medicare to private payers can be as high as 40%. [viii] [ix] [x] Instead, we should pursue strategies to improve quality while lowering the overall cost of care.

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[i] Additional information about the IOCP program can be found at http://www.pbgh.org/iocp.
[ii] Milstein, A and Kothari P, Health Affairs, October 20, 2009. Accessed at http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/
[iii] This model was also highlighted in Atul Gawande's "Hot Spotters" article in the New Yorker, and documented on the Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange. http://www.innovations.ahrq.gov/content.aspx?id=2941. Additionally, Steve Jacobson, MD and Jennifer Wilson-Norton of The Everett Clinic presented on "Connecting Providers and Managing High Risk Beneficiaries" at the CMS ACO Accelerated Development Learning Session on September 16, 2011, https://acoregister.rti.org/docx/dsp_lnks.cfm?doc=Module 3B. Connecting Providers Managing High Risk.pdf.
[iv] http://www.pbgh.org/key-strategies/paying-for-value/28-aicu-personalized-care-for-complex-patients.
[v] CalPERS Press Release. (2011, April 12). Press Release: April 12, 2011. Retrieved February 21, 2012, from www.calpers.ca.gov: http://www.calpers.ca.gov/index.jsp?bc=/about/press/pr-2011/april/integrated-health.xml.
[vi] CalPERS Agenda Item 4. (2011, October 18). Agenda Item 4 Memo to the Members of the Health Benefits Committee. Retrieved February 21, 2012, from www.calpers.ca.gov: http://www.calpers.ca.gov/eip-docs/about/board-calagenda/agendas/hbc/201110/item-4.pdf.
[vii] Blue Shield of California Press Release. (2011, September 16). HHS Secretary Kathleen Sebelius Reviews Key Pilot Program Tied to Health Care Reform Goals. Retrieved June 3, 2013, from www.blueshieldca.com: https://www.blueshieldca.com/bsca/about-blue-shield/newsroom/sebelius-reviews-aco-pilot-programs.sp.
[viii] W Fox & J Pickering. Cost Efficiency at Hospital Facilities in California: A Report Based on Publicly Available Data. Milliman. Oct 2007.
[ix] Analysis of Hospital Cost Shift in Arizona. The Lewin Group. March 2009.
[x] Health Care Trends in America. BlueCross BlueShield Association. 2009 Edition.