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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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June 26, 2013

Dr. Jeffrey B. Rich
Mid-Atlantic Cardiothoracic Surgeons
Sentara Heart Hospital
600 Gresham Drive, Suite 8600
Norfolk, VA 23507

Dear Dr. Rich:

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

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. From your testimony, it appears that the Society of Thoracic Surgeons have been doing measurement development and promotion for years. Do you believe that specialties that may not be as advanced as thoracic surgery can catch up?

2. How beneficial can a system of primary care and specialty-specific quality and efficiency measures be to our seniors, taxpayers, and the Medicare program as a whole?

3. You mention in your testimony the importance of linking administrative and outcome data for providers in the field. How important in such a process as outlined in the Committees legislative framework will it be for providers to have timely access to their own performance data? How early and often in the process of measurement should such access happen?

4. Your testimony and past feedback to this committee raised a concern about the sharing of best practices should a system of quality measurement be linked to payment in the wrong way. Do you have any recommendations for appropriate ways to apply such measurement that would not negatively impact the sharing of best practices among providers?

5. How important will specialty specific clinical registries be for a process such as the one outlined in the Committee's legislative framework? Could such a registry serve as a source of continual physician feedback and data as some have stated will be so important?

6. 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 that are advanced in these areas might be able to help those who lag behind?

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 Cathy McMorris Rodgers

1. Phase II of the House Energy and Commerce, health Subcommittee's proposal to repeal and replace the flawed Sustainable Growth (SGR) formula requests that providers submit "clinical practice improvement activities" to the HHS Secretary for approval. Clinical

practice improvement activities are defined as activities that improve care delivery and, when effectively executed, are likely to result in improved health outcomes.

It has come to my attention that other medical providers are already using clinical decision support tools (embedded with medical specialty society appropriateness criteria) as an example of a clinical improvement activity. These tools are both software and web-based.

One example is in the area of advanced diagnostic imaging. Clinical decision support tools, designed and used by radiologists, have demonstrated savings of health care dollars by reducing inappropriate utilization; reduction of patient exposure to unnecessary radiation; better care coordination; and shared decision making between the doctor and patient.

In light of this doctor-initiated success, please comment on the merits and concerns about using such technology in other areas of medicine.

Do you think it is feasible to consider this use of clinical decision support tools as one tool in the tool box of improving quality in healthcare?

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?

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

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?

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?

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?

The Honorable Michael Burgess

1. During the hearing, you mentioned the difficulty of obtaining some of the hospital data that CMS is releasing for developing performance metrics. You mentioned that asking CMS each time you request access to the data has become a bottleneck. Are there any other bottlenecks that you would identify for the committee?