

Statement of

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On behalf of

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Hearing on

"Medicare Physician Payment: How to Build a Payment System
that Provides Quality, Efficient Care for Medicare Beneficiaries"

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Mr. Chairman and members of the subcommittee, let me first thank you for holding this important hearing on Pay-for-Reporting and Pay-for-Performance. I appreciate your giving me the opportunity to present the perspective of medical specialists on this initiative, as well as provide recommendations on how to create a system that enhances our ability to deliver high-quality, evidence-based medical care.

In addition to working as an emergency physician in Norristown, Pennsylvania, I also serve as Chair of the Federal Government Affairs Committee for the American College of Emergency Physicians (ACEP). I am here today representing the Alliance of Specialty Medicine – a coalition of 11 medical societies, representing nearly 200,000 specialty physicians.

The Alliance of Specialty Medicine represents physicians who care for millions of patients each year. Patient safety and quality are cornerstones of the patient care we deliver. Even before the concept of Pay-for-Reporting or Pay-for-Performance was introduced on Capitol Hill, medical specialty societies within the Alliance were already developing, and constantly updating, best practices and clinical guidelines to ensure our patients receive the best medical care possible, based on sound clinical evidence and principles. In fact, some of the Alliance specialty societies were, and continue to be, involved with developing and reporting hospital measures that were included in the "Medicare Prescription Drug, Improvement and Modernization Act of 2003" (P.L. 108-173).

Hospital reporting measures were not created overnight, but in an incremental, orderly process that has been ongoing for years. These measures are voluntarily reported. However, P.L. 108-173 provided a new, strong incentive for eligible hospitals to submit their quality data. The law specifies that if a hospital does not submit performance data, it will receive a 0.4 percent reduction in its annual payment update for fiscal years 2005, 2006, and 2007. In contrast to

recent years where physicians have been exposed to statutory Medicare payment reductions, which were only averted due to congressional action, hospitals receive yearly, positive payment updates based on inflation. It is also important to understand that hospitals are currently involved with a Pay-for-Reporting program and not Pay-for-Performance – there is a distinct difference between the two initiatives.

Every Alliance organization is a member of the Physician Consortium for Performance Improvement (Physician Consortium) of the American Medical Association and has a committee focused on Pay-for-Performance (P4P) or Quality Improvement. Each organization has targeted efforts on turning evidence-based clinical guidelines into quality measures, or developing guidelines where none previously existed. However, there are challenges in creating standard quality measures for the diverse medical specialists and sub-specialists that we represent. For example, only 10 to 20 percent of a medical specialty may be represented by a given quality measure due to the high rate of sub-specialization.

Clinical practice guidelines are the foundation for developing quality measures, and for various reasons, such as liability concerns or lack of an appropriate level of supporting evidence, not all medical specialty societies have developed practice guidelines. Also, due to the nature of certain specialty care, no randomized, controlled clinical trial data exists that would lead to the development of practice guidelines in these areas.

Measure Development Process

The Alliance of Specialty Medicine members have worked diligently to prepare physicians for a quality improvement initiative that rewards physicians for providing, or improving their delivery

of high-quality medical care. We have worked closely with the Centers for Medicare & Medicaid Services (CMS) on the initial development of quality measures that could be voluntarily reported through a claims-based system and helped develop the new CMS Physician Voluntary Reporting Program (PVRP). Unfortunately, some of the measures presented by medical specialty societies were not included in the final PVRP, because those measures had not been properly scrutinized through the consensus-building process. Therefore, most of our medical specialty organizations have not been able to participate.

As with many newly created programs, the PVRP, while a promising first step, could use refinement in selected measures and processes. The current structure for the submitting and approving quality measures can be a long, complex process – one that has never been formally identified in either statute or regulation.

The members of the Physician Consortium understand the current measure development process to include (1) a medical specialty organization proposes a quality measure, based on a practice guideline; (2) the measure is reviewed by the Physician Consortium; (3) the Physician Consortium-approved measure is submitted to the National Quality Forum (NQF), which endorses the measure and gathers stakeholders – including health plans, employers, consumers, etc. – to review and approve; (4) the NQF-approved measure is then submitted to the Ambulatory Care Quality Alliance (AQA), which focuses on how the measure could be implemented; and (5) once the quality measure has been cleared by the Physician Consortium, the NQF and the AQA, it is sent to CMS for implementation. So how long does it take for a quality measure to go from its initial Physician Consortium submission to CMS implementation? The answer is two years or more. Of course, this does not take into account the medical society's own timeframe to discuss, develop, test and approve the original practice guideline that is the foundation for the quality measure.

Our medical specialty societies are working as expeditiously as possible within the process operated by the Physician Consortium, and there are, thus far, a number of quality measures that have been developed by Alliance members currently under review by various Physician Consortium committees.

While the measure development process should be fully understood and uniformly applied across all organized medicine, as well as scrupulously followed, it has been vulnerable to misunderstanding. For example, we are aware of an effort by CMS to circumvent the consensus-driven measure development process by requesting the AQA review several measures that have not yet been approved by the Physician Consortium.

We urge Congress to clearly define the measure development process before moving toward a Pay-for-Reporting or Pay-for-Performance initiative. While it may be necessary to streamline this process in order to meet statutory or regulatory deadlines that may be imposed, we urge caution because quality may be sacrificed in an expedited process. For these reasons, the Alliance of Specialty Medicine will make a formal request to Congress and the Administration for clarification of the procedure to be followed by medical societies that have quality measures that they would like to submit for implementation by CMS.

As Congress continues to discuss the creation of a statutory Pay-for-Reporting or Pay-for-Performance initiative, the Alliance of Specialty Medicine would like to share our clinical experience, expertise and recommendations with you in terms of what should be considered when developing its Pay-for-Reporting or Pay-for-Performance initiative.

Pay-for-Reporting/Pay-for-Performance Recommendations

We urge you to make sure quality measures are developed by the medical specialty societies with expertise in the area of care in question, based on factors physicians directly control, and kept current to reflect changes in clinical practice over time. Risk stratification should be considered to appropriately account for patient demographics, severity of illness and co-morbidities in order to provide meaningful information, and ensure the system does not penalize physicians who treat patients who have complex medical problems, create incentives to avoid sicker patients, and increase healthcare disparities.

In addition, quality measures must be pilot-tested and phased-in across a variety of specialties and practice settings to help determine what does and does not improve quality. If successfully pilot tested, Pay-for-Reporting or Pay-for-Performance should be phased-in over a period of years to enable participation by all physicians in all specialties.

Understanding that a suitable platform must be identified to allow physicians to report on their implementation and use of quality measures, it is important that the federal government establish national standards for Health Information Technology (HIT) systems to ensure prudent investment by physicians in HIT systems that will not become obsolete. Many solo practitioners or small group practices will need financial assistance to make up-front investments in HIT and Congress and the Administration should recognize that lost productivity and practice disruption typically occur when a fundamental change in work processes takes place, such as the implementation of new HIT systems.

In addition to these fundamental and technical issues, there are legal issues that must be considered as well when developing and implementing a Pay-for-Reporting or Pay-for-

Performance system. Performance quality must remain confidential at all times and not be subject to discovery in legal or other procedures – such as credentialing, licensure and certification – aimed at evaluating whether or not a physician has met standards of care. Because state peer-review laws vary in the scope of protections afforded to physicians participating in quality improvement activities, a national standard (similar to the one included in recently enacted federal patient safety legislation, P.L. 109-41) should be implemented. A non-punitive auditing system is necessary to ensure accurate information is entered into the system. Prior approval from patients to collect and report data must not be required and HIPAA should be amended as needed to facilitate data collection efforts.

Financing of a Pay-for-Reporting or Pay-for-Performance system is critical. Physicians, as is currently the case with hospitals, should be rewarded with "bonus" payments for participating in a new data collection and reporting initiative. Such bonus payments should be in addition to, or outside the scope of, the current Medicare physician payment system. If additional money is not provided for a Pay-for-Reporting or Pay-for-Performance initiative, and there are still physicians who are not yet able to participate because their measures have not completed the lengthy development and approval process mentioned previously, the system would become punitive, potentially further eroding physician availability for Medicare beneficiaries.

Physician compliance with a Pay-for-Reporting or Pay-for-Performance system has the potential to increase the volume of physician services and, therefore, the annual Medicare Sustainable Growth Rate (SGR) expenditure target formula must be replaced.

Finally, due to the nature of the funding silos that exist in the Medicare program, when physicians' efforts result in fewer complications and fewer or briefer hospitalizations for

Medicare beneficiaries, thereby creating additional savings to Medicare Part A, that money should flow to Medicare Part B in recognition of where the savings were generated.

Medicare Payments

The Alliance of Specialty Medicine recognizes and appreciates the leadership of this committee in preventing cuts in physicians' Medicare payments since 2003, and we hope to have your continued support. We understand that Congress and the Administration are intent on moving the Medicare program into a quality-reporting and value-based purchasing system. We are asking Congress to acknowledge the fundamentally flawed Sustainable Growth Rate (SGR) Medicare physician payment formula is incompatible with Pay-for-Reporting or Pay-for-Performance systems. For physicians to embrace Pay-for-Reporting or Pay-for-Performance, it is critical for the SGR to be replaced with a more equitable and stable payment system so that physicians can invest in HIT and pilot-test data collection methods and quality measures as steps toward establishing a Pay-for-Performance system that actually improves care for the Medicare patients we serve.

Conclusion

The Alliance of Specialty Medicine's physician organizations are continually striving to offer the highest level of quality care to all of our patients. The recommendations we have made here today are crucial in moving to a system that produces a more efficient, reliable and stable patient care system. We stand ready to work with Congress and the Administration to enhance quality measurement for the specialty care provided to our nation's seniors and individuals with disabilities.