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Statement for the Record

Pacific Business Group on Health

Hearing before the United States Senate Committee on Finance

“Health Care Quality: The Path Forward”

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Statement of:

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Introduction

Good morning. My name is David Lansky, and I am the President and Chief Executive Officer of the Pacific Business Group on Health (PBGH). On behalf of PBGH, I would like to express our appreciation to Chairman Max Baucus and Ranking Minority Member Orrin Hatch for convening today's hearing on the path forward for improving health care quality. I applaud the Committee for its efforts to promote the use of performance measures to drive improvements in our health care system.

Background

The Pacific Business Group on Health represents large health care purchasers who are working together to improve the quality and affordability of health care. PBGH consists of 60 member organizations, with employees in all 50 states, which provide health care coverage to 10 million Americans and their dependents. Our members include many large national employers such as GE, Wal-Mart, Boeing, Tesla, Target, Disney, Intel, Chevron, Wells Fargo and Safeway, as well as public sector purchasers such as CalPERS and the City and County of San Francisco.¹ PBGH and its members have been leaders, both in California and nationally, in implementing innovations in care delivery, provider payment, and consumer choice.

I have served in a variety of leadership roles in quality measurement and health information technology. I have served as a board member or advisor to the National Quality Forum, the National Priorities Partnership, the Joint Commission, the National Patient Safety Foundation, the Leapfrog Group, and the Medicare Beneficiary Education Advisory Panel. I also was the founding President of the Foundation for Accountability (FACCT), a public-private venture developing quality measures and web-based tools to help consumers and purchasers assess the value of health care services and providers. I currently serve as the purchaser representative on the federal Health Information Technology Policy Committee and, until recently, I chaired its Quality Measures Workgroup. I also serve as a member of the Congressional Budget Office's Panel of Health Advisers.

¹ Full list of PBGH members can be found at <http://www.pbgh.org/about/members>.

In 1979, I began working for a heart surgeon in Oregon who happened to have been the co-inventor of the first successful artificial heart valve – which he had implanted in a patient in 1959. Dr. Albert Starr was remarkable in many ways, but most important to me was his passionate belief in the continuous improvement of medical care. He believed that the state-of-the-art techniques he used in 1959 or 1979 would be regarded as antiquated or even foolish twenty or fifty years later. And he was committed to being among those who discovered the better way. So when he began implanting heart valves in 1959, and later performing bypass surgery, he committed himself to keeping track of every patient until he or she died, and of monitoring changes to their overall health and cardiac health every year. As a result, he built one of the world's largest databases on patient outcomes from heart surgery, and was able to publish the first studies of the long-term effectiveness of different heart implants and surgical techniques. He subjected himself to rigorous, continuous measurement of his patients' outcomes because he wanted to learn what worked and what didn't, and because he cared about whether his treatments helped his patients to live longer and healthier lives.

I have known many physicians with personal dedication similar to Dr. Starr's. They have demonstrated that it is possible to measure the results of medical care in systematic ways, and in ways that matter to you and me as patients, and to the employers and government agencies who pay the bills. After I have heart surgery or a stent, will I feel less chest pain? Will I be able to climb stairs, play golf, and live a normal life? If I have a knee replacement, how likely is it that I will have a serious infection or dislocation of the new joint? Will I be able to walk or play tennis, will I feel less pain? If my child has asthma, will treatment help him play school sports, sleep through the night, and stay out of the emergency room? Which doctor in my town is better at helping my child achieve a normal life?

These are the outcomes American families and employers care about – improvements in quality of life, functioning, and longevity. Alas, we have been operating a measurement enterprise for over twenty years that leaves us unable today to make any of these straightforward judgments about the quality of doctors, hospitals, or health care organizations.

Quality Measurement

There are many reasons to measure quality systematically. Of course one is Dr. Starr's: to help clinicians evaluate and improve the care they provide. But in today's environment, three other reasons are at least as important. First, patients have a fundamental right to know whether they are likely to receive good care from a doctor or hospital they are considering. Increasingly, patients are bearing a large proportion of the costs of care, and must make decisions about where to seek care while weighing the likely benefits and costs of the services they are considering. We do the American people a disservice if we impose increasing costs on them with no information on quality.

Second, employers and other purchasers of care are committed to improving the value of the health care services they pay for. PBGH's member organizations are experiencing annual increases in health care costs well above inflation. These increases are eroding their profitability and competitiveness and undercutting employee wages – and workers and companies do not appear to be receiving any increase in value for these extraordinary expenditures. In no other area of their business do our members incur ever-increasing costs with no corresponding benefit. PBGH members are committed to identifying those providers most likely to achieve good results and using innovative contracting and benefit designs to assist patients in getting care from those providers. This is a fundamental and almost universal strategy of PBGH's member companies, but they are unable to execute it effectively without standardized, comparative quality information.

Finally, we have a well-documented national failure in accountability. Our society is spending upwards of \$2.8 trillion dollars every year on health care – and our federal government is responsible for \$750 billion of that. It is unconscionable that we have virtually no information to indicate if these dollars are well spent. Innumerable research studies from communities and institutions throughout the country suggest that much of this spending is unnecessary or even harmful. So the third reason to measure health care quality is to evaluate and improve the effectiveness and accountability of our health care system.

Purchaser Perspective on Quality Measurement

I am speaking with you today on behalf of large health care purchasers. I cannot overstate their frustration with our government, with their insurance carriers, and with the community of health professionals and institutions. We have collectively failed to establish the infrastructure that would permit a robust health care marketplace to exist. Instead, the absence of useful quality information leaves them and the American people in an unacceptable situation, where the only information to differentiate hospitals or clinics or doctors is their price tag. It's as if the SEC had mandated disclosure of the price of a security -- but nothing about the company itself or its financial performance -- and we expected investors to make smart choices.

Recent efforts at establishing national standards for quality measurement were stimulated by three factors: first, prior to the 1990s, in the absence of national standards, every health plan and every purchaser came up with its own way of measuring performance. This created chaos and unreasonable burden for the individual providers who were being measured, leading to general recognition that a standardized set of performance measures should be developed. A second factor was Congressional direction to the Medicare program to shift hospital and physician payment towards "value" -- which required some fair and objective way of measuring quality. In addition, introduction of new Medicare payment models such as Medicare Advantage, accountable care organizations, and episode payments naturally raised questions about whether these models provided care that was as good as or better than the prevailing system, and CMS was appropriately obligated to apply strong evaluative measures to these programs. In all of these cases, we recognized that the production of standardized national quality measures is a public good. It cannot be achieved by the private sector alone. It is the responsibility of the government to ensure the availability of quality performance information that permits the health care market to work. And the government has thus far failed to meet this responsibility. As a result, the market does not work, putting millions of people at risk of poor quality outcomes and perpetuating the tsunami of unaccountable spending that is sabotaging our economy.

Today, however -- almost 20 years since the widespread adoption of the HEDIS and CAHPS measures for managed care plans, and fifteen years since President Clinton's commission on

health care quality² recommended an accelerated process for developing quality measures – we still do not have the performance measures we need. At a strategic planning session last week, I asked the members of PBGH to rate the value of the existing performance measurement enterprise to meet their needs. Their response? “Abysmal.” Today, these private sector leaders are developing innovative provider contracts and benefit designs, but find themselves forced to develop their own quality requirements and measures. They need better measures now. For my members, new measures are needed within 18 or 24 months – much more quickly than the cycle time of today’s quality measurement enterprise. The failure to create a useful and responsive national strategy and reporting infrastructure will lead to a proliferation of new measures – some valuable and some meaningless, but all creating headaches and costs for doctors and hospitals across America. A proliferation of *ad hoc* measures will not lead to a much-needed improvement in patients’ understanding of their own care.

Health care purchasers encourage the Congress to take note of four observations and to take steps to remedy them:

1. The quality measurement enterprise has failed to meet the needs of consumers and purchasers. Those who receive and pay for health care should be the primary voice in identifying the quality measures to be used in holding physicians and hospitals accountable for providing high quality patient-centered care.
2. The measures available today are not capable of driving a successful private sector health care market. We need to rapidly develop and use measures that matter most to consumers, purchasers, providers and health plans.
3. The nation does not yet have the information infrastructure needed to support a viable health care marketplace. Federal leadership is needed to go beyond the EHR incentive program created in 2009.
4. Congress has already legislated a quality measurement framework but the government has failed to fulfill its mandate. Congress should hold HHS accountable for establishing

² The President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry said, in 1998: “Steps should be taken to ensure that comparative information on health care quality is valid, reliable, comprehensive, and available in the public domain for use by consumers, purchasers, practitioners, quality oversight organizations, and others,” and “applicable to each sector of the industry (i.e., health plans, hospitals, nursing homes, individual physician practices, etc.)” See <http://archive.ahrq.gov/hcqual/final/execsum.html>.

the information tools and infrastructure to support a successful health care marketplace.

1. Ensure that the Measurement Enterprise reflects the needs of patients and purchasers

Many parties have a stake in the development and use of better health care performance measures. PBGH has worked collaboratively with providers, payers, consumers and other stakeholders to support efforts to improve health care quality and outcomes while at the same time getting better value for the health care dollar. We engage in, and sometimes lead, multi-stakeholder collaborative processes to develop, evaluate, endorse, and recommend performance measures for use in federal and California-based reporting and payment programs. Provider involvement is critical in this process, but the ultimate stakeholders and decision-makers are those who receive and pay for medical care. Congress should make explicit that the process for developing and implementing standardized performance measures must reflect the interests of patients, purchasers, and society at large.

2. Develop and Require Collection of Better Performance Measures

There is wide variation in the quality of care patients receive from health care providers. Useful measures will permit patients and purchasers to discriminate among available service providers along the dimensions they care most about and are most likely to affect their well-being. Organizations like the National Quality Forum and federal initiatives such as the National Quality Strategy have laid out a sensible framework for evaluating quality performance, but we remain unable to put useful comparative information into the hands of the public. That is the only important test of the measurement enterprise.

Among the nearly 700 measures endorsed to-date by the National Quality Forum, the large majority are clinical process or structural measures³ yet the health care system exists to improve health outcomes. While process and structural measures can be useful to providers in quality improvement initiatives, consumers and purchasers care most about outcomes. Indeed,

³ “Developing a Viable Physician Payment Policy”. Statement of: Frank G. Opelka, MD, FACS, National Quality Forum. House Ways & Means Committee, Health Subcommittee hearing, May 7, 2013. <http://waysandmeans.house.gov/calendar/eventsingle.aspx?EventID=332173>.

national standardization and implementation of process measures “locks in” the care processes of today that may not be the most useful tomorrow, and actually impedes innovation. We believe that outcome measures should be nationally standardized with that information widely available to the public, but that process measures should be developed and implemented by providers and professional societies in whatever ways they deem helpful towards improving the publicly reported outcomes. That way, patients have the information they most need to guide their choice of providers and treatments, and providers can identify priority areas and drive rapid improvement.

As an example of where the performance measurement enterprise has not served us well to date, consider total joint replacement. Knee and hip surgeries have become the highest volume—and highest cost—procedures for both Medicare and private payers. From 2001 to 2009, the rate of primary hip replacements increased by 52%, while the rate of primary knee replacements almost doubled.⁴ We know a great deal about what patients want to know following a knee replacement, and there are widely used measures available and already in use in clinical registries around the world. Yet the Physician Quality Reporting System, which provides incentives (and, in 2015, penalties) for merely reporting data, does not include any of the measures of interest to patients and purchasers. For the most recent 2011 reporting year, an orthopedic surgeon could have selected any three of about 20 measures relevant to his or her specialty. Of the top five measures actually reported, four pertain to when antibiotics were administered and stopped, and the fifth counts whether the surgeon is using a computerized medical record. The average performance for all reporting orthopedic surgeons was above 92% on each of these five measures, which would not permit any useful comparisons.⁵ Moreover, data on even these low-value measures are not made available to the public.

Yet far better measures are already available and in use throughout the U.S. and the world. The Minnesota Statewide Quality Reporting and Measurement System requires all orthopedic surgeons in the state to measure patient outcomes one year after surgery (with an optional

⁴ The Agency for Healthcare Research and Quality. National and regional estimates on hospital use for all patients from The HCUP Nationwide Inpatient Sample (NIS). <http://hcupnet.ahrq.gov/>. Accessed June 3, 2013.

⁵ APPENDIX. 2011 Reporting Experience Including Trends (2008-2012). Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program. Accessed at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> June 22, 2013.

three-month post-surgery follow-up as well), and ask standardized questions about pain and functioning.⁶ Similarly, the California Joint Replacement Registry is a voluntary system in which surgeons are tracking the outcomes of hip and knee replacements, and have committed to issue public reports of outcomes data.⁷

We strongly recommend that Congress provide support for the rapid development and use of better performance measures, with a focus on priority “gap” areas such as patient-reported outcomes, patient experience of care, care coordination, appropriateness of care, and total resource use. The new measures should adhere to certain technical specifications to ensure their value for use by consumers and purchasers.⁸

In addition, Congress should direct CMS to accelerate the development, endorsement and prioritization of standardized measures. CMS could either continue reliance on a multi-stakeholder consensus process under a new and more stringent mandate, or take on this responsibility directly in order to expedite action. The criteria for continued funding of the measurement enterprise should include:

1. Definition and application of consumer-oriented criteria for measures development and adoption, including review of the statistical criteria required and consumer testing for relevance and importance
2. Rapid and large-scale implementation of measures that address public needs
3. Measurement priorities and timelines determined by expected uses of funded measures in payment and recognition programs deployed by CMS and other purchasers
4. Collaboration with publishers so that performance information is designed for and distributed to the public through generally accessed channels.

Finally, Congress should embed these more useful measures into new recognition and payment programs, including PQRS, the EHR Incentive Program, and the physician value-based modifier. In particular, the current interest in replacing the Sustainable Growth Rate mechanism with a value-based payment update could take advantage of these value-oriented measures by tying

⁶ http://www.mnmed.org/Portals/mma/PDFs/SQRMS_Dec_5_2012_webinar.pdf and http://www.health.state.mn.us/healthreform/measurement/2010_TotalKneeReplacement.pdf.

⁷ <http://www.caljrr.org/>

⁸ For more information, refer to [Ten Criteria for Meaningful and Usable Measures of Performance](#).

positive incentives to collection and reporting of measures of appropriateness, patient-reported outcomes, care coordination, and other high-value domains.

3. Develop needed information infrastructure

We also recommend that Congress direct HHS and the Office of the National Coordinator for Health IT to prioritize the accelerated use of inter-operable electronic health records and clinical registries as sources of performance data. The EHR incentive program, known widely as “meaningful use,” has achieved remarkable levels of adoption of computerized health records across the nation’s hospitals and doctors’ offices. Yet information technology has rapidly evolved – to take advantage of the internet, cloud computing, and mobile devices – and our understanding of the serious consequences of fragmented care delivery has also evolved. Federal dollars are no longer needed to stimulate adoption of basic clinical computing technology, but federal funding is needed to support the public good of coordinating and measuring care delivered over an episode or a period of time. ONC and CMS should be charged with implementing a framework that will allow for evaluation of a patient’s care over time, including the appropriateness of care decisions, their outcomes, and the total resources consumed. This information framework should also permit Congress and the public to assess whether new models of care, such as episode payment, accountable care organizations, and even the new insurance marketplaces are contributing to improved health.

This framework should include accelerated use of claims and other administrative data, building upon the new Qualified Entity program defined by Section 10332 of the Affordable Care Act. CMS beneficiary data could be used, for example, to identify patients who could be contacted to assess their health outcomes or patient experience. Qualified entities could be permitted to develop alternative information products for decision support, quality improvement and other appropriate uses, and to integrate laboratory results and other clinical data when producing quality reports.

4. Require the Secretary of the Department of Health and Human Services to meet Congressional intent

In Section 10331 of the Affordable Care Act, Congress required the Secretary of HHS to accelerate provision of quality information to the public in specific terms:

“Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program ...

To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include--

- (A) measures collected under the Physician Quality Reporting Initiative;
- (B) an assessment of patient health outcomes and the functional status of patients;
- (C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;
- (D) an assessment of efficiency;
- (E) an assessment of patient experience and patient, caregiver, and family engagement;
- (F) an assessment of the safety, effectiveness, and timeliness of care.”

Yet today, there is less information available on Physician Compare than in the Yellow Pages, Yelp, or any health plan provider directory.⁹ Patients will turn to whatever information is available to them, and the available cost and quality information will increasingly dictate where patients go for care and the corresponding market signals transmitted to providers. Recognizing this, Congress required rapid implementation of Physician Compare and other important information channels, but the agencies have thus far failed to implement this mandate. Private purchasers, such as PBGH member organizations, are now developing their own measurement dashboards to fill the vacuum left by federal inaction. The recent model contract issued by the

⁹ Compare, for example, a search for orthopedic surgeons in San Francisco: <http://www.medicare.gov/find-a-doctor/provider-results.aspx?searchtype=PHP&specgrpids=24&loc=94118&pref=No&specids=20&gender=Unknown&dist=15&lat=37.78229&lng=-122.4637> with a similar search on Yelp: http://www.yelp.com/search?find_desc=orthopedic+surgeon&find_loc=San+Francisco%2C+CA&ns=1#find_loc=san+francisco,+ca

new health insurance marketplace known as Covered California included a request for health plans to address fourteen quality initiatives so that the public could be made aware of each plan’s quality-focused services.¹⁰ In developing contracts for Accountable Care Organizations, bundled payments, and direct primary care services, many of our members are developing their own quality requirements to address gaps in the publicly available information and to assist their employees in selecting high-value providers. It is imperative that the federal agencies provide the data needed for consumer and purchaser choice over the next 24 months. As part of fulfilling this statutory commitment, HHS should:

1. Require collection and disclosure of patient-reported outcome measures that have been successfully used in the U.S. and other countries, including measures for ophthalmology, orthopedic surgery, and cardiac surgery;
2. Require that results for all measures submitted by providers to federal recognition and payment programs, including the Physician Quality Reporting System, the “qualified entity” program, and the EHR Incentive Program, be made available to the public on Physician Compare;
3. Align measures between public and private purchasing programs to ensure that services provided to all patients are reflected in publicly available data, to minimize burden on providers, and to ensure that recognition and payment programs are providing consistent signals to the market.

Conclusion

PBGH members provide health insurance coverage to over 10 million Americans and incur over \$50 billion in health spending each year. In national surveys, over three-quarters of US employers say they do not expect to continue providing health benefits ten years from now.¹¹ Purchasers believe that a health care marketplace where providers compete based on their ability to improve health outcomes and efficiently manage resources can produce a sustainable system that improves the health of all Americans. But time is short. Such a system must be

¹⁰ <http://www.healthexchange.ca.gov/Solicitations/Documents/130521%20CoveredCA%20QHP%20Model%20Contract-%20Attachments%20clean%20for%20posting%205-22-13.pdf>, pages 15-16.

¹¹ *18th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care (2013)* accessed at <http://www.towerswatson.com/en/Insights/IC-Types/Survey-Research-Results/2013/03/Towers-Watson-NBGH-Employer-Survey-on-Value-in-Purchasing-Health-Care>

based on reliable performance information in the public domain. Just as we created the SEC, and fuel-efficiency ratings, and nutrition labels to drive successful markets, we must create a flow of information that consumers and purchasers can use to make critical health decisions. You have the opportunity to direct federal resources to address this vital national interest and you have the support of major employers to accelerate this agenda.

Thank you for your interest in the purchasers' perspective.