TESTIMONY

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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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Presented by
John E. Brush, Jr., MD, FACC

On behalf of the
American College of Cardiology

For more information, contact the American College of Cardiology at (800) 435-9203

Chairman Deal and Members of the Subcommittee, thank you for holding this hearing today and for affording me the opportunity to discuss efforts by the American College of Cardiology (ACC) that support the provision of high quality care to Medicare patients.

I am board-certified in interventional cardiology, as well as in general cardiology and internal medicine. I am a member of a 19-member private practice cardiology group in Norfolk, Virginia. I am chair of the ACC's Quality Strategic Directions Committee, a committee that directs and coordinates the ACC's quality efforts. I am also the president of the Virginia ACC Chapter. Nationally and in Virginia, I have had extensive experience in quality improvement initiatives and in the design and implementation of pay for performance programs. I represent the ACC, a 33,000-member organization that is committed to helping Congress address daunting health care challenges. I am honored to give testimony today, and am hopeful that my testimony will facilitate the important work of this Subcommittee.

The U.S. health care system is in the midst of a quality revolution. At a time of spiraling national health care costs, health care providers and payers are struggling with the need to improve the quality of care through systems improvements. At present, medical care consumes 16 percent of the gross domestic product (GDP), and experts project that medical spending will increase to 20 percent by 2015.[1] Undoubtedly the economic burden of cardiac care will continue to rise because of the rising costs of cardiac technological advances[2] and the increasing

[1] Borger C, Smith S, Truffer C, et al. Health spending projections through 2015: changes on the horizon. Health Affairs (Millwood) 2006; 25:w61-73.
[2] Lucas FL, DeLorenzo MA, Siewers AE, Wennberg DE. Temporal trends in the utilization of diagnostic testing and treatments for cardiovascular disease in the United States, 2993-2001. Circulation 2006; 113:374-9.

prevalence of cardiac disease.[3] Our tremendous medical advances have turned once deadly diseases into chronic diseases that create a growing economic burden. Therefore, we can expect that public and private payers will continue to focus on improving both the quality and efficiency of cardiac care.

Current payment models do little to create a business case for physician practices to invest in the systems that will provide reliable, high quality care. Payment is not currently based on performance, except in emerging demonstration projects. Cuts in Medicare physician payments, including cuts in medical imaging payments and those associated with the current sustainable growth rate (SGR) formula, coupled with rising overhead costs leave smaller operating margins and little incentive for physicians to invest in long-term system improvements.

Many practitioners note that high quality does not always pay and sometimes can lead to less pay. Traditional models of payment, such as fee-for-service, pay for inputs of medical care, but do not pay for outcomes, and do not create a solid business case for investing in long-term system improvements that yield better outcomes. Fee-for-service payment may tend to encourage overuse, but other payment models like prospective payment in managed care have their own unintended consequences and may reward under-use. What payers and providers can agree upon is that a medical payment system that consistently encourages and rewards appropriate, high quality care has yet to emerge.

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[3] Association AH. Heart Disease and Stroke Statistics – 2005 Update. Dallas, TX: American Heart Association, 2005.

In the words of Avedis Donabedian, "there's lip service to quality…but real commitment is in short supply."[4] The ACC recognizes the importance of inspiring greater focus on improving care delivery systems and supports the concept of paying for performance. However, the ACC believes that physician pay-for-performance programs should support and facilitate the quality improvement process and strengthen the patient- physician relationship rather than solely report performance and outcomes for the purpose of quality assurance.

Programs that support a continuous quality improvement process can serve to unify multiple participants in the health care system, to improve patient care and to realize the full potential of America's health care system. The old quality assurance method sought to "cull out bad apples" and did not engender general improvement. Similarly, poorly designed pay-for-performance programs could be divisive and impede a coordinated effort to improve care. Our current quality deficiencies are the result of deficient systems rather than the result of a few bad apples and we should focus our efforts on creating incentives for system improvement.

Today I will demonstrate the ACC's current and ongoing commitment to the development of clinical standards in cardiovascular care and the translation of those standards at the bedside through the adoption of decision support tools and system change. We are confident that our commitment to clinical standards naturally supports the development of progressive models of payment that will align incentives, and thereby facilitate the provision of high quality, appropriate care. You will learn that the ACC has been a leader in the development of clinical guidelines, performance measures, and other quality improvement documents, strategies and

[4] Donabedian, A. A founder of quality assessment encounters a troubled system firsthand. Interview by Fitzhugh Mullan. Health Affairs (Millwood) 2001; 20:137-41.

tools. The ACC continues to reach out across stakeholder boundaries with the goal of moving those standards of cardiovascular care into practice.

I will also attempt to outline the challenges and complexities associated with instituting a pay-for-performance system, particularly for ambulatory care. We firmly believe that inadequate understanding of these complexities, or bypassing the complexity of performance measurement with an overly simplistic approach, may not only fail to improve patient care, but could have other costly and damaging unintended consequences.

Continuous Quality Improvement: ACC Leading the Way in Cardiovascular Care

The ACC was founded in 1949 as a home where practicing cardiologists can exchange knowledge on the best ways to treat patients with cardiovascular disease. Consistent with the ongoing fulfillment of the ACC's founding mission is the challenge of closing the gap between what is known to be best practices as shown by science and taught in educational courses, and what is applied in everyday practice.

Guideline Development

The ACC was an early promoter of evidence-based medicine and professional standards. Beginning in the early 1980s, the ACC partnered with the American Heart Association (AHA) to develop clinical practice guidelines that would take the best science and interpret it for everyday practice. The ACC is proud to carry the distinction of publishing one of the first clinical practice guidelines. Published in 1994, the Pacemaker Guideline was published in part to proactively

respond to the then Health Care Financing Administration's (HCFA) concerns about the costs and benefits of pacemaker implantation.

Guidelines provide the foundation for evidence-based performance measures. It should be noted, however, that the development of guidelines is time consuming and costly to professional medical societies. The average amount of time it takes the ACC to develop and publish a guideline is approximately two years, and once published, those guidelines require periodic updating. It costs the ACC and AHA more than a million dollars a year to support development and updating more than 2,100 recommendations contained in 15 published guidelines. Despite the cost, the ACC views the development of guidelines and performance measures as a core responsibility and a critical function of the organization.

National Measurement and Information Exchange Standards

The ACC has been active in developing and promoting national standardization of performance measures and electronic medical data. The ACC understood from the start of the pay-for-performance movement that a single, evidence-based national standard for measuring improvement would be essential. Beginning in 2000, the ACC partnered with the AHA to develop national performance measurement standards and data standards for both inpatient and outpatient care based on our guidelines. Together, the ACC and AHA published a methodology for the development of performance measures that outlined criteria to ensure that measures were not only evidence-based but actionable and feasible for quality improvement purposes. To ensure the successful implementation of these measures, the ACC has developed programs such as the National Cardiovascular Data Registry (ACC-NCDR®) and the Guidelines Applied in

Practice (GAP) program. To facilitate the development and implementation of performance measures, we have partnered with other national organizations, including the Physician Consortium for Performance Improvement (PCPI), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the Ambulatory Quality Alliance (AQA). These activities have ensured the relevance of measurement standards to cardiologists' daily practice and to the larger stakeholder community, including patients.

Cardiovascular Appropriateness Criteria

Quality improvement efforts cannot ignore the reality that increasing health care costs are imposing fiscal pressures on payers, insurers, employers and patients. Increased demands for health care services, especially expensive diagnostic imaging tests, have led to unsustainable trends in health care economics. The response from the ACC has been the development of clinical appropriateness criteria which not only foster improved quality, but help providers avoid unnecessary tests.

These directives are patient-centric and define "when to do" and "how often to do" a given procedure in the context of scientific evidence, the health care environment, the patient's profile and the physician's judgment. Ultimately, appropriateness criteria can help facilitate reimbursement in a performance measurement-based system.

Development and Adoption of Cardiovascular Performance Measures: A Status Report

Pay-for-performance programs are unlikely to improve patient care without a foundation in valid performance measures. Professional organizations are a trusted source of scientifically valid performance measures and the ACC is a leader in setting professional standards for cardiovascular care. The ACC is committed to continuing the task of developing and field-testing performance measures, a labor-intensive process that can take months or years to complete.

In 1993, the ACC lent support to development by CMS (then HFCA) of some of the earliest national clinical performance measures based on the ACC/AHA Guideline for the Early Management of Patients with Acute Myocardial Infarction. Since then, the ACC has made tremendous strides in the development and adoption of cardiovascular performance measures. For the outpatient setting, the ACC and the AHA, in collaboration with the PCPI, developed measurement sets for patients with coronary artery disease, heart failure, and perioperative care. We are currently working with several other organizations to develop measures for atrial fibrillation, cardiac rehabilitation, primary cardiovascular disease prevention, and peripheral artery disease. For the inpatient setting, the ACC along with the AHA have developed measurement sets for patients with acute myocardial infarction and heart failure.

To date, 16 measures have been endorsed by the National Quality Forum (NQF) and eight measures have been endorsed by the AQA for physician-level measurement for cardiologists.

Putting Cardiovascular Performance Measures into Practice

Through the use of national measurement standards it is possible to bridge the gaps between science and practice. Thanks to ACC, AHA, AHRQ, CMS and JCAHO, the entire United States now has a uniform set of measures that is the standard of care for every physician and every hospital in the country when caring for a patient with an acute myocardial infarction (heart attack).

We cannot ignore the power and importance of such efforts for our practices and for our patients. In a study published last year on the use of the JCAHO core measures (aligned with ACC/AHA measures), the overall rates for four of the measures for acute myocardial infarction *(heart attack)* showed gratifying improvement.[5]

In patients with myocardial infarction, 95 percent received recommended aspirin treatment and 93 percent received recommended treatment with beta blocking agents. Getting those measures right for every patient, every time, truly matters. Research has shown that for every 10 percent increase in adherence to these few, simple measures, there is a commensurate reduction in mortality. We are committed to further improvements in the reliability of care, where every patient gets the appropriate life-saving treatment every time. We have worked with the Institute for Healthcare Improvement and other organizations to improve the reliability of heart care. We are preparing to launch a national campaign that seeks to ensure that patients with heart attacks who require urgent complex care will get that care consistently across the country. Finally, we

[5] Williams, S. C., Schmaltz, S. P., Morton, D. J., Koss, R. G., Loeb, J. M., Quality of care in U.S. hospitals as reflected by standardized measures, 2002-2004, N Eng J Med 2005; 253(3):255-64).

are committed to updating those measures to remain in step with emerging science and accumulating evidence.

In Virginia, the ACC has worked with the commercial payer, Anthem Blue Cross Blue Shield, to develop two pay-for-performance programs. The first, called Quality-In-Sights® Hospital Incentive Program (QHIP), rewards hospitals for reaching specified quality targets. Forty-two percent of this program involves cardiac care. A second program, called Quality Physician Performance Program (QP3) was recently introduced. This program rewards physicians based on aggregated hospital-wide performance and distributes the rewards to physician groups at each hospital based on a market share calculation. This voluntary program gives physician groups the opportunity for up to an 8 percent across-the-board enhancement in the Anthem fee schedule. Because the program uses aggregated hospital-wide performance data, it overcomes problems with small numbers and difficulties with attribution. Because the rewards are based on shared performance, the program is intended to create incentives for competing physician groups to work together with hospital administration in a cooperative manner to achieve continuous quality improvement.

Is Pay for Performance the Key to Quality?

The key to quality improvement is matching clinical performance to the goals and standards set by the profession. The ACC supports a Medicare payment system that properly aligns incentives, inspiring greater focus on clinical standards and on health care delivery systems that help practitioners reach those standards. However, we need to recognize that the rapid movement toward pay for performance is occurring despite little experimental or empirical

evidence that pay for performance achieves its intended effect in the short or long term.[6] While there are as many as 100 existing pay-for-performance programs in different economic markets throughout the country,[7, 8] there are essentially no randomized controlled trials demonstrating the effectiveness of these programs and very few reports that analyze existing programs.[9, 10, 11, 12, 13] Paying for performance seems logical, yet without thoughtful design and ongoing evaluation, it may fall short of expectations and could have damaging unintended consequences.

Program Design

Before a performance-based physician payment system is adopted by Medicare, program design must be thoughtfully considered and developed with the input of the physician community. Pay-for-performance programs generally are designed to reward providers for achieving specified levels of clinical performance, as measured by standardized quality indicators. Typically, these programs provide more or less than the standard payment for a particular service using a formula based on measures of structure, process, outcome or cost.

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[6] Dudley RA. Pay-for-performance research: how to learn what clinicians and policy makers need to know. JAMA 2005;294:1821-3.
[7] Med-Vantage. Pay for Performance. 2006.
[8] The Leapfrog Group for Patient Safety. Incentive and Reward Compendium. 2006.
[9] Rosenthal MB, Frank RG, Li Z, Epstein AM. Early experience with pay for performance: from concept to practice. JAMA 2005;294:1788-93.
[10] Kouides RW, Bennett NM, Lewis B, Cappuccio JD, Barker WH, LaForce FM. Performance-based physician reimbursement and influenza immunization rates in the elderly. The Primary Care Physicians of Monroe County. Am J Prev Med 1998;14:89-95.
[11] Fairbrother G, Hanson KL, Friedman S, Butts GC. The impact of physician bonuses, enhanced fees, and feedback on childhood immunization coverage rates. Am J Public Health 1999;89:171-5.
[12] Amundson G, Solberg LI, Reed M, Martini EM, Carlson R. Paying for quality improvement: compliance with tobacco cessation guidelines. Jt Comm J Qual Saf 2003;29:59-65.
[13] Roski J, Jeddeloh R, An L, et al. The impact of financial incentives and a patient registry on preventive care quality: increasing provider adherence to evidence-based smoking cessation practice guidelines. Prev Med 2003;36:291-9.

While all pay-for-performance programs are meant to induce change in individual or organizational behavior, specific programs can vary widely. Programs can vary in scope (primary care physicians, specialists, hospitals, clinicians), in the dimensions of performance that are measured, or in the form of payment (straight bonus, enhanced fee schedule, block grant, or indirect payments). Pay-for-performance programs can also vary in how the reward relates to the measurement of performance. A program can reward a provider either for showing a set amount of improvement, or for achieving a threshold of performance. Programs that reward for improvement will stimulate providers at all starting points, but providers who start at high levels of performance may reach a ceiling where the reward will diminish. On the other hand, programs that reward achievement of a threshold level of performance may discourage providers who start at a low level from participating and exacerbate existing disparities in care. Programs may reward for reaching absolute levels of performance, or may reward by grading providers on a curve relative to their peers. Fixed targets and absolute thresholds provide a predictable opportunity for reward, whereas the latter model provides no up front guarantee and can inhibit cooperation, but may provide a competitive environment that creates sustained incentives. Thus, the type of program can have different effects on providers, depending on one's specialty or practice environment. It would be unrealistic to hope for a "one size fits all" design that would simply and easily address all of our current quality and efficiency challenges.

Operational Challenges

The approach of adopting a set of basic, core performance measures that cut across all physicians generally follows the pattern Congress established for hospital payment policy beginning with passage of the Medicare Modernization Act in 2003. The unique challenges to adopting

ambulatory pay-for-performance programs were identified through a survey conducted of participants at the ACC's 2005 Medical Directors Institute (MDI), discussions with national quality leaders, and a review of existing literature. The challenges raised focus around the nature of care delivery in the outpatient setting. Unlike the inpatient setting, where patient care can be tracked by a single organization, the ambulatory care setting involves multiple physician groups often lacking a centralized data collection infrastructure. This presents a number of challenges about how to implement performance measurement, especially when it is directed at the individual physician.

The cost of data collection is a major barrier. It is possible that administrative data collection using g-codes can help streamline this process, but this will require pilot testing and careful design. Data collection in the fragmented outpatient care setting raises important concerns regarding the need for data standards and standardized reporting methods.

Using outcomes measures in the outpatient setting (e.g. mortality, or endpoints like blood pressure or cholesterol levels) raises methodological questions about attribution. For example, whose performance is being measured when the performance measure is the blood pressure of patients treated by multiple providers? Will we create incentives for providers to shun difficult or non-adherent patients?

Finally, there are substantial statistical limitations when measuring the performance of an individual physician. We would not judge a baseball player based on a batting average after only a few times at bat, and we should not judge physicians and adjust payments without robust

statistical methods that allow us to make the sound judgments. Adjusting payment based on statistical inferences requires accumulated measurement over time, or aggregated measurement of multiple providers to avoid problems of hasty judgments based on small sample sizes.

For all its promise, we should recognize that pay for performance may have unintended adverse consequences. These programs may have detrimental effects on professionalism, intrinsic motivation, cooperation and team building. There may be an incentive to game – that is, to change behavior primarily for the benefit of achieving a reward. Incentives could encourage physicians to narrowly focus on measured tasks, leaving unmeasured but important tasks undone. Providers could tend to shun sicker patients or those perceived as non-compliant and seek patients who will produce a better return. Public awareness of performance may cause sicker patients to choose certain providers, and measurement may not adequately adjust for differences in risk incurred by different providers. Physicians working in underserved areas and treating disadvantaged patients may lack resources to perform at reward levels, which would further widen disparities in performance. We should remain aware of the potential for unintended consequences as we design and implement new models of payment.

Beginning Quality Improvement by Starting with What Works

The challenges to adopting a Medicare physician pay-for-performance system are daunting. Yet, current trends in Medicare growth, if left unchecked, are likely to result in arbitrary cuts in Medicare payments, such as those to imaging services contained in the Deficit Reduction Act, that ultimately will have adverse effects on patient access and quality of care. We caution Congress from attempting to employ a "one size fits all" approach to pay for performance. No

matter how well intended the effort, clinicians are unlikely to change their approach to gain rewards – particularly if the rewards are negligible – for actions they do not consider in the best interests of their patients or for which they do not believe they have much influence. Physicians must believe that the measures truly reflect quality of care. Furthermore, collecting data necessary to calculate rewards in both the in-patient and out-patient setting is costly and could be subject to inaccuracies. Administrative or claims data may be easiest to collect, but inaccurate; and clinical data may be a better reflection of actual care, but obtaining data through chart abstraction is costly.

In the absence of widespread health information technology (HIT) adoption to facilitate the collection of clinical data, and in the absence of widespread systems change, there may be modest but meaningful changes that are worth exploring. In the short term, we could begin to focus on specific behaviors, processes and modes of practice. In the ACC's GAP project in Michigan, we introduced a tool called a "discharge contract" which addresses key processes of care at the time of discharge. For hospitalized patients with heart attacks and heart failure, there are about eight processes of care that can prevent subsequent death and readmission, and these processes are currently tracked as "core measures." In our GAP project, we bundled these processes of care in a discharge document or contract, which is signed by the discharging physician, the nurse and the patient. A discharge contract is a disease-specific checklist that provides patients with instructions and a follow-up plan upon discharge. The discharge contract bundles key care processes in a single simple process. Use of this simple tool was associated with a substantial reduction in 30-day and one-year mortality among Medicare beneficiaries with

myocardial infarction[14] as well as a reduction in 30-day hospital readmission rates and mortality among Medicare beneficiaries with heart failure.[15] The quality improvement team at Intermountain Health showed similar results using a similar discharge tool.[16]

A CPT code or modifier code could be developed to pay physicians who discharge their patients using a certified discharge contract, giving physicians a financial incentive to use this proven quality improvement tool. Thus, a very simple pay-for-performance program could be developed that creates a financial incentive to use a discharge tool targeted to improve the care of Medicare beneficiaries with heart attacks and heart failure.

As mentioned above, integration of an HIT infrastructure will be absolutely critical to the success of any pay-for-performance program. The ACC thanks Chairman Deal for his leadership on HIT legislation and hopes that Congress will send a bill to the President's desk this year. The reality is that physician practices have been slow to acquire and implement electronic health records (EHRs). Both cost and the current lack of national standards are the most significant barriers to EHR adoption. Physician practices face substantial implementation and maintenance costs without any defined return on investment. CMS and other payers may actually see the return on the investment in EHR because the information systems will help coordinate care and will likely help weed out duplicative tests, thus generating long-term cost savings. As such, it only seems appropriate that the federal government would provide some financial assistance to facilitate more widespread adoption by physician practices. The ACC recommends that HIT

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[14] Eagle, et al. J Am Coll Cardiol 2005;46:1242-8.
[15] Koelling, Todd. Presented at the AHA Scientific Sessions, 2005
[16] Lappe JM, et al. Improvements in one-year cardiovascular clinical outcomes associated with a hospital-based discharge medication program. Annals of Int Med 2004: 141(6): 446-53.

legislation include financial incentives for adoption. Medicare, as well as commercial payers, should provide an enhanced fee schedule to providers that can document the use of a certified EHR.

We should recognize the damaging effect of our current tort system on quality of care. Other industries, like aviation and nuclear power, have developed mechanisms to learn from mistakes and near misses. Because of the current malpractice environment, physicians have strong financial and even stronger emotional incentives to hide mistakes, missing valuable opportunities to seek ways to improve systems of care. In Florida, peer review and quality improvement efforts are in serious jeopardy as a result of a recent constitutional amendment that subjects to discovery previously protected peer review proceedings. As a result, my cardiovascular colleagues in Florida say that physicians in the state are ill-advised to participate in peer-review or other quality improvement efforts at this time.

Finally, we encourage members of this Subcommittee to support federal funding for health services research, such as that being conducted by AHRQ. Outcomes research provides a reality check on what is working and what is not, and will be invaluable for assessing the effectiveness of pay-for-performance programs.

ACC Principles to Guide Physician Pay-for-Performance Programs

Due to the lack of health services research and solid supporting evidence regarding pay-for-performance programs, the ACC has developed principles to guide payers through the development of such programs. (Table 1) The ACC agrees with numerous other professional

organizations that pay for performance should be based on valid, scientifically derived measures, should create true and sustainable incentives, and should use methods that are fair and predictable.

Conclusion

National efforts to address health care quality are critically important and the need is immediate. The ACC has invested significant resources to address this issue, including support for education, clinical guidelines, appropriateness criteria, data collection, benchmarking, quality improvement tools and programs, and national standards. Based on our experience, we know that deficiencies in quality and efficiency are not generally the result of uneducated or recalcitrant physicians, but rather the result of misaligned incentives and inadequate systems. The ACC supports the concept of aligning financial incentives with the performance of evidence-based medicine and with improving our care delivery systems. The ACC is committed to working with Congress and with Medicare to design payment models that will ultimately achieve the intended results of improving the health of all Americans. Thank you for allowing us to share our experience in quality improvement.

Table 1. ACCF Pay for Performance Principles
1. Built on established evidence-based performance measures
2. Create a business case for investing in structure, best practices, and tools that can lead to improvement and high quality care
3. Reward process, outcome, improvement and sustained high performance
4. Assign attribution of credit for performance to physicians in ways that are credible and encourage collaboration
5. Favor the use of clinical data over administrative claims data
6. Set targets for performance through a national consensus process
7. Address appropriateness
8. Positive, not punitive
9. Audit performance measure data

10. Establish transparent provider rating methods
11. Not create perverse incentives
12. Invest in outcomes and health services research

For more details on the American College of Cardiology's principles for pay for performance, go to: http://www.acc.org/advocacy/pdfs/ACCFP4PPrinciplesFinal.pdf