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Physician Payment Reform

Designing a Performance-based Incentive Program

Cheryl L. Damberg

RAND Office of External Affairs

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Testimony presented before the House Energy and Commerce Committee, Subcommittee on Health on June 5, 2013

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The RAND Corporation

***Physician Payment Reform:
Designing a Performance-based Incentive Program²***

**Before the Committee on Energy and Commerce
Subcommittee on Health
House of Representatives**

June 5, 2013

Chairman Pitts, Ranking Member Pallone, and distinguished Members of the Subcommittee, thank you for inviting me here today. My name is Cheryl Damberg and I am a senior health policy researcher at the RAND Corporation. I appreciate the opportunity to appear before you to discuss physician payment reform. As you work to shift physician payment policy from one that currently incentivizes the delivery of more services without regard to quality or outcomes to a payment policy that incentivizes the delivery of high quality, resource conscious (i.e., high value) health care, there are a number of important design elements that I ask you to consider. The lessons draw from the experiences of both public and private sector payers who over the last decade have implemented performance measurement and performance-based incentive systems. Thoughtful incentive design can ease the transition process for both physicians and the Medicare program, provide a robust, credible system of measurement that will serve as the basis for determining who receives incentive payments and how they receive them, and enhance the likelihood of program success—all of which serves the ultimate goal of improving care for Medicare beneficiaries. My comments derive from research I have conducted examining the use of financial incentives tied to performance and my experience working with provider organizations over the past decade to measure health care quality and costs.

As highlighted in testimony that I gave to this committee in February (Damberg, Cheryl L., "Efforts to Reform Physician Payment: Tying Payment to Performance," testimony presented before the House Energy and Commerce Committee, Subcommittee on Health, February 14, 2013. As of May 28, 2013: <http://www.rand.org/pubs/testimonies/CT381>), performance-based incentive models (also referred to as pay for performance or value-based payment (VBP))—which tie payments to performance on a set of defined quality and cost measures—are relatively new to the health system and represent a work in progress. It is vitally important to

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signal to providers what patients and payers expect them to be working towards in terms of delivery of appropriate care and care that helps achieve the best outcomes for patients. Explicit measures—when tied to payment—help focus and redirect physicians and the organizations in which they work towards redesigning care processes and how they coordinate actions with other care providers in order to deliver better value. Value is defined as the outcomes (outputs) achieved divided by the cost or resources used (inputs) to generate those outcomes.

By linking payment to performance, value-based payment programs seek to incentivize providers to innovate and redesign care delivery to drive improvements in quality and how resources are used (i.e., costs). Including costs as part of what is measured and how providers are paid is critical to ensure that services are efficiently delivered. Physicians who make decisions about treatments have a central role to play in helping to ensure that health care remains affordable for patients and other entities (employers, government agencies) that pay for care. The current fee-for-service (FFS) system used in Medicare to pay physicians contains incentives to the opposite effect. I will return to this issue at the close of my testimony.

Designing a performance-based incentive program is a complex undertaking and how it is designed will determine the likelihood of its success. I will touch on several of the central design features that are important for you to consider.

(1) Structure of Payment Incentives: There are several elements that comprise an “incentive payment structure,” including whether providers are paid for attainment or improvement or both, the performance thresholds used to determine who gets paid, the form of the incentive (e.g., bonuses, shared savings, or penalties³), and the size of the incentive. Each of these, depending on how structured, can lead to different responses by providers. Below I comment on several of these elements and the approaches that will likely yield the desired result.

a. ***Pay for improvement along the gradient:*** Medicare should pay providers using a continuous payment incentive approach so as to incentivize improvement along the continuum of performance. A continuous payment approach is used by Blue Cross Blue Shield of Massachusetts in its Alternative Quality Contract.⁴ In the case of the Alternative Quality Contract (AQC), providers receive a bonus ranging from 2% to 10% of per member per month payments depending on where they are on the performance distribution. Providers receive additional payouts for each increment of improvement—they are paid along the continuum once they hit a

³ Penalties (i.e., downside risk) are not favored by providers. They tend to be used to discourage actions/outcomes that should not occur such as hospital acquired infections which can be prevented.

⁴ Song et al., Health Care Spending and Quality in Year 1 of the Alternative Quality Contract. NEJM. 365:10. September 8, 2011.

minimum threshold of performance. This approach avoids the “cliff” effects that are common in payment structures that tie payments to a single all or nothing cut point (such as having to hit the 75th percentile of performance among providers); all or nothing payment structures set up a large number of providers who will receive nothing despite the fact that they are making improvements and making investments to improve. In the AQC model, the formula that translates each increment of improvement into payment incentivizes improvement at the beginning and middle of the continuum more than toward the top part of the distribution. This approach acknowledges that providers at the lower end of the performance distribution likely need to make more substantial investments to achieve quality improvement than providers who move from 95% to 98% performance.

b. **Use fixed thresholds:** Over the last decade, many performance-based incentive programs used relative thresholds that were only known to providers after the close of the performance measurement period.⁵ While this “tournament style” approach incentivizes continued improvement because the target moves as the entire group of providers improve, it creates a great deal of uncertainty for providers and can lessen the response to the incentive, particularly for those providers who are a distance from the anticipated threshold. The incentive structure should establish fixed performance targets that remain stable over some time period. This will help providers understand what level of performance they need to achieve to secure incentive payments and it will send a clear signal about performance expectations. Providers should compete against a national benchmark rather than a moving target based on relative comparisons of performance. This will establish an environment where all providers who improve and hit the designated targets win; because there isn’t a competition between providers for a limited number of winning positions, this will help to foster the sharing of best practices among providers. One approach to setting targets that is used in the Alternative Quality Contract is to use empirically derived cut points based on the data.⁶ Another approach is to use national benchmarks—such as the National Committee for Quality Assurance’s (NCQA) Health Employer Data Information Set (HEDIS) measure benchmarks. The highest level benchmark can be set for what is best in class and is achievable, based on the actual performance of peer specialty physicians.

c.. **Make payments meaningful:** In the beginning, while physicians are learning how to participate in the incentive program (learning how to collect/capture the data and submit the

⁵ For example, physicians who might receive a bonus payment in 2013 based on their 2012 calendar year performance would not know the threshold for winning (say the 75th percentile cutpoint) until May of 2013 once scores are in for all physicians.

⁶ Safran, DG et al. *Evaluating the Potential for an Empirically-derived Standard of Performance Excellence in Ambulatory Patient Care Experience Measures: Analysis in Support of NCQA’s Efforts to Develop a Physician Recognition Program in Patient-Centered Care.* October 2007.

information and redesigning care processes to improve), incentives could be relatively modest; however, over time (and in the nearer rather than longer term), bonuses should be increased. Incentives on the order of 5% to 10% of pay are required to change the behavior of physicians. The experiments of the last decade in the area of pay for performance generally found weak results, in part, because incentives were relatively small (on the order of 1%). I have conducted interviews with physician leaders who have indicated that incentives of 5% to 10% are required to be meaningful.

(2) Quality Measurement Infrastructure: Measures are the foundational element for determining payments under incentive-based payment models. While there are some measures ready to use, significant investments will need to be made over the next five years to develop and bring measures to market. A concerted effort will need to be undertaken, by specialty area, to advance measure development; in the near term, CMS should identify and focus development efforts on 10-12 clinical subspecialty areas that contribute to a significant portion of Medicare spending and utilization (e.g., cardiology, gastroenterology, endocrinology, orthopedics, oncology).

a. **Leverage the measurement precedent in primary care:** It is important to recognize that much work has gone on over the past decade to advance the development of performance measures—particularly for care delivered by primary care physicians (PCPs). These measures address preventive, acute, and chronic care areas and have been widely deployed by private sector payers and Medicaid agencies over the last decade in the context of performance measurement, accountability, and incentive programs—both on the managed care side and the PPO/FFS side. The Committee and Congress need to understand that a majority of PCPs in the United States have already been exposed to these performance measures and are familiar with the concept of pay for performance. Because these existing measures represent evidence-based practice and have been well tested, there is no reason that these should not be immediately deployed in the context of an incentive-based fee schedule within Medicare. For example, Medicare could start (and thereby align the measurement activities targeting ambulatory care providers) with existing measures used in the Medicare Advantage Star rating program. These measures are also the focus of the Physician Quality Reporting Initiative (PQRI), which will be the basis of the physician value-based payment modifier that will go into effect in 2015 as called for in the Affordable Care Act. Therefore, PCPs could begin immediately reporting on a set of measures during the payment stability period, to gain experience with data capture and reporting and to receive benchmarking reports from Medicare to identify areas for improvement well in advance of transitioning to incentive payments.

b. Invest in measure development, particularly for clinical subspecialists. Efforts to develop measures for clinical subspecialists have lagged those addressing primary care. Some clinical specialties have taken steps—such as through the American Medical Association’s Physician Consortium on Performance Improvement (PCPI)—to develop measures; however, for many clinical subspecialties measures are completely lacking or there are few available measures that could be readily deployed. Recent efforts by the American Board of Internal Medicine Foundation (ABIMF), in partnership with clinical specialty societies, have generated a list of more than 90 recommended areas to reduce the overuse of services.⁷ While not performance measures, these types of recommendations and clinical guidelines produced by specialty societies represent a starting place for identifying measure concepts that could be advanced for measure development. Substantial investment of resources is required to advance the development of measures for clinical subspecialties, and it will take several years (2.5 to 3 years) from measure concept identification to having measures ready for deployment.

c. Use a rigorous measure development process. Development of measures needs to occur using a scientifically rigorous process that is transparent, inclusive of physicians and other stakeholders, and ensures the reliability and validity of measures that become the basis of payment. Measure development is a science. It requires careful review of the scientific evidence to identify areas that define high quality care (which form the measure concept), vetting the evidence and concepts with clinical expert panels, specification of the concept using various data sources (e.g., claims data, electronic health records (EHRs)), field testing the measures across an array of providers with different data systems, assessing the measurement properties (reliability, validity of the measure), and finalizing the specification for uniform application across physicians in different settings. A model for development is the work that was conducted at RAND to develop the RAND Quality Assessment Tools (QA-Tools) and the ACOVE measures for the vulnerable elderly. (McGlynn et al., 1995; Wenger et al., 2003). Measures used in the incentive program should meet the scientific soundness criteria identified by the National Quality Measures Clearinghouse (NQMC).⁸ These include the clinical logic (evidence supporting the measure is explicitly stated and strongly supported) and measure properties (i.e., reliability, validity, case-mix adjustment if appropriate).

To expedite measure development in a cost-effective manner, measure developers should have a consortium of EHR data partners that will be test beds for rapid testing of electronic health record (i.e., e-Measure) concepts and alternative specifications at an early stage to identify the strongest

⁷ Choosing Wisely: an initiative of the ABIM Foundation. 2012 [updated 2012; cited 2012 October 29th, 2012]; Available from: <http://choosingwisely.org/>.

⁸ Agency for Healthcare Research and Quality. National Quality Measures Clearinghouse. <http://www.qualitymeasures.ahrq.gov/tutorial/attributes.aspx>

candidates for full development.

Because of the high stakes application of measures for payment and for driving provider performance, the measure development work should undergo a peer review process—meaning that the work of the measure developers and clinical panels should be published in clinical journals. Transparency of the process and underlying science will enhance the face validity of the process and the acceptability by the clinical community.

d. CMS should establish a process where measure development experts work with clinical specialties to identify performance gap areas and work to develop those as measures. To engage providers to achieve the three aims of the National Quality Strategy, we must enlist them as true partners in defining the measures for which they will be held accountable as individuals, and more broadly, as care teams and systems of care. Physicians have a vitally important role to play in the selection of measure concepts, weighing the scientific evidence related to specific actions providers can take to influence the process or outcome, specifying measures (including how to adjust for differences in the patient populations they treat and which patients to exclude), assessing the feasibility of a measure in practice, and ultimately endorsing the measures once developed. Some physician specialty organizations have taken steps to identify measures and create registries containing process and outcome measures. These measures and data sources could provide a starting point. For example, the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP[®]) generates validated, risk-adjusted, outcome measures to help surgeons improve the quality of surgical care. Prior to considering use of measures from specialty societies, the measures would need to meet the requirements of any measures—meaning that they are valid, reliable and evidence-based.

e. Alignment and coordination is critical to reduce provider confusion and burden. Medicare has a number of existing measurement and payment incentive programs that target ambulatory care providers. These include Medicare Advantage, the Physician Quality Reporting System (PQRS), which will support the emerging physician value-based payment modifier program, and the meaningful use (MU) of EHRs incentive program. The requirements that are introduced within the reformed SGR incentive program for physicians need to coordinate and align with these efforts to avoid creating a more complex environment for physicians to navigate. For example, MU standards for EHRs could require that vendors support the capture of data elements needed to construct measures that will be used in the SGR and physician value-based payment modifier programs.

f. **Build out the measure set to address other priority areas:** The measures being used in the Medicare Advantage Star rating system that determine Quality Bonus Payments to plans, as well as those used by private payers, represent a starting place for the early phases of the incentive program implementation. However, Medicare will need to work collaboratively with clinical specialists and measure developers to address other important performance areas where performance measures are currently lacking—including access to care, care coordination, overuse of services/resource use, and patient outcomes (e.g., functioning, health status)). The areas for future measure development should consider the work of the National Quality Forum’s National Priorities Partnership (NPP) and the Department of Health and Human Service’s National Quality Strategy (Table 1), which have outlined key domains or areas where performance should be measured. Measure development for use in the context of the Medicare FFS incentive program should align with these areas.

g. **Promoting the delivery of high quality care means providing appropriate care and reducing the overuse of services.** Development of efficiency measures is a national priority and these measures currently lag in development. While the concept of efficiency raises red flags of cost cutting in the minds of physicians, physicians will focus on reducing the overuse of services when they understand that the desired action (whether it is shifting from a name brand drug to a generic or watchful waiting before advancing to imaging) is equivalent to the alternative, more costly approach to managing the patient or that the alternative, less desired action could lead to unnecessary harm. When measures of clinical overuse/misuse of services are supported by evidence, this will facilitate physician buy-in.

Table 1

National Quality Strategy’s three aims:

1. **Better Care:** Improve the overall quality of care, by making health care more patient-centered, reliable, accessible, and safe.
2. **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
3. **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

National Quality Strategy’s six priorities:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family are engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

(3) Shifting to New Payment Models

Some providers have already started to migrate towards alternative payment models such as accountable care organizations (ACOs), bundled payments that pay for pre-defined episodes of care, and medical homes. These payment models generally embed performance-based incentives into their structures and have pre-defined performance measures that must be met to receive shared savings or other types of incentive payments. ACOs require a certain size to enable providers to manage risk, and not all physicians will join ACOs. Primary care physicians, regardless of the size of their practice, can participate in medical homes, where they can earn extra dollars for managing patients at a high level of quality that can reduce the utilization of care in high cost settings such as emergency departments and hospitals. For some areas of care—such as an annual episode of diabetes or hip replacement surgery—specialists may be able to participate in bundled payment arrangements that provide a fixed fee with incentive payments tied to performance on quality measures (both process and outcome). All of these constitute value-based payment arrangements and should be considered acceptable opt-out arrangements to the extent that they address the Medicare population. The subset of physicians who do not participate in new payment models should minimally demonstrate they are able to perform parallel functions to deliver high quality, efficient care—such as connectivity to other providers (e.g., specialists, PCPs, hospitals) through health information exchange to better coordinate care, use of clinical decision support tools, and performance monitoring.

(4) Uniqueness of Providers

While there is diversity among physicians in where they practice (urban versus rural), their mix of patients (i.e., demographic and socioeconomic status (SES)), practice type, and specialty, it is important to remember that performance measures are “patient-driven.” By that I mean that the measure defines what the patient needs, regardless of the type of physician practice where the patient is treated. Receipt of a flu shot should not be dependent on whether a patient is managed by a physician in a rural versus urban setting or solo practice versus large integrated system. Physicians who manage more complex patients (higher level of severity of illness) or who have lower SES patient populations often are concerned that they will be disadvantaged under performance-based accountability and payment systems. For outcome measures, it is important to adjust for differences in the patient mix to level the playing field and to ensure that the measures are valid. There is debate about whether to adjust for SES factors related to process measures; some practices have been successful in raising performance for minority patients and those who are disadvantaged economically when held accountable for these populations. Incentive structures can be designed to help mitigate these concerns related to redistribution of

resources away from practices that may need resources to help care for more challenging populations and to reduce the likelihood that providers will avoid more challenging populations. For example, my RAND team was involved in modeling an incentive design that sorted physician practices into “leagues” (based on the education level of patients and capitation rates of practices), and held the mean incentive payment equivalent across leagues to avoid large redistributions of money, while preserving incentives for improvement (meaning you earned more the better you performed within your league).

(5) Help create an environment where physicians can succeed.

The goal of incentive programs is to improve care delivery. Medicare can best work to change physician culture by helping physicians understand that Medicare is working to do this *in partnership* with physicians, rather than simply imposing change on them. Again, the design of a program can set the players up for cooperation to achieve desired goals, which will help promote successful implementation. Successful programs work to provide physicians with data and reporting to support problem identification and quality improvement, best practices sharing, coaching and training, and consultative advice.

a. Provide on-the-ground quality improvement support. The Centers for Medicare and Medicaid (CMS) could support, through cooperative agreements, funding of local community collaboratives and organizations that already have established relationships with physicians and that have experience helping providers make the changes to drive improvements. An example is the California Quality Collaborative, which for the past seven years has been working with physicians on practice redesign so they can succeed in improving performance on clinical, efficiency, and patient experience measures—all in the context of performance-based payment models. Additionally, because private plans are working with the same physicians to drive improvements and frequently investing quality improvement resources, CMS could partner with private commercial plans in cost-sharing the quality improvement support locally. Many commercial plans have the same “stake” in the game because they are financially at risk for quality performance in the context of the Medicare Advantage program—and these bonuses are substantial in size. The efforts of the public and private payers could align to support physicians in improvement.

b. Continue to support the advancement of clinical decision support (CDS) tools embedded within EHRs. To deliver high quality care, physicians need access to information that can help them make clinical decisions that are evidence-based and that help them evaluate cost-effective alternatives at the point of care. Meaningful use requirements seek to expand the use of CDS tools for clinical subspecialties and these tools should be focused on areas where there are performance gaps. Development of these tools should help providers be more successful in

meeting quality requirements.

c. Allow physicians multiple ways to participate (i.e., submit their data). Various options exist for submitting data on individual physician performance, including direct submission by the physician (e.g., EHR), submission by the physician's practice or physician group on behalf of the physician, or by a physician's specialty society drawing from their registry data. All data, regardless of method of submission, should be submitted at the individual physician level, not at the practice or group level. Physician-level data are needed to establish benchmarks (performance thresholds) and physician level data are required to account for the variation at the physician level (note: variation tends to be less at the practice site or group level as it blends the results of high and low performers; therefore, using these data would not reflect the entire distribution of physician performance). Additionally, should the data be eventually used in the context of Physician Compare, the results would need to be physician specific. A number of clinical professional societies—such as the American College of Cardiology or the Society for Thoracic Surgeons—maintain patient registries that contain important information about the quality of care (e.g., appropriateness of procedures, clinical process measures, outcomes). These registries are an important potential source of data and may help reduce the burden on physicians to comply with program requirements. Several issues that would need to be addressed prior to allowing this type of data submission are the need for audit, a data integrity assurance process related to the comparability of coding across different providers (e.g., is there training of data coders so that they are consistently applying definitions), and permission by the specialty society to allow Medicare access and use of the data.

d. Provide meaningful, timely feedback on performance. To take action to improve, physicians will need timely feedback on their performance and how they vary compared to peers. Generally, the sponsors of incentive programs are not in the business of providing real-time information; instead, that has fallen to the organization within which the physician works because the organization is better equipped to provide real time information. Increasingly, in the context of ACOs, health plans are partnering with health systems (physicians and hospitals) to provide daily reports to alert physicians that a patient's situation is worsening (so at risk for hospitalization) or that the patient has been admitted to the hospital or emergency department. Such data are valuable to the physician practice so they can intervene quickly to manage the patient in the most appropriate setting. Similarly, some integrated health systems are providing real time feedback to physicians on their performance (e.g., monthly), flagging areas where performance is lagging or signals a problem. While ideally real time data monitoring and feedback would be universal in our health system, it is not a near term reality. However, as electronic data systems improve and CMS is able to leverage data submissions from physicians on a more frequent basis, there is

potential to develop systems where CMS could generate more timely feedback reports (relative to benchmarks)—such as on a quarterly basis.

e. Foster HIT capabilities to support measure construction. EHRs can be leveraged as a data collection and reporting tool. Substantial progress has been made over the past few years in working to move EHRs into ambulatory practices. Providers are already receiving technical assistance related to EHR implementation through the efforts of the Office of the National Coordinator for Health Information Technology (ONC). Within the next five years, the capabilities of EHRs will be enhanced and should be designed to support capture of the data elements needed to construct performance measures, and CMS working with ONC and EHR vendors need to create the appropriate tools to extract needed data and organize it in formats for submission to programs such as the SGR incentive program. The ability of physicians in all practice types and sizes to collect and report data on performance measures should be enabled by HIT. Already, providers across the country are making significant investments in HIT—to enable their participation in new care delivery models and payment structures that demand quality outcomes. These systems are at the heart of clinical redesign and can provide the front line physician with clinical decision support and feedback on performance. CMS should work collaboratively with ONC and Electronic Health Record (EHR) vendors to ensure that EHR platforms are able to capture required data elements in a structured format to construct performance measures that are contained within Medicare measurement, reporting, and incentive programs. Measure development moving forward should emphasize e-Measure (meaning constructed from data contained in EHRs) development and e-Measures should be tested in a wide array of EHR environments prior to being applied nationally to minimize implementation problems.

6. Period of Transition

A period of payment stability will allow time to develop and vet measures and build the quality infrastructure. The question is how much time is required to start the transition. As noted earlier, because measures for primary care already exist and are widely deployed, the Medicare program should quickly advance the use of these measures and start all PCPs on the path to data collection, reporting, feedback, and improvement. It will likely take the next three years to generate a measure portfolio for specialists and to build out other high priority measure areas, provided we begin investment today. A potentially faster path for subspecialists is leveraging data already captured by specialty societies in registries that could allow the transition to begin sooner for the subset of clinical subspecialists that are reporting data to registries.

Earlier in my testimony I had commented on the perverse incentives in FFS payment structures

to provide more services irrespective of quality or costs. While the focus of my comments has been on embedding performance-based incentives into the existing FFS payment model, I would underscore for the Committee that more wholesale payment reform is required to move us beyond a payment structure that incentivizes physicians to do more, often with little to no clinical benefit or that may even harm the patient. The incentive structures I've discussed today work at the margin rather than on the structure of the base payment. To that end, I would encourage Congress to enable CMS and local communities to conduct payment reform innovations across the United States, allowing payers, physicians, and other stakeholders in communities to innovate to advance the delivery of high value health care.

Conclusion

In summary, design does matter related to whether and how providers will respond and how successful the incentive program will be. The ability to move successfully forward with new performance-based payment models is predicated on having (1) a robust set of measures; (2) a good incentive design; and (3) a support structure that can help physicians participate and succeed in the program.

As Congress considers the design of an incentive program, there are several areas where federal leadership and investment can facilitate and support the transition to performance based payment.

1. *Provide federal investment in the development of measures, to address the care delivered by subspecialists and to fill important performance measure gap areas (such as efficiency/overuse of services, care coordination, and outcomes):*

- ***Use a rigorous, transparent and inclusive process to develop measures.*** Because performance measurement will affect the behavior of physicians and the organizations in which they work, it is important that what we ask them to focus on is based on scientific evidence related to actions they can take to influence the outcomes of interest. While CMS may fund or lead efforts to develop measures working with measure development experts, physicians should be actively involved in these efforts, could lead such efforts. Existing physician-led data registries that track processes and outcomes could be leveraged.
- ***Ensure measures are valid and reliable.*** The development process should ensure that the measures that will be applied in high stakes applications are valid

and reliable. Results from testing of measures should be publicly available for physicians to review; such transparency will build confidence in the measurement system.

- **Ensure that measures reflect the current evidence base:** CMS should provide resources to update measures (or retire them) to incorporate changes in the scientific evidence.

2. **Begin the transition now for Primary Care.** CMS can leverage the ambulatory care measures (most of which address primary care) drawn from Medicare Advantage and private payer performance measurement programs. These are well-vetted measures that are in routine use nationally.

3. **Structure the incentive to achieve the desired result.**

- **Pay along the continuum:** The incentive structure should provide incentive rewards along the continuum of performance (with some minimum threshold that must be met to get any incentive) so that providers are rewarded for each increment of improvement. Incentivize improvement more at the low and middle of the continuum more than at the top, as the lower performers are making critical investments to succeed.
- **Use fixed thresholds**
- Make payments meaningful

4. **Create an environment where providers can succeed:** CMS can create a culture of working in partnership to achieve the desired goals by supporting providers in their efforts to improve. Recommended actions include:

- Work to build support structures with local community partners who can help physicians with quality improvement support and system redesign.
- Facilitate sharing of best practices and learning networks among peer subspecialties
- Provide meaningful, timely feedback on performance.

- Continue to support the advancement of clinical decision support to help providers meet quality requirements. Work with EHR vendors to ensure that EHR are able to capture in structured data fields (rather than free text) the data required to construct performance measures.
- Allow providers flexibility in how they can participate and submit data

RAND researchers have developed performance measures, (McGlynn et al., 1995; Wenger et al., 2003), evaluated the impact of pay-for-performance (Damberg et al., 2009), and more recently value-based purchasing programs, helped to define alternative measurement approaches that can support new payment models (Hussey et al., 2009), and assessed the implications of alternative incentive designs and scoring systems to reward performance (Schneider et al., 2012; Mehrotra et al., 2010; Damberg et al., 2009; Stecher et al., 2010; Friedberg and Damberg, 2012). We are happy to work with Committee members to share the work we have done in this area to inform policy making.

Again, let me thank you Mr. Chairman, Mr. Ranking Member, and members of the Subcommittee for allowing me to appear before you today to discuss this important issue. I would be happy to take your questions.

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