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# Physician Payment Reform

## *Designing a Performance-based Incentive Program*

Addendum

Cheryl L. Damberg

RAND Office of External Affairs

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Document submitted on July 12, 2013 as an addendum to 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 Program  
Addendum<sup>2</sup>***

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

**July 12, 2013**

*The subsequent questions and answers found in this document were received from the Committee for additional information following the hearing on June 5, 2013 and were submitted for the record.*

**The Honorable Joseph R. Pitts:**

- 1. In your testimony, you state that “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)”. Do you believe that payment reforms like those envisioned in the committee legislative framework hold the potential to improve the quality and value of the Medicare program for seniors?**

Since the committee’s framework has specifics yet to be filled in, it is difficult to accurately predict what the effects would be. The ability to improve quality and value in the Medicare program is contingent on the value-based payment program design, which will affect how physicians and the organizations in which they work respond. So yes, I believe that with the appropriate design, incentivizing physicians to deliver the right care will help to improve the quality and value of the Medicare program for seniors. The design of the program is critical in encouraging providers to innovate and redesign care delivery. For example, in the context of the emerging Accountable Care Organizations (ACOs), the providers (physicians and hospitals) in the ACOs are collaborating and working across their individual care-setting silos on care redesign to ensure they hit the cost and quality targets for which they are now jointly accountable. The joint accountability is a key design feature. In this case, incentives are aligned across the system to ensure that providers are working to achieve the same goals--better quality and better value for the patient and the payer. This is a sea change from what has historically been occurring in the delivery of

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health care, where heretofore each physician and hospital has been working independently without regard to the actions of others, often resulting in duplication of services with little or no value to patients and patients falling through the cracks as they transition between providers and health care settings. These have cost and quality implications for patients, and for the government as the payer of care. In the context of SGR reform, holding physicians accountable for their performance can lead to improvements in care and overall value. Ensuring that the measures for which providers are financially accountable are evidence-based (so that providers agree they are important because studies show taking the action leads to benefit for the patient) or focus on important patient outcomes can lead to improvements in the reliability of the care patients receive and the outcomes they experience. In a recent Expert Panel on value-based purchasing (comprised of providers, payers and researchers) that I conducted for the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services, there was consensus among the experts that we should hold physicians and hospitals accountable for the outcomes we seek and that if we do, the providers would determine what actions to take (through innovation, coordination with health and social service community providers, and care redesign) to work towards achieving those outcomes, as multiple factors besides selected processes of care may influence them. Outcome measures should include both clinical and cost (measures of overuse of services) dimensions; 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.

While my comments focused on embedding performance-based incentives into the existing FFS payment model as part of the SGR reform, I would underscore for the subcommittee that more wholesale payment reform is required to move us beyond the current payment structure that incentivizes physicians to do more, often with little to no clinical benefit or that may even harm the patient. Transitioning physicians to performance-based pay (in lieu of the SGR) is the first step in a larger journey towards restructuring the underlying incentives in health care in order to deliver value. The incentive structures I discussed at the subcommittee's hearing on June 5 work at the margin rather than on the base payment. While physicians over the next 3-5 years gain greater comfort with measurement and incentives within the FFS structure, I would encourage Congress to support CMS and local communities to conduct more wholesale 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. Experiments such as the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract, which sets a global payment for care and provides performance-based incentives, represent an important step in this direction.

- 2. Your testimony outlines the need for “meaningful” payments to help drive value-based payments. You also mention that incentives on the order of 5 or 10% would be needed to**

**drive meaningful improvement in the system. However, right now the financing of the Medicare program is weak and I don't envision that Congress could pass a 10% increase for providers (or even a 5% increase) during these times. Are there other ways to structure incentive payments without having to rely on a 5 or 10% bonus to providers for practicing quality care?**

The implementation of value-based purchasing programs in the United States has emphasized budget neutrality, unlike the implementation of pay for performance in the United Kingdom, which involved new money on top of a raise for primary care physicians. In the context of no new money, this means that the funding for incentives would come from withholds—either from existing payments or from envisioned updates to payment—or from savings. In the private sector over the past decade, payers held back a portion of anticipated payment updates (e.g., if the year-to-year increase was to be 4%, then 2% would be guaranteed and the other 2% would be held back and paid out based on performance) and over time accrued more money at risk. Increasingly private payers are moving towards shared savings approaches to funding the incentive pool, with providers first needing to hit quality targets and then if they hit cost targets, they receive a portion of the savings (typically 50% of the savings).

**3. You state that many primary care providers have already been exposed to the kinds of performance measures outlined in the draft legislative framework. In your opinion, are the types of programs envisioned in the committee's legislative framework achievable goals for the Medicare program and providers? Also, do you believe they are goals that will improve the lives of seniors and taxpayers?**

Private sector and Medicaid plans have been experimenting with pay for performance for much of the past decade, and most of the measures in those programs focus on primary care. Because physicians typically see a mix of patients from different payers, the concept of pay for performance is not new to primary care physicians. The subcommittee has outlined a general framework that I believe builds an important path forward for moving providers towards accountability for quality (and hopefully cost)—for both primary care and subspecialists. I do believe the framework sets out achievable goals for Medicare and providers, and that these will benefit seniors and the taxpayers. A central piece of the work over the next five years is the development of measures for each specialty that address important performance gap areas and that target areas that benefit patients in terms of their health and functioning. Additionally, addressing areas where care is delivered with little or no value will help seniors—who are exposed to therapies that may actually harm them—and will help ensure the viability of the Medicare program, which must focus on controlling health spending.

- 4. While primary care and some specialty groups have a long standing history of measure development and performance, others unfortunately lag behind. Do you believe that all provider groups adopting a system of quality measurement will be good for the provision of care in this country, and do you believe that provider specialties which are advanced in these areas might be able to help those who lag behind?**

There are many clinical subspecialties that have not developed performance measures, while some have made significant progress (Oncology, Cardiology, Cardiac Surgery, and Orthopedics). Without doubt, the sub-specialties that have made advancements in measure development, measurement and reporting through clinical registries, and that make use of that information for quality improvement, can be a resource for the specialties that lag in these areas.

Measure development efforts by the American Medical Association's Physician Consortium on Performance Improvement (PCPI) could be a foundation to support development of measures for those subspecialties that are currently lacking measures. Also, the recent efforts by the American Board of Internal Medicine Foundation (ABIMF), in partnership with clinical specialty societies, to generate recommended areas to reduce the overuse of services provides another opportunity that could be leveraged to support subspecialists in the transition.<sup>3</sup>

I would note that the current process of measure development being deployed through the Medicare program requires modification to support the work envisioned by the proposed legislation. As I have stated, it will be critical to pull physician leaders together from a particular specialty to identify areas of evidence-based practice and areas where performance gaps exist, and to pair them with measure developers who can work in concert with the clinicians to develop robust, valid measures.

- 5. Your testimony touches on an important point. It is not whether we measure per se but really how meaningful the measure is and what it is measuring. In a system like that envisioned by the draft legislative framework, how do you believe Congress and CMS should ensure that measure development and application are meaningful both now and in the future?**

For measures to be meaningful, they must be based on scientific evidence that taking the action (e.g., providing beta blockers for those who have had a heart attack) will lead to better patient outcomes (i.e., lower mortality). We should not be asking physicians to provide care that has no clinical benefit to the patient. Similarly, we should hold physicians accountable for providing care that has little/no benefit (e.g.,

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<sup>3</sup> Choosing Wisely: an initiative of the ABIM Foundation. 2012 [updated 2012; cited 2012 October 29th, 2012]; Available from: <http://choosingwisely.org/>.

per the Choosing Wisely and other specialty recommended areas related to overuse of health care services that are low value). So, CMS should first require that the measures it selects for focus are evidence-based. Secondly, CMS should move toward measuring outcomes that both physicians and patients agree are important and that can be influenced by the actions of the health care system. The value of outcome measures is that they transcend time; they are important now and will be in the future. As such, they will require less modification than process measures, which are tied to clinical evidence that can change year to year given medical advancements. For measurement of outcomes to be meaningful to physicians, it must account for differences in the sickness level of patients across different physicians. Otherwise, physicians will have incentive to remove sicker patients from their panel of patients in order to perform well on the measures. Third, the 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. 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 or in other publications that rely on a similar review process. Transparency of the process and underlying science will enhance the face validity of the process and the acceptability by the clinical community.

**6. The legislative draft puts a heavy emphasis on best practices as decided by medical specialties and primary care as the bed rock upon which measures should be founded. Your testimony also states that CMS should establish a process where measure development experts work with clinical specialties to identify performance gap areas and work to address those as measures. In your opinion, how important is this iterative relationship between CMS and medical providers around developing and maintaining a system of value-based performance?**

Those who measure and those who are measured need to be involved together in developing the system of value-based performance—so I would say the iterative relationship is critical. Successful VBP programs employ this partnership and it extends beyond identifying/developing measures to working in collaboration to improve. Fundamentally, this is the concept behind ACOs, which have the payer (i.e., CMS), physicians and hospitals all at the table working together to solve the problem. This relationship

will be critical to the success of new value-based performance payment systems. Physicians will offer important insights on patients who should be excluded from a measure, what is a reasonable performance target (given other factors that influence the result), and where the performance gaps are. They have deep knowledge of the science and this information is critical to developing a measure that is meaningful. For example, recent research conducted by Dr. Eve Kerr at the University of Michigan (Ann Arbor Veteran's Administration) shows that performance measurement should be moving towards "risk-based" measurement to avoid over treating patients; her work is showing that physicians are working to get HbA1c levels in diabetics below values of 7 and 8, often with little clinical benefit to the patient and substantial side effects. Such knowledge emanating from clinicians engaged in quality of care is vital to the construction of sound measures that Medicare can advance in the context of VBP. Medicare can best work to change physician culture by helping physicians understand that Medicare is working *in partnership* with physicians to do this, rather than simply imposing change on them. Development of the measures is the first step in building a partnership built on credibility and respect.

**7. Do you believe Medicare can benefit from thought leaders like Independent Health and others who are currently employing new models of care delivery in the marketplace?**

Absolutely! There are important innovations in play throughout the country and the Medicare program (which faces more statutory and regulatory constraints that impede its ability to experiment quickly and nimbly) should actively monitor and seek to learn from innovation that is occurring in the private sector. Much is being learned on the ground by organizations like Independent Health, Dartmouth Hitchcock, Aurora Healthcare, Hill Physicians, Sharp Healthcare, Geisinger, Mayo Clinic, Intermountain, etc., and unfortunately most of these insights are not being published. CMS should engage in annual outreach efforts to providers and payers around the country to learn from the innovations that are happening that could inform what Medicare does.

**8. How important is meaningful, timely feedback on performance for such a system to work?**

To take quality improvement action, 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. If the VBP program in the physician fee schedule were to establish fixed performance benchmarks that are known long in advance of the performance measurement year, physicians could periodically monitor their own performance throughout the year to get more immediate feedback. A key challenge in American healthcare is that most providers (save for systems like Kaiser and Geisinger) do not have ready access to a dashboard of performance indicators to tell them how they are doing in managing their patient

population. I fundamentally believe that embedding VBP into the physician fee schedule and other performance-based payment innovations (ACOs, bundled payments, medical homes) will work to change this; over the last decade, Kaiser has transformed itself to have a dashboard of performance indicators to be able to respond to VBP—such as in the Medicare Advantage star rating program. 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, that 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.

**The Honorable John Shimkus:**

- 1. Page 21 of the legislative framework released last week calls for the development of a “process by which physicians, medical societies, health care provider organizations, and other entities may propose” Alternative Payment Models for adoption and use in the Medicare program. Do you believe that model development from private payers and providers like those at Independent Health can lead to reforms that could benefit patients, providers, and taxpayers?**

I believe that physicians should have flexibility to participate in alternative performance-based payment models, be they ACOs, medical homes, bundled payments for episodes of care, or other models that have not yet been developed—and that these should “qualify” physicians as meeting the requirements of VBP as they will be measured on a set of performance measures. There is much innovation going on nationally in the private sector, such as at Independent Health, and as these types of models emerge and show benefit, CMS should consider ways to embed similar features into the Medicare program. Private payers, working with local providers, have greater flexibility and nimbleness to innovate, and the lessons from these experiments could yield benefits if applied in Medicare.

**The Honorable Gus Bilirakis:**

- 1. In your testimony, you talk about a continuum of performance. Should we have a target percentage for performance of quality measures? For example, should the average of**

**physicians meet 75% or 85% of performance measures? If we do use targets for performance measures and the averages are above the target percentage, should we recalibrate the metrics every five years or so, to adjust the metrics and increase the standards of care?**

I encourage the committee to examine the way in which targets are set in the Alternative Quality Contract (Blue Cross Blue Shield of Massachusetts), where targets are set based on empirically derived cut points based on the data.<sup>4</sup> In this program, they pay along the continuum, so providers are rewarded for each increment of improvement. The highest level benchmark is set for what is best in class and is achievable, based on the actual performance of peer specialty physicians. They have found the highest level tends not to change over time (unless there is a significant change in the underlying therapy). Congress or the Secretary should set a minimum performance threshold below which no incentives would be paid. Performance targets do need to be periodically reviewed and reset; however, the Medicare program should seek stability and thus only change targets as necessary. Specifically, a framework should be put in place that allows for measures to be updated as needed. There are some measures in place now that are being achieved by almost all physicians. As measures top out, CMS should be empowered to retire those measures and implement new ones that allow physicians to continue to improve and be rewarded by such improvements.

Another approach for setting cut points 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.

I am unclear on the portion of your question about “should the average of physicians meet 75% or 85% of performance measures.” You may be asking about the use of a composite measure that aggregates information across a group of measures. For example, a composite could be constructed by adding together all measures for which a physician “passes” the measure divided by all the measure opportunities. In this case, you would arrive at the percent of all opportunities achieved. There is ample literature on composite construction, and I would be happy to discuss this topic with the subcommittee if this is an area of interest.

**2. How much of these quality measures should be developed for the physician in general or should we have measures for specific diseases? There are hard to diagnose diseases with**

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<sup>4</sup> 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.

**small populations. If we do develop metrics for specific conditions, how do we responsibly develop measurements for these conditions when research may be more limited?**

Performance measures should be “patient-driven.” By that I mean that the patient’s health care needs define the measure. For some measures, multiple physicians could be accountable for the same measure (such as the management of high blood pressure where a primary care physician and a cardiologist could be accountable). Many of today’s measures have a disease or condition focus such as for diabetes, heart attack, or congestive heart failure. In these instances, there are multiple evidence-based processes of care and intermediate outcome measures that form a collection of measures for diabetes or heart disease. What generally drives performance measurement are the following things: 1) prevalence of a condition; 2) treatment impact (meaning that there is evidence that doing X will result in improved outcomes—better functioning and maintenance of health, lower comorbidity, and lower mortality); 3) identification of a gap in care (i.e., underuse); and 4) variation across physicians in care delivered with no demonstrable effect on outcomes (i.e., areas of potential overuse of services).

You flag two critical problems in the area of performance measurement. The issue of small numbers: generally measurement has focused on areas where there is greater prevalence of the problem in the patient population. Unless there is an opportunity for large impact from addressing care for less prevalent conditions, the focus hasn’t been on these types of clinical problems. In the future, this may change as electronic health records provide a vehicle for providing clinical decision support to ensure that patients with less common problems still receive evidence-based care. One strategy for dealing with small numbers is to create a composite measure (see above) from all the possible measure areas for a given physician; this approach aggregates information across all care provided by the physician. This may be a potential approach for clinical subspecialists who deal with less common health conditions. Developing measures that are reliable at the individual measure may not be possible, but when aggregated across multiple measures, we may be able to get a good signal on the overall quality of care provided by the physician.

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

Patients are an important stakeholder group that should be consulted at various stages in what gets measured. Patients routinely identify issues such as access to care, coordination, communication, and costs as key concerns. Currently, patient groups are involved in the NQF’s National Priorities Partnership, which identifies core areas for measure development. CMS could similarly engage patients at the front end of the process to identify key areas for development.

- 4. Should the system evolve to allow a direct feedback loop to the doctor? For example, the physician would know that they were paid X because they did or did not do Y to patient Z. Do we want that granular a system, or should the information and payment be done on a more aggregate level?**

As I mentioned in my response to Chairman Pitts, (see question 8, above), to take quality improvement action, 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. If the VBP program in the physician fee schedule were to establish fixed performance benchmarks that are known long in advance of the performance measurement year, physicians could periodically monitor their own performance throughout the year to get more immediate feedback. A key challenge in American healthcare is that most providers (save for systems like Kaiser and Geisinger) do not have ready access to a dashboard of performance indicators to tell them how they are doing in managing their patient population. I fundamentally believe that embedding VBP into the physician fee schedule and other performance-based payment innovations (ACOs, bundled payments, medical homes) will work to change this; over the last decade, Kaiser has transformed itself to have a dashboard of performance indicators to be able to respond to VBP—such as in the Medicare Advantage star rating program. 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, that 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.

- 5. Is it possible to use physician quality measures to encourage patients to better follow a doctor's plan to manage diseases? For example, a newly diagnosed diabetic getting a follow up call by the doctor reminding them to check their blood sugar or reminding them to schedule an appointment with a nutritionist. Should these metrics be limited to what is done inside the physician's office?**

The question you raise seems to refer to use of patient incentives. VBP programs tend to focus on incentives for the physician to do the right thing; however, patients have a significant role to play, and some parties are experimenting with the use of patient incentives to encourage their engagement.

**6. Should the quality measures be weighted? If there are 10 things that a doctor can do to increase their performance measure, should they be rated equally for payment bonuses or weighted to account for time or difficulty?**

There is no single correct answer here. The use of weights can signal “importance” and thus direct provider attention to areas deemed more important by payers and other stakeholders. For example, the Medicare Advantage program places more weight on outcomes, intermediate weight on patient experience measures, and the lowest weight on process measures. These are “policy” derived weights. Weighting of measures can be used to encourage greater focus or as you note, provide some accounting for level of difficulty. Weights can also be empirically derived (using tools such as factor analysis), based on which measures are providing the strongest signal on performance (i.e., those measures where the reliability of measurement is greatest). The advantage of empirically derived weights is that the program sponsor can work to minimize the risk of misclassifying a provider’s performance by increasing the reliability of the composite measure. Some VBP programs have chosen to assign weights to different measure domains in determining payouts, such as 50% on clinical, 20% on patient experience, and 30% on safety. In this case, these represent the values of the stakeholders involved in the program. The use of weights is a policy option that should be left to the discretion of the Secretary, who should consult with affected stakeholders. Note that in any measurement system, even if all measures receive a weight of 1, if there are more diabetes measures (let’s say they represent 5 out of a total of 10 measures), then de facto they will account for 50% of the total weight in an equal weight scheme.

**The Honorable John D. Dingell:**

1. During the hearing, you agreed that Congress should look at the innovations and changes being made in the private sector when considering reforms to SGR. Would you please list some suggestions of what you feel might be useful?

The types of changes being envisioned in reforming the SGR at this stage are reflective of early pay for performance (P4P) efforts over the past decade, where physicians were paid differentially (at the margin) for a set of measures. Much has been learned from these P4P experiments---and I would encourage Congress to examine the California Integrated Healthcare Association P4P program and the P4P efforts by private plans in Massachusetts. In California, the program is evolving to include costs, and it will now be called the value-based pay for performance program; in this program providers have to hit both cost

and quality targets and incentives will be based on shared savings. Such an approach could be considered in SGR reforms, once an established program of performance measurement is put in place (the first building block). In the near term, if Congress wants physicians to focus on helping to reduce health spending, measure development needs to prioritize the development of measures of overuse. Additionally, physicians need to understand where they deviate in the delivery of care and what factors contribute to them being high cost outliers (after controlling for the difficulty of their patient mix). These are the types of actions that are in play by numerous private payers and provider organizations—such as United Healthcare, Blue Cross Blue Shield of Massachusetts, Kaiser, Mayo Clinic, Aurora Healthcare, the Palo Alto Medical Foundation (and Sutter Medical Group). In constructing the bill, Congress should outline the path for physicians and set expectations that measurement in the early term may focus on closing quality gaps (underuse of services), but over the longer term focus on cost reduction through variation reduction and reduction in the overuse of low value services. This is the focus in the private market, and ACOs are working aggressively on these areas to ensure they meet targets to secure shared savings.