



May 13, 2009

The Honorable Max Baucus
United States Senate
511 Hart Senate Office Building
Washington, DC 20510-2602

Dear Chairman Baucus:

Congratulations on an outstanding start to the health reform debate. Your April 29 options paper contains many creative, innovative and essential reforms.

Consumers Union, the independent, non-profit publisher of *Consumer Reports*, appreciates the opportunity to comment and present you with some ideas of our own.

Thank you very much for your consideration of the enclosed response.

Sincerely,

DeAnn Friedholm
Director, Campaign for Health Reform
Consumers Union
Washington, D.C.

cc: All other Senate Finance members and key staff

Consumers Union
Headquarters Office
101 Truman Avenue
Yonkers, New York 10703057
(914) 378-2029
(914) 378-2992 (fax)

Washington Office
1101 17th street N.W. # 500
Washington, DC 20036
(202) 462-6262
(202) 265-9548 (fax)

West Coast Office
1535 Mission Street
San Francisco, CA 94103-2512
(415) 461-6747
(415) 431-0906 (Fax)

South West Office
506 W. 14th, Suite A
Austin, TX 78701-1723
(512) 477-4431
(512) 477-8934 (fax)



**Comments on Policy Options
Delivery System Reform and Quality Improvement**

Consumers Union
May 13, 2009

Summary Of Recommendations

Proposal	Page in SFC Options Paper	Our Recommendations and Concerns
Linking Payment to Quality Outcomes	2	<ul style="list-style-type: none"> - 5 percent should not be an absolute cap - Add a hard deadline for Hospital Compare Web site renovation - Specifically mention hospital acquired infections and publicly report total infection rates for individual hospitals. - Don't permit excessive appeals latitude
Physician Quality Reporting Initiative	5	<ul style="list-style-type: none"> - Larger carrots and sticks may be needed to drive substantial change
Transparency in Self-Referrals – Imaging Services	7	<ul style="list-style-type: none"> - Set a time-table for this experiment consistent with HITECH, ARRA, and HHS's plans for the NHIN.
Chronic Care Management	11	<ul style="list-style-type: none"> - Include the type of documentation support proposed by Senator Wyden in his legislation Empowering Patient Choices Pilot Act of 2009)
Hospital Readmissions and Post-Acute Bundling	13	<ul style="list-style-type: none"> - Include healthcare acquired infections in the “eight conditions”) - Include a more accelerated phase-in schedule, with full implementation in FY2013 or FY2014

Sustainable Growth Rate	16	- Charge MedPAC with developing options, within 18 months, to essentially scrap the SGR formula and replace it with a new provider payment system based on promoting quality improvements and informed by the payment demonstrations now underway in Medicare
Health IT	19	- Expand HITECH to specifically encourage HIT-enhanced coordination of care for Medicare beneficiaries - Explore ways to structure the PHR demonstration so that it rewards physicians for involvement (perhaps through PQRI and payment reforms) but also gives incentives to beneficiaries to participate - Accelerate the ‘carrot and stick’ incentives to promote e-prescribing, and to require e-prescribing after 2015
Improving Quality Measurement	21	- Insert a required assessment of the progress towards more rigorous outcome measures
Comparative Effectiveness Research	24	- We have concerns about the “patient safeguards” (page 25). In particular, the phrase “relies on all available evidence” is problematic. We recommend rewording to remove any unintended consequence. - Include provisions addressing conflict of interest
Transparency	25	- Add disclosure rules for gifts to institutions and especially medical schools - Do not pre-empt State disclosure laws that have stronger transparency provisions
Workforce Issues	33	- Strengthen the proposal (page 34) to ensure that new residency slots are actually used for the training of primary care and general surgery students
Medicare Advantage (MA) Plans	37	- Add a CMS-run coverage option that resembles one of the more popular A-L Medigap plans, and permit premiums to be deducted from Social Security checks - Require a major simplification of the Part D options
Maternity Care	Not in document	- We propose recommendations around maternity care services.

Linking Payment to Quality Outcomes (page 2)

We strongly support the Committee’s proposal to expand the Hospital Value Based Purchasing (VBP) program to promote quality improvements. We support setting clear quality thresholds based on a set of approved measures for the initial conditions specified. We agree with giving the Secretary the authority to expand the list beginning in 2013. In our view, the faster the list is expanded the more robust the program will be. As the committee knows, quality measurement, data collection, and public reporting of quality measures by hospitals is a rapidly maturing area. Consumers Union has commented to CMS and Congress on the VBP program in the past and we would be pleased to provide you that more detailed material if helpful.

The incentive phase-in schedule is reasonable, to 5 percent in 2016. However, we would suggest that 5 percent not be an absolute cap. Beyond 2016, it may be warranted and advisable to expand the proportion of payments to hospitals directly linked to performance and meeting quality benchmarks. The Secretary and CMS will learn from program experience over time, and that should drive the amount of money that gets set aside. Ongoing private sector experience may also inform these judgments.

We concur with establishing an appeals process. However, we would warn against giving hospitals excessive appeals latitude, possibly permitting them to disrupt the program with disputes over methodology and payment amounts. The Medicare program has been beset for years, in our view, with too much accommodation of the provider industry even as costs ballooned. HHS and CMS need clear lines of authority to implement a *fair program* that will improve quality but which also simply must become more rigorously targeted at constraining cost growth.

We believe that all quality and performance data gathered under the VBP program should be publicly reported and that the Hospital Compare Web site be made more user-friendly as quickly as possible. We would suggest the committee set a hard deadline for Web site renovation.

On the conditions list, we appreciate the inclusion of “surgical care activities.” We would suggest, however, that hospital acquired infections be specifically mentioned and that total infection rates for individual hospitals be publicly reported, with a phase-in of a mandate to do so. Roughly one American dies every five minutes from a healthcare acquired infection. There is broad agreement these are largely preventable deaths. Twenty five states now require some form of reporting and data from Pennsylvania show that public reporting can help speed the reduction in infections. We urge you to include legislation similar to Senator Menendez’s S. 2525 (of the 110th Congress) in your final proposal.

Physician Quality Reporting Initiative (page 5)

We support the addition of Maintenance of Certification (MOC) to meet PQRI objectives. The IOM’s landmark 1999 report *To Err Is Human* made a similar suggestion. Developing a system to ensure continuing professional medical competence (just as we ensure pilots maintain their skills) is an essential step toward better quality. However, we would urge that CMS track the MOC program (run by the American Board of Medical Specialties) to assure that it is rigorous enough over time and produces results that comport with the rest of the PQRI program. We believe the MOC program is evolving in a positive direction, but the standards set for certification are derived by doctors for doctors and may have a tendency to be less demanding over time.

We agree the structure of the relatively new PQRI program needs improving, in consultation with medical groups, consumers and other stakeholders.

The incentive structure specified on page 7 is reasonable through FY2014. We prefer option 1. Past 2014, we believe (as above in the context of hospital care) the bonus or penalty should not be specifically capped in the law at the present time. Rather, the success of the program should be tracked and future bonuses and penalties should be based on experience and the needs of the program. Many experts believe that larger carrots and sticks may be needed to drive substantial change.

Transparency in Self-Referrals – Imaging Services (page 7)

We strongly support the proposed initiative to slow the growth in imaging services by those who profit from the use of imaging machines. Per your question on page 9, we propose the following demonstration project idea to engage consumers in this area: In several major metropolitan areas, establish (through bidding and quality criteria) imaging “centers of excellence.” If a patient is referred for an image and chooses to use such a center, they can share in the savings. For example, if an image is currently reimbursed \$300 in doctor and clinic offices, the patient’s share of the cost might be \$60 (20%). If a center of excellence bid to provide the same image is \$250, the patient’s share would be \$50. Medicare saves \$40. We suggest consumers be encouraged to use the center of excellence by lowering their co-payment to, say, \$30. (We would note that this is a form of “value based insurance design,” an emerging trend that CMS is watching closely to create incentives on the “demand side” of medical services.

A by-product of this kind of proposal would be to shed light on the “true cost” of providing images.

We endorse the suggestion to use electronic health records and the fledgling National Health Information Network (NHIN) to track imaging services and reduce duplication of image tests and excessive imaging. We concur with the notion that this would be an excellent trial use of the NHIN – nationwide. We would urge a time-table be set for this experiment consistent with HITECH, ARRA, and HHS’s plans for the NHIN.

Payment for Transitional Care Activities (page 10)

Per your query, we strongly support dedicated payments for coordination of care for targeted patient populations with chronic conditions, both those who have experienced bouts of hospitalization and those who are at risk of hospitalization.

Chronic Care Management (page 11)

We support the creation of a Chronic Care Management Innovation Center and an affiliated Medicare Rapid Learning Network. Both ideas build on years of research showing severe gaps in this area and findings which signal gains to be made in patient care and efficiency when programs are well executed.

We would urge particularly close attention to end-of-life care planning since this area has been the source of policy friction, suffering, and budgetary hand-wringing. All people

deserve to have their wishes for end-of-life care respected; many do not want excessive care if evidence overwhelmingly indicates it will not yield benefits. Experiments in new palliative care models should be fostered. We recommend the committee to include the type of documentation proposed by Senator Wyden in the Empowering Patient Choices Pilot Act of 2009.

Hospital Readmissions and Post-Acute Bundling (page 13)

We strongly support targeting hospital readmissions for prevention, via improved post-acute care coordination and payment reforms. We urge you to include healthcare acquired infections in the “eight conditions” (page 14). We would note that several European nations have been able to almost eradicate MRSA and some other infections.

We support bundled payments as described and would strongly urge a more accelerated phase in schedule than proposed, and with full implementation in FY2013 or FY2014.

We urge that the proposed readmission and bundling proposals be developed in a way that allows the committee’s quality and performance initiatives to be implemented, and that consumers get meaningful information on the quality of care at their local hospitals.

Sustainable Growth Rate (page 16)

In addition to the proposed temporary adjustments, we would urge the committee to charge MedPAC with developing options, within 18 months, to essentially scrap the SGR formula and replace it with a new provider payment system based on promoting quality improvements and informed by the payment demonstrations now underway in Medicare and those mandated in the legislation. MedPAC should also be tasked with developing options for reengineering the RBRVS system within 2 years. These efforts should be funded with an amount that allows for MedPAC and its staff to complete the task but also allows for key external studies to inform that process and expert testimony taken.

Shared Savings - Accountable Care Organizations (page 16)

We support the concept of gain sharing if rigorously structured to avoid conflict of interest and abide by self-referral rules. We concur with the proposed criteria.

Health IT (page 19)

We support expanding the ARRA HITECH provisions to encompass nurse practitioners and physician assistants. In addition, we would urge the committee to expand HITECH to specifically encourage HIT-enhanced coordination of care for Medicare beneficiaries, in coordination with existing and planned demonstration projects. This should include the planned Personal Health Record (PHR) demonstration project. We would urge the committee to explore ways to structure this project in a way that rewards physicians for

involvement (perhaps through PQRI and payment reforms) but also gives incentives to beneficiaries to participate. We see this as a major opportunity to enhance patient engagement, and especially Medicare beneficiaries with chronic conditions.

We note that a preliminary CMS assessment of a Florida electronic prescribing demo shows significant savings and quality improvements.

We also urge the committee to accelerate the ‘carrot and stick’ incentives to promote e-prescribing, and to require—mandate—e-prescribing after 2015. Similarly, we favor a trigger that requires the adoption of EHRs by a date certain if a set percentage of doctors have not adopted a networked system.

Improving Quality Measurement (page 21)

We concur with the proposal to build on MIPPA to expand the development of more robust and rigorous clinical quality measurements via the National Quality Forum. Over time, outcome measures need to replace process measures. The NQF public-private stakeholder process is sound and has become more patient-centered in recent years. We would urge the committee to insert into any health reform law a specific assessment of the progress towards more rigorous measures in the context of the periodic reports proposed.

In addition, we support the committee’s proposal to engage NQF in measurement and quality improvement priority setting. (In full disclosure, we have been a part of the NQF’s National Priority Partners project since its inception.)

We thank the committee especially for this statement on page 23:

“the Secretary would...develop a strategy for improving the public reporting of quality and performance information that includes making information available on the internet in a standardized, understandable and easy-to-use format for consumers, providers and purchasers.”

We believe this is essential and must extend to helping consumers make insurance option choices, per our previous papers to you on the need for quality and pricing data in any insurance exchange or connector.

Comparative Effectiveness Research (page 24)

We strongly support a dedicated all-payer (public and private mix) permanent source of funding for CER research. We do not believe CER money should flow through annual appropriations. Rather, a trust fund or similar mechanism should be built over time, perhaps supplemented with funds from the Medicare trust fund, providing a stable and predictable source of CER funds.

Regardless of whether the infrastructure and administration of the CER program is established in a new entity or with an existing government agency, we believe the deployment of the research dollars and the grants management processes should be independent of the political process and run as a fully transparent science enterprise, subject of course to regular Congressional oversight and public accountability, as proposed.

We believe that a permanent CER program will have more support if the committee clearly states that reducing harmful health disparities is one of the goals of CER. Representatives of ethnic and minority communities should be included in the various advisory bodies the committee proposes, along with other consumer and patient representatives. (We are making detailed recommendations on this to the CER Federal Coordinating Council and the IOM committee charged with assessing CER priorities. We would be pleased to share those with the committee at your request.)

We are concerned with the committee's language under "patient safeguards" on page 25 and seek clarification of its intent. This paragraph appears to make it hard for public and private payers to use the results of objective and independent CER to help guide improvements in the quality of care. In particular, the phrase "relies on all available evidence" is problematic. Much of the so-called 'evidence' from those selling drugs, devices, and other medical services is nothing more than a sales pitch. Good CER will include review of prior research before proceeding and if there is available evidence worth considering, it will be. To further require CMS to "rely" on other "evidence" risks being a perversion of the CER process.

We strongly urge the committee to include in any legislation provisions addressing conflict of interest (COI) and industry ties for members of all CER advisory boards and for researchers themselves. The recent IOM report on COI should guide the committee in drafting these provisions. We would also bring to your attention a study of cancer research findings released the week of May 11 in the journal *CANCER*. It is just the latest study to show the scope and scale of COI in medical research. The study found that of 1,534 cancer studies in important journals, almost one-third were either funded by industry or conducted by authors with significant ties to industry.

We also urge the committee to underscore provisions in ARRA that support increased and dedicated funding for dissemination of CER results to both providers and consumers/patients. This is a developing area vital to maximizing the full benefits of CER. For example, we urge the committee to examine the work of Drs. Schwartz and Woloshin of the White River Junction Vermont VA. These researchers have created "drug fact boxes" which have recently been endorsed as a new public education tool by an FDA advisory committee on medical and prescription drug risk communication.

Any CER program has the potential to be controversial and politically divisive. It is critical in our view to create a structure and function that is tightly focused on building knowledge through methodologically sound research. Congress should not dictate how the results of CER be used or not used. Rather it should focus on provisions that

adequately support the broadest possible dissemination of CER findings to providers, patients and health system stakeholders.

Transparency (page 25)

We support the committee's proposal as outlined. We have supported the general thrust of the Grassley-Kohl Physician Payment Sunshine Act (S. 2029, a new version of which was submitted in Jan. 2009). But we would also advise the committee to consult MedPAC's recent recommendations in this area as well as the IOM's recent report on conflict of interest in medicine.

In particular, we believe legislation should include disclosure of gifts to institutions and especially medical schools. Many institutions are taking steps on their own to expel inappropriate industry influence from their campuses. Your bill can help assure the process of restoring integrity is more rapid.

On the issue of samples, the Consumer International organization will soon release a report comparing international efforts to deal with industry payments to providers. Other nations are taking stronger actions against samples, which could be a model. We urge you to keep the de minimis threshold at no more than \$100 (page 26). As research has shown, even small gifts creates a psychological sense of obligation and reciprocity.

Finally, please do not pre-empt State disclosure laws that seek to do more. The states have been leaders in the process of restoring integrity to this sector and should be allowed to continue to innovate.

As this is an area of particular interest for CU, we would welcome the opportunity to further consult with you on shaping requirements on disclosure, transparency and COI.

Nursing Home Transparency (page 29)

We strongly concur that care at nursing homes deserves attention in any health reform legislation. Consumers Union/*Consumer Reports* has probed nursing home quality and presented ratings on nursing homes. We have found that 'bad actors' are seldom removed from the system. Your proposed reforms will go a long way toward improving business practices and care in this sector.

We support all the committee's proposed options, but would put special emphasis on upgrading Nursing Home Compare. We would add the following idea and funding request: a directive to the HHS Secretary to contract with an outside entity to study and present options for educating the public about the existence of Nursing Home Compare and the criteria on which to compare nursing homes.

Workforce Issues (page 33)

We would urge the committee to strengthen the proposal on page 34 to ensure that an institution's new residency slots actually are used for the training of primary care and general surgery students. We support the national workforce strategy option on page 36, and would suggest special attention to promoting primary care in rural and underserved areas.

In addition, we strongly urge the committee to develop options to address the disastrous shape of our nation's Emergency Medical Systems (EMS). In this regard, we commend to you the IOM's landmark three-volume report on EMS in 2006, which has basically been ignored. Senator Stabenow has a proposal in this area that represents a start on addressing this issue

Medicare Advantage (MA) Plans

We support the committee's efforts to bring financing reforms and quality improvement initiatives to MA plans. Whatever you do, however, is likely to result in considerable turmoil in the current plans and the benefits that are offered to enrollees. Specifically, it would be useful to review the Medicare Supplement rules to ensure that people can return to a supplemental policy without underwriting if they have been in a MA plan for more than a year.

In addition, if Medicare were to offer a CMS-run coverage option that resembled one of the more popular A-L Medigap plans (where the premiums could be deducted from Social Security checks), past CBO analysis has shown that huge efficiencies would be achieved. In other words, MA beneficiaries could receive *many of the extra benefits offered by MA plans at very low cost* (see CBO analysis of previous proposals by Rep. Stark in the late 1990s). Having an option such as this available may reduce the level of confusion, real hardship, and anger that would otherwise accompany a reduction of benefits by the MA plans.

We support the committee's proposal to explore setting benchmarks based on plan bids, and related payment reforms, to compel MA plans to compete on the basis on price and quality and to ramp-up chronic care management programs. (Pages 39-41) These proposals are parallel to those for providers presented by the committee. As we have stated above, increasing amounts of money over time may need to be put in a pool that will provide bonuses to MA plans for high quality care. This should be done of course on a budget neutral basis (and thus payments will be *reduced* to plans that do not meet quality benchmarks. Those quality benchmarks should be synced up with NCQA's work to promote high quality plan services and preventive care measures.

We strongly support efforts to simplify the extra benefits offered by MA plans (page 41) and Part D plans. We support the committee's legislation from the 109th Congress to require a major simplification of the Part D options and to make the choices easier for consumers to understand. We hope such measures can be added to the committee's

legislation. Again, this proposal is similar to the type of simplification we are seeking in whatever ‘connector’ or ‘exchange’ may be established for insurance for those under age 65.

We hope you will be careful to ensure that any extra benefits do not permit the avoidance of sicker-than-average beneficiaries. (Page 42) In particular, the example given of allowing cost sharing for home health care services could be a way of discouraging enrollment of people with chronic illnesses and repeated hospital admissions.

Public Program Integrity (page 42)

The idea of a single source data base (page 44) where consumers and others can check a provider for integrity issues is outstanding. Today it is almost impossible for the average consumer to find all this data.

CU Idea on Maternity Care

Pregnancy and childbirth are the most common reasons for hospitalization for people under age 65 in the U.S. Maternal and newborn hospital charges far exceed those for any other conditions (\$86 billion in 2006). Yet maternity outcomes in the U.S. are poorer than for most industrialized nations, as well as many developing nations. In addition, in the U.S. Caesarian rates have soared to more than 30% of all deliveries; they were 5% in 1970 and are the most common operating room procedure. The World Health Organization deems a reasonable expected Caesarian rate to be 5-10%.

Medicaid bears 43% of the cost of pregnancy and childbirth, while private insurers cover 49%.

Some of our nation’s most shocking and shameful health disparities are our infant and maternal outcomes—for example, maternal mortality of African-American women in the U.S. is three times that of other women.

A paradigm shift is desperately needed to transform prenatal and childbirth care from treatment as an “acute illness” to focus on a wellness model that will not only improve care but has the potential to reduce cost growth.

Many existing forces – including current payment and workforce training structures – foster high-tech, high-cost interventions, rather than safer, time-tested and validated low-tech, lower-cost models. We suggest creating a “Maternity Care Excellence Center” within the proposed CER program to gather systematic reviews on prenatal and maternity care, and prioritize how to fill the research gaps.

We also urge making Medicaid a leader in fostering effective, high quality prenatal and maternity care by requiring it to:

- Cover both hospital and non-hospital deliveries

- Pay midwives on a par with Ob-Gyns for deliveries
- Provide bonus payments for providers with strong safety records and reduced maternal mortality with sensitivity to not creating disincentives to avoid certain patient populations or high risk women.
- Reward providers that rely on “evidence-based practices” that have been proven to improve maternal and infant safety.

In addition, we would urge changes in workforce training. The current structure of the Graduate Medical Education program feeds the tendency to high-tech maternity interventions. We urge redeploying GME dollars to incentivize non-physician educators, such as nurse practitioners and midwives, to teach their skills to residents, and to reward training programs that foster the full range of delivery options and a coordinated team-based approach, rather than the focus on surgical interventions.

Finally, we recommend that (a) free standing birth centers and midwives be covered as providers; (b) maternity quality and safety measures be more fully developed and made publicly available; (c) pilots for bundled maternity services be undertaken; and (d) effective priority services such smoking cessation for pregnant women and breastfeeding support be covered.