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# PROGRAMS THAT REWARD PHYSICIANS WHO DELIVER HIGH QUALITY AND EFFICIENT CARE

## HEARING

BEFORE THE

## COMMITTEE ON WAYS AND MEANS
## U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

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# PROGRAMS THAT REWARD PHYSICIANS WHO DELIVER HIGH QUALITY AND EFFICIENT CARE

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**TUESDAY, FEBRUARY 7, 2012**

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10:01 a.m., in Room 1100, Longworth House Office Building, the Honorable Wally Herger [chairman of the subcommittee] presiding.

[The advisory of the hearing follows:]

# *ADVISORY*

## FROM THE COMMITTEE ON WAYS AND MEANS

## SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 7, 2012
112–HL07

CONTACT: (202) 225–1721

# Chairman Herger Announces Hearing on Programs that Reward Physicians Who Deliver High Quality and Efficient Care

House Ways and Means Health Subcommittee Chairman Wally Herger (R-CA) today announced that the Subcommittee on Health will hold a hearing to explore how private sector payers are rewarding physicians who deliver high quality and efficient care. With this hearing, the Subcommittee will continue to examine potential ways to reform Medicare's physician payment system. The Subcommittee will hear from witnesses who have developed, supported, and participated in quality and efficiency measurement programs. **The hearing will take place on Tuesday, February 7, 2012, in 1100 Longworth House Office Building, beginning at 10:00 A.M.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing. A list of witnesses will follow.

**BACKGROUND:**

Medicare currently reimburses nearly every physician on a fee-for-service (FFS) basis. While the physician fee schedule generally takes into account the work, time, and effort associated with each service, it does not account for the quality and efficiency of the care provided. Furthermore, the mechanism used to annually update the fee schedule—the Sustainable Growth Rate (SGR) formula—limits spending growth to growth in the economy but does not recognize value or quality. There is broad acknowledgement of the shortcomings of the current payment system, including the disruptive role of the SGR, and the growing importance of incentivizing patient-centered, high-quality, and outcomes-oriented care.

In consultation with physicians, many private payers have developed programs to measure and reward the quality and efficiency of care provided. Some of these programs also recognize practice transformation activities. Preliminary results from these programs have shown reductions in unnecessary emergency room visits, surgical complications, and repeated procedures. Some physician organizations are also very active both in collecting data to enhance performance and in developing programs that recognize physician excellence. These organizations have encouraged widespread dissemination of clinical evidence, improved patient outcomes, and reduced unwarranted variations in care. Such physician-driven programs and activities may offer valuable lessons for reforming the Medicare physician payment system.

In announcing the hearing, Chairman Herger stated, **"As we continue to seek a long-term solution to the Medicare physician payment system, this hearing will enable the Subcommittee to learn more about how programs developed by physicians and private payers are successfully rewarding quality and efficiency in care delivery while reducing complications and wasteful spending. The experience of those at the forefront of these innovative ef-**

**forts will help the Subcommittee as it considers how to better reimburse physician services in Medicare."**

**FOCUS OF THE HEARING:**

The hearing will focus on innovative quality and efficiency recognition and reward programs developed by physicians and private payers.

**DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

**Please Note:** Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov, select "Hearings*." Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, submit all requested information. *ATTACH* your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, February 21, 2012**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

**FORMATTING REQUIREMENTS:**

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at http

The subcommittee met, pursuant to notice, at 10:01 a.m., in Room 1100, Longworth House Office Building, Hon. Wally Herger [chairman of the subcommittee] presiding.

Chairman HERGER. The Subcommittee will come to order.

We are meeting today to hear from individuals to have experience to share that will inform us as we continue our effort to reform Medicare payments to physicians. At our last hearing on this topic, we heard about different payment model options and efforts to test them in the private sector.

This second hearing focuses on more incremental, private sector-driven approaches to reforming patients. We will hear shortly from private payers, a physician organization, and a practicing physician who are engaged in efforts that reward physicians who provide high-quality and efficient care to patients. A common theme will be how all of these key stakeholders are collaborating in private sector efforts to improve care while lowering the cost of providing it.

All but one of our witnesses, even those representing health plans, are physicians who are leading efforts to achieve this shared goal. I fully expect you will find their stories compelling. Our Democrat colleagues have called an economist who talk about the need for collaboration but with the view that government, not those providing the care, should lead the way.

Our end goal in all of this remains addressing the Sustainable Growth Rate formula through comprehensive physician payment reform done in a fiscally responsible manner. This past December, the House passed a bill that would have provided a two-year reprieve from SGR cuts. This would have provided the longest period of stability for Medicare physician payments in nearly a decade.

It is worth noting that the last time that physicians knew what their payment updates would be for 24 months was when a Republican-led Congress enacted the Medicare Modernization Act in 2003. It would have also provided time to determine a payment reform policy that constitutes a true solution—it is important to remember that merely averting cuts is not a fix.

The House bill would have facilitated the collection of information to assist in determining a sound policy prescription for paying physicians moving forward. The bill directed studies by the nonpartisan Medicare Payment Advisory Commission and the Government Accountability Office. It prompted this and other congressional committees with Medicare jurisdiction to consult with physician organizations. The focus of this information collection effort is, not coincidentally, the topic of today's hearing, how to reward physicians for providing quality, efficient care to beneficiaries.

Unfortunately, the Democrat-controlled Senate continued its habit of providing patches a couple months at a time, which led us to our current situation, one that again sees us too close to an unsustainable physician payment cut. While I am concerned about my Northern California constituents and the other beneficiaries and physicians throughout the country, I trust that the Conference Committee will address this issue in a more responsible manner.

In the meantime, this Committee is focusing on what it can do now to bring a permanent resolution to the SGR program. I am confident the experience that our witnesses will share today will assist us greatly as we continue down this path.

Before I recognize Ranking Member Stark for the purpose of an opening statement, I ask unanimous consent that all Members'

written statements be included in the record. Without objection, so ordered.

I will now recognize Ranking Member Stark for five minutes for the purpose of his opening statement.

Mr. STARK. Thank you, Mr. Chairman, for holding this hearing today to try and explore how the private sector payers are rewarding physicians who deliver high-quality and efficient care. This continues discussions we began, I guess, last May to review innovative delivery and payment system reform efforts.

I agree with you, Mr. Chairman, that it is important to hear from the private sector. But I also would note that we are only three weeks away from a 27 percent cut in Medicare physician payments. We keep avoiding the topic of Sustainable Growth Rate formulas in favor of the easier conversations about delivery system reforms, around which we have much stronger agreement. If we don't fix Medicare's physician payment formula, we are going to lose the ability to collaborate with the private sector because the physicians will abandon Medicare.

We all share the blame here. I would like to blame it all on the Republicans, but I can't. We are more than a decade away into the debacle known as SGR reform. We have known this hasn't worked for many years, but neither side has been able or willing to come together to enact a permanent solution. And the biggest reason is the cost.

The way the formula was designed, we would have over $300 billion to correct the formula. We have an opportunity. Members on both sides of the aisle and the capital are agreeing to—more members are agreeing to the idea of using the war spending, overseas contingency operations, it is called, as a financing mechanism to pay off the SGR program.

Without objection, I would like to make part of the record a letter signed by most of America's physician professional societies in support of this.

**Information Not Provided**

Chairman HERGER. Without objection.

Mr. STARK. Thank you, Mr. Chairman.

I am encouraged by this conversation and I am curious to hear from our witnesses today. And I think most of them will agree that SGR reform is the number one issue facing physicians. We have got to get this issue behind us, and then we will be able better to devote our attention to implementing reforms, as discussed at today's hearing.

I would like to note also that to look at purely private sector efforts is not exactly the answer. Mr. Nichols, I think, will highlight the synergy between government initiatives to change payments to promote quality efficiency in their private sector counterparts.

Though many of my more conservative colleagues are loath to hear this, the new health reform law is promoting public-private initiatives to incentivize high-quality, efficient care. Examples like the Challenge grants through the new Center for Medicare and Medicaid Innovation, accountable care organizations, bundled payment initiates, are all public-private partnerships, and they are moving ahead.

Their impact goes beyond Medicare, and we are testing models we want to spread across payers. So I am excited about the synergy that we are seeing between the private sector and government, and I look forward to hearing from today's witnesses and hope we can discover new opportunities for collaboration.

Thanks very much.

Chairman HERGER. Thank you.

Today we are joined by five witnesses, who are in the order they will testify: Dr. Lewis Sandy, who is the senior vice president of Clinical Advancement at UnitedHealth Group; Dr. David Share, who is vice president of Value Partnerships at Blue Cross Blue Shield in Michigan; Dr. Jack Lewin, who is the chief executive officer of the American College of Cardiology; Dr. John Bender, who is the president and CEO of the Miramont Family Medicine in Fort Collins, Colorado; and Mr. Len Nichols, who is a professor of Health Policy at George Mason University and the director of the Center for Health Policy Research and Ethics.

You will each have five minutes to present your oral testimony. Your entire written statement will be made a part of the record.

Dr. Sandy, you are now recognized for 5 minutes.

**STATEMENT OF LEWIS G. SANDY, M.D., SENIOR VICE PRESIDENT, CLINICAL ADVANCEMENT, UNITEDHEALTH GROUP, MINNETONKA, MINNESOTA**

Dr. SANDY. Thank you, Mr. Chairman. Mr. Chairman, Ranking Member, and Members of the Committee, my name is Dr. Lewis Sandy, and I am senior vice president for Clinical Advancement at UnitedHealth Group, a diversified health and well-being company based in Minnetonka, Minnesota. Our mission is to help people live healthier lives.

I would like to highlight some of our innovative programs in transparent physician performance assessment, practice transformation through payment and delivery reform, and the importance of aligned incentives, all of which help the millions of Americans we serve. I thank you for the opportunity to testify this morning.

Private sector innovations can be applied to the modernization of public programs such as Medicare. Medicare need not start from scratch nor go it alone. By working with and learning from private sector innovations, public programs can more rapidly be modernized to meet the needs of those they serve.

For example, we are implementing a large-scale transparent performance assessment program that provides feedback to both physicians and to consumers, the UnitedHealth Premium Designation Program. Anyone inside health care knows there are differences in quality. Just ask a doctor or a nurse. But how are doctors to know how their practices compare? How are patients to know? And how can more information help both?

The premium program uses the extensive data we have from claims and other administrative data sources and analyzes care patterns using sophisticated analytics. We evaluate physician performance on quality and efficient across 21 different areas, including primary care and specialties such as cardiology and orthopedics. Quality is measured first, and only those physicians who

meet or exceed quality benchmarks are then evaluated for cost efficiency.

The measures we use are based on national standards, and incorporate feedback and guidance from specialty societies and practicing physicians. We display the results in summary form on our consumer websites to inform their health care decisions, and we provide physicians we detailed information to support their quality improvement.

This program includes now nearly 250,000 physicians in 41 states, and through this program we know that quality and efficiency variations are significant and that they matter. Cardiologists, for example, who earn our quality designation have 55 percent fewer redo procedures and 55 percent lower complication rates for stent placement procedures. Orthopedic surgeons who earn a quality designation have 46 percent fewer redo procedures and a 62 percent lower complication rate for knee arthroscopy. And the overall incremental savings between a premium-designated quality and efficient physician and a non-designated physician is 14 percent.

This program demonstrates that large-scale, transparent performance assessment can be done today, and that the information helps physicians and patients. But we have also learned that information alone will not achieve transformation and higher levels of system performance.

Thus we have also launched practice transformation programs and payment and delivery reforms, working again in collaboration with physicians and hospitals, that combine support for delivery system improvement with aligned incentives.

We currently are piloting patient-centered medical home programs in 13 states, and we are developing 8 to 12 accountable care organization projects this year across diverse communities that help care providers modernize the way they deliver care.

These are promising payment and delivery reforms, but even these are not enough. Another key component is consumer empowerment and activity, coupled with aligned incentives. For example, we developed an incentive-based diabetes health plan to help patients with diabetes stay healthy and adhere to their physician's recommended care plan.

Many lessons from our experiences can be applied to public programs.

First, expert physician and specialist society collaboration is critical in developing appropriate measures for quality, efficiency, patient safety, and other dimensions of performance, and these measures in the measurement program must be fully transparent.

Second, this information must be presented in actionable format and with aligned incentives. Information alone, while helpful, is unlikely to move the needle.

Third, financial incentives must be significant and must come from savings achieved from ongoing improvements in delivery system efficiency.

Fourth, new models of care, new roles in information technology support, are needed for true transformation. For example, embedded nurse care managers in our patient-centered medical home programs provide vital support for care transitions, patient education, and coordination.

And fifth, programs such as value-based benefit designs can help people become more activated and involved in their own care.

In conclusion, stakeholders must work together to develop an integrated, comprehensive approach to transform care delivery.

Thank you for the opportunity to share our experience with the committee. I look forward to your questions and comments.

[The prepared statement of Dr. Sandy follows:]

Committee on Ways and Means

Subcommittee on Health

Testimony of Lewis G. Sandy, MD

Senior Vice President for Clinical Advancement

UnitedHealth Group

February 7, 2012

Mr. Chairman and Members of the Committee:

My name is Dr. Lewis Sandy and I am Senior Vice President for Clinical Advancement at UnitedHealth Group, a diversified health and well-being company based in Minnetonka, Minnesota. Our mission is to help people live healthier lives, and the goal of all of our innovative work in transparent performance assessment and payment and delivery reform is to improve the quality of care for the millions of Americans we serve.

We have learned four key lessons in advancing quality and cost-effectiveness in care delivery over the years – lessons that can benefit public sector health care programs as well.

- First, physicians benefit from meaningful feedback on their clinical performance to support their continuous professional development and their innate desire to provide the best care possible to their patients;

- Second, patients benefit from actionable information on delivery system performance, as well as coaching and other support services to help them make informed decisions;

- Third, meaningful improvement in quality and efficiency of care requires practice transformation through new models of care, built and supported by new tools and capabilities, such as health information technology;

- Fourth, this transformation requires alignment of incentives for quality and cost-effectiveness across the delivery system, including incentives for both patients and doctors, all supported through new benefit designs.

Let me provide a few examples of the innovative programs we have deployed at UnitedHealth Group, at scale, to advance this agenda, and the lessons we have learned in implementing them. The first example is large scale transparent performance assessment and feedback that provides clear and actionable information about the quality and cost-effectiveness of individual physicians, groups of physicians and hospitals, to assist people in making personally appropriate decisions.

A landmark study published in 2003 in the New England Journal of Medicine noted that people receive evidence-based clinical services just ove: half the time[1], and the Agency for Healthcare Research and Quality's (AHRQ) 2010 National Quality Report shows, at best, modest improvements in quality of care since then[2]. Physicians know there are differences in quality—an October 2011 Optum Institute/ Harris Interactive survey showed that 64% of physicians say "there are significant differences in the quality of care provided by doctors" in their local area.[3] And yet physicians, extraordinarily busy and dedicated to their patients, often do not have a sense of how their patterns of practice relate to evidence-based standards of

[1] N Engl J Med 2003; 348:2635-2645
[2] http://www.ahrq.gov/qual/nhqr10/Key.htm
[3] http://institute.optum.com/research/featured-publications/sustainable-health-a-manifesto-for-improvement/~/media/OptumInstitute/Page_Elements/Articles/11-27376%20Optum%20Manifesto%20LO8.pdf

performance measures that have been reviewed and endorsed by the National Quality Forum and the National Committee for Quality Assurance, as well as performance measures developed in collaboration with medical specialty societies and reviewed by committees of practicing physicians. This Premium Designation Program evaluates physician performance on quality and efficiency across 21 different areas – including primary care and specialties such as cardiology and orthopedics.

The Premium Designation Program analyzes the performance of physicians against both quality and efficiency benchmarks. Quality is measured first, and only those physicians who meet or exceed quality benchmarks are then evaluated for cost-efficiency. Quality is assessed using more than 300 national standards and metrics developed by physician specialty societies. Efficiency is measured using more than 230 measures and benchmarks that are risk-adjusted and tailored to each physician's specialty and geographic area to account for differences in average costs. On both dimensions, performance is measured relative to other physicians.[5]

[5] For more information, see: https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Premium%20Methodology/UnitedHealth_Premium_Detailed_Methodology.pdf

performance measures that have been reviewed and endorsed by the National Quality Forum and the National Committee for Quality Assurance, as well as performance measures developed in collaboration with medical specialty societies and reviewed by committees of practicing physicians. This Premium Designation Program evaluates physician performance on quality and efficiency across 21 different areas – including primary care and specialties such as cardiology and orthopedics.

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[5] For more information, see: https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Premium%20Methodology/UnitedHealth_Premium_Detailed_Methodology.pdf

We display the results in our provider directories using a "star" format, with one star for quality and another for efficiency. Physicians receive both summarized information as well as access to extremely detailed data, down to the individual patient level in a HIPAA-compliant format. We used consumer focus groups and outside experts to create a readable, usable format for consumers. We created an online reporting and "drilldown" tool for physicians to help them understand their opportunities to improve quality and efficiency. This online system has been well received, with positive feedback from physicians and medical societies.

We have discovered that quality and efficiency variations are significant, and they matter. While the specifics vary by specialty (and we make it a point to share the overall picture with each specialty society, as well as with individual physicians), here are a few illustrative facts:

- Cardiologists who earn a quality designation have 55% fewer redo procedures and 55% lower complication rates for stent placement procedures than cardiologists who did not receive the quality designation.

- Orthopedic surgeons who earn a quality designation have 46% fewer redo procedures and a 62% lower complication rate for knee arthroscopy surgeries than other orthopedic surgeons who did not receive the quality designation.

- For all 21 physician specialties evaluated in the UnitedHealth Premium program, the incremental savings between a Premium designated (Quality and Cost Efficient) physician and non-designated physician is 14%.

This program demonstrates that large scale transparent performance assessment can be done today, and that the information is used by physicians and patients to improve both the quality of clinical care delivery and the choice of personally appropriate care by consumers. But this alone will not achieve transformative changes towards higher levels of system performance. Performance assessment, while a valuable tool for improving care quality, is not sufficient on its own. Performance assessment must be incorporated into an aligned reimbursement system that provides rewards and incentives for demonstrating true value in care delivery.

Thus, we have launched practice transformation programs and payment and delivery reforms, working again in collaboration with physicians and hospitals, to combine support for delivery system improvement with aligned incentives. We currently are piloting Patient Centered Medical Home programs in 13 states. Additionally, our goal this year is to have 8 to 12 Accountable Care Organization projects across diverse communities that will help providers modernize the way they deliver care. These practice models are combined with new payment models that reinforce both the desired direction of practice transformation and are tied closely to achievement of actual, meaningful improvements in quality and efficiency. These include population-based measures of cost-efficiency and direct measures of appropriate key health services utilization[6].

These are significant, and promising, payment and delivery reforms. But even these are not enough. Another key component is consumer empowerment and activation. As I mentioned earlier, it is important to provide people with information that helps them understand the strengths and weaknesses of physicians and hospitals, so they might make more informed, personally appropriate care choices. And, just as with physicians,

[6] Key measures for our new payment programs include a core set of HEDIS measures for quality, quality and efficiency measures such as hospital readmission rates, hospital-acquired infection rates, ER-to-Inpatient admission ratios, physician generic prescribing rates, use of in-network laboratories and specialists, and total cost of care, where statistically feasible.

we have learned that it is important to augment that information with incentive-based health benefit products that further encourage people to use the information, and that can provide lower cost health care for those who successfully do so. The end result: Better quality and more affordable care.

To that end, we have deployed incentives in programs such as our Diabetes Health Plan to help patients with chronic conditions stay healthy and adhere to their physician's recommended care plan. Through such initiatives, physician incentives for improvement and practice transformation are aligned and reinforced by consumer-focused incentives.

Many lessons from our experiences can be applied to public programs.

- First, we have learned that meaningful differences in quality and efficiency of care can be measured, and that they matter. Just as important is how we develop the measures and measurement program. For example, ongoing expert physician and specialty society collaboration is critical in developing appropriate measures for quality, efficiency, patient safety, and other dimensions of

performance. And these measures and the measurement program must be fully transparent.

- Second, this information is only useful if it is presented in an actionable format with aligned incentives. Information alone, while helpful, is unlikely to "move the needle."

- Third, financial incentives must be significant, not marginal. Yet, they cannot increase the overall costs of care. They must come from the savings achieved from ongoing improvements in delivery system efficiency.

- Fourth, financial incentives, even significant ones, cannot lead to true transformation without support for new models of care, new roles such as care transformation coaches, and information technology support. For example, we have learned the importance of embedded nurse care managers in patient-centered medical homes, who provide vital support for care transitions, patient education, and coordination among care providers.

- Fifth, the "supply side" interventions described above can be accelerated by deploying "demand side" programs such as value-based benefit designs, consumer navigation and information resources, and programs to help people become more activated and involved in their own care.

We have learned that individual transparency or payment programs, important as they are as building blocks, are inadequate on their own to significantly improving quality and efficiency in our health care system. Instead, stakeholders must work together to implement an integrated, comprehensive performance measurement program, innovative payment reforms that incorporate quality and cost-efficiency measures along with material financial incentives, transformation of the care delivery process, patient-focused transparency programs, and value-based insurance designs, so that patients are financially rewarded for making decisions that reflect higher quality and cost outcomes.

Programs like the ones I've outlined, developed and deployed in the private sector, with continuous refinement and ongoing collaboration with physicians and other stakeholders, can be applied to public programs such as

Medicare. Innovations in the private sector can be fielded, tested, and refined though rapid cycles of improvement and ongoing collaboration with physicians, thus informing the design and deployment of public sector innovations. Medicare need not start from scratch, nor go it alone. By working with, and learning from, private sector innovations, public programs can more rapidly be modernized to meet the needs of those they serve.

Thank you for the opportunity to share our experiences and perspectives with the Committee, and I look forward to your questions.

Chairman HERGER. Thank you.

Dr. Share, you are now recognized.

**STATEMENT OF DAVID SHARE, M.D., MPH, VICE PRESIDENT, VALUE PARTNERSHIPS, BLUE CROSS BLUE SHIELD MICHIGAN (BCBSM), DETROIT, MICHIGAN**

Dr. SHARE. Thank you, Chairman Herger, Congressman Stark, and Members of the Subcommittee for inviting me to participate in your discussion about private payers' efforts to improve provider performance.

I am Dr. David Share, vice president of Value Partnerships at Blue Cross Blue Shield of Michigan, which is a nonprofit insurer with 4.3 million members. It is one of the 38 Blue Cross Blue Shield plans covering nearly 100 million people in every county and zip code in the country.

Decades of private payer and government efforts have fallen short of ensuring that people have ready access to affordable, effective, high-quality care. In 2004, BCBSM wiped the slate clean and began a dialogue with physician leaders aimed at creating a common vision of a high-performing health system and an incentive program to help realize it.

A key learning was that imposing solutions on providers is an extrinsic motivation, with providers putting half of their creative energy into doing an end run around new expectations and resisting meaningful change. In contrast, harnessing intrinsic motivation and professionalism inspires physicians to devote the full measure of their creative energy to transforming the systems they use and the results they achieve.

In 2004, the Physician Group Incentive Program, or PGIP, arose out of these discussions based on communities of caregivers with shared responsibility for an identified population of patients, with the aim of enhancing community well-being and, in doing so, relying on shared information systems, shared care processes, and shared responsibility for outcomes at a population level, all guided by the patient-centered medical home model.

Other requirements for success including physicians forming organizations with effective leadership, administrative and technical support, tools to help in reengineering systems of care, and having both latitude and autonomy. Nearly 15,000 physicians in PGIP serve 2 million Blue members and 5 million Michigan residents.

The participants include about 6,000 primary care physicians in over 90 physician organizations comprised of over 4,000 physician practices, and only two of these are integrated delivery systems, with the vast majority being one to four physician practices, most of those being in private practice. There are 780 patient-centered medical home-designated practices, with another 3,000 actively working to achieve that status.

In response to an organized system of care program aimed at aligning and integrating primary care physicians, specialists, and facilities, 40 nascent organized systems of care have been established. In contrast, the 700 pages of the ACO regulations have inspired three prospective Michigan pioneer ACO applicants.

A culture of cooperation has emerged. At quarterly meetings, 350 physician organization leaders discuss best practices and common

challenges; and between meetings, regional learning collaboratives delve more deeply. These collaborative relationships and physician's leadership role have generated palpable enthusiasm and a full sense of ownership of the program and its goals across the state.

We have transformed fee-for-service payment into a fee-for-value approach, with all fee increases for primary care and specialty physicians now dependent on system transformation and population performance. I want to emphasize: Payment is a tool, not a solution. Without full engagement of physicians, a focus on community, and an explicit vision and purpose, any payment method will fall short and can be misused.

Fee for service isn't the problem, and global payment isn't necessarily the solution. We have established an annual incentive pool of $110 million, which rewards physician organizations for modernizing systems of care and optimizing performance. There are over 30 distinct initiatives available to these physician organizations, which keeps them constantly modernizing at the edges of their individual current capabilities. The more ambitious they are, the more resources are made available to them.

Physicians in the patient-centered medical home-designated can earn up to a 20 percent increase in office visit fees, focusing on relationship-based care, not procedures. Physicians also can receive additional fee-for-service payments for chronic illness care management services. And starting in 2012, hospitals' payment will be tie-barred to population-level performance, effectively aligning their incentives with those of physicians.

Early results are compelling, with a 22 percent lower rate of admission for potentially avoidable conditions, 10 percent lower ER use, 8 percent lower radiology use, and overall, a 2.2 percent total cost trend or increase for the Blue PPO products.

The physician group incentive program, with its focus on partnership, system transformation, population management, and fee-for-service payment, has moved Michigan from procedure-based care to relationship-based care and from volume to value.

I appreciate your interest and attention, and look forward to the discussion. Thank you.

[The prepared statement of Dr. Share follows:]

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**FROM PARTISANSHIP TO PARTNERSHIP: THE PAYOR-PROVIDER PARTNERSHIP PATH TO PRACTICE TRANSFORMATION**

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*"These new regulations will fundamentally change the way we get around them."*
*-The New Yorker* March 9, 2009, by P.C. Vey

**Blue Cross Blue Shield of Michigan's Physician Group Incentive Program: Building a Shared Vision of a High Performing Health System**

Thank you Chairman Herger, Congressman Stark and members of the Subcommittee on Health for inviting me to participate in a discussion about how private payers are rewarding physicians who deliver high quality, efficient care. I am Dr. David Share, Vice President of Value Partnerships at Blue Cross Blue Shield of Michigan. BCBSM is a non-profit health plan providing healthcare benefits to 4.3 million people in Michigan. It is one of 38 Blue Cross Blue Shield Plans covering nearly 100 million people, in every county and zip code in the US.

I appreciate the opportunity to share our experience at BCBSM partnering with the provider community to transform the health care system and to assure that care is of high quality, accessible and affordable.

Decades of government and commercial payor efforts, including cost containment, utilization management, disease management and managed care -- all of which initially appeared to hold great promise -- have fallen short of ensuring that people have ready access to affordable, effective, high quality care.

Blue Cross Blue Shield of Michigan postulates that the problem is not that physicians are inherently incapable of creating effective organizations and substantially improving value in health care, but that the relationship between payors/purchasers and providers is characterized by control and competition. Providers' creative efforts are, in large part, directed at obviating controls and maintaining the status quo to the extent possible. The quote, above, from the cartoon by P.C. Vey, captures the essence of this longstanding dynamic in the health care community.

In addition, payers' and purchasers' efforts to influence provider behavior have focused on managing the behavior of individual providers in the context of a highly fragmented system of care rather than being focused on catalyzing the development of systems designed to yield optimal value from the hard work of providers and their patients.

In 2004, Blue Cross Blue Shield of Michigan embarked on a mission to redirect the nature and tenor of its relationship with providers. The goal was to establish an active partnership, predicated on harnessing the full measure of physicians' creative efforts and forging a common vision of an optimal future state of health care in Michigan. In conversations with state health care leaders at the Michigan State Medical Society, Physician Organizations, and other healthcare organizations, Blue Cross Blue Shield of Michigan's approach was not to tell providers what to do, but to ask what we could do together.

As a result of extensive discussion over the course of twelve months, a vision emerged:

- Lack of system-ness is the root cause of poor cost and quality performance and an explicit focus on **system development** and **transformation** is needed to achieve good results for individual patients and at a population level
- Achieving substantive and sustainable system transformation depends on **physicians collectively owning the responsibility to change the systems** in which they practice.
- The locus of control of such change efforts should be in the hands of **natural communities of caregivers** who have shared responsibility for caring for a population of patients (through cross-coverage, referral relationships, and shared responsibility in a variety of clinical contexts, including office, emergency department, inpatient, and long term care settings)
- To create highly functioning systems which reliably produce high quality, efficient care, **physicians need to create "Physician Organizations" with sufficient leadership, structure and technical expertise to support the development of shared iuformation systems and shared processes of care**. Physician Organizations are legal entities with physician leadership, and administrative and technical infrastructure, comprised of groups of physicians in a geographic area which can accept money on behalf of their members and use it to support transforming the structure and processes of the systems they use and to measure and reward physicians for improving and optimizing cost and quality performance. Physicians themselves determine who constitutes the community of providers in a Physician Organization. Independent physicians can retain their identities as private practices when they join a Physician Organization.
- **Exhorting individual physicians to improve the quality and efficiency of their practice is unlikely to succeed**. One provider, acting independently, simply doesn't have enough time in the day to provide all of the preventive, acute care and chronic illness management services patients need without the support of a multi-disciplinary team (Landon 2003; Moore 2003; Sandy 2003; Yarnell 2003).

- **Performance should be measured at the Physician Organization level.** Measuring performance at the individual physician level is fraught with methodological limitations (e.g., low "n", non-random distribution of patients, variability in case mix which can't be fully accounted for by current adjustment methods). Measuring at a population level focuses on system performance, encourages system accountability and supports system improvement. Measuring at the individual practice and individual physician level is essential for focusing providers' attention on opportunities to improve processes and outcomes of care. But, given the methodological limitations which constrain the accuracy of results, ideally it is best to hold a community of caregivers responsible for aggregate performance at a population level and leave the management of individual cases, and individual performance, to the community of providers in the Physician Organization. Importantly, this reduces the incentive for Physician Organizations to cherry-pick doctors and for doctors to cherry-pick patients.

**Launch of the Physician Group Incentive Program**

Based on these tenets, and the concepts of the Chronic Care Model, Blue Cross Blue Shield of Michigan launched an incremental yet ambitious approach to health care reimbursement reform: the Physician Group Incentive Program. The Physician Group Incentive Program, known as "PGIP", has the goal of catalyzing health system transformation in partnership with Physician Organizations across the state of Michigan.

Including Physician Organization leaders as active partners has been vital to the success of PGIP, helping harness the full measure of physicians' creative energy in the hard work of system transformation. PGIP began by offering incentive payments to communities of physicians to organize into Physician Organizations where they didn't exist, or to redirect existing Physician Organizations toward the challenge of system reform. Physicians were encouraged to create and join Physician Organizations based on their own assessment of factors such as cross-coverage and referral patterns, hospital affiliation and geography. From the outset, there has been an explicit expectation that physicians in these Physician Organizations will develop and use shared information systems and processes of care, and that they will collectively be accountable for aggregate, population level quality and efficiency outcomes.

Measuring at the Physician Organization level keeps the focus on catalyzing system improvement rather than on individual physician performance on a narrow set of performance measures in pay for performance programs. By catalyzing system transformation, providers can develop systems which support them in reliably delivering high quality, efficient care. This is something that a community of physicians' practices can do more successfully by aggregating resources than can an individual practice.

An important benefit of measuring at the population level is that individual providers who choose to serve patients with particularly complex conditions, or who are especially burdened by socioeconomic challenges, will not be discouraged from doing so because of

a concern that measurement to judge and reimburse is focused on their individual performance.

Blue Cross Blue Shield of Michigan provides relevant, aggregate data to support Physician Organization accountability. Data are also provided to the Physician Organization to support its own efforts to assess and improve performance at the practice and individual physician level. This leaves the responsibility to monitor and improve the performance of doctors' practices and of individual physicians up to their peers, with the group being collectively responsible to the payer for the net result on cost and quality measures at a population level.

Incentive payments take into account both absolute performance and rate of improvement, and are paid to the Physician Organization. The incentive pool is funded through a percentage of all professional payments (beginning with 0.5% and now at 4.2%, creating a total annual pool of $110M); all of the money is paid out in the year in which it is accrued.

At its inception, in January, 2005, PGIP consisted of 10 Physician Organizations and about 3,000 physicians. Initially, specialist participation was limited to those involved in chronic condition management, care transitions, and high cost diseases (e.g., cardiologists, oncologists, pulmonologists, and endocrinologists). In 2011, PGIP was opened to all specialists. As of late 2011, PGIP had increased in size to 40 Physician Organizations (representing 92 sub-Physician Organizations) and 14,776 physicians, including 5,631 primary care physicians (about 67% of those actively practicing in the state) and 9,145 specialists (about 44% of those in the state). Physician Organization size ranges from 25 physicians to 1,600. There are two integrated delivery systems in PGIP; the vast majority of PGIP physicians are in small practices (consisting of one to four physicians), with most of those being in private practice. Approximately 2 million members are attributed to these physicians through analysis of health care claims, and these practices care for approximately 5 million Michigan residents.

A key principle of PGIP is that all new systems and processes of care should be designed as "all-patient" system improvements, not health plan-focused changes. This is to maximize impact on community wellbeing and ensure that overall cost and quality performance improvements are deep and durable.

Most of the 92 sub-Physician Organizations in PGIP started out as independent practice associations focused on contracting with health plans on behalf of individual physicians or small groups of physicians, with some attention paid to helping physicians succeed at earning incentive payments from insurers for good scores on selected quality and cost measures. Physician Organizations vary widely in how they are organized and in their level of sophistication regarding information systems and care management capabilities. An explicit PGIP goal is to help Physician Organizations evolve from loose federations of physicians in independent practice associations to highly functioning inter-dependent groups of physicians capable of affiliating with specialists and facility-based provider

organizations to create what we call Organized Systems of Care, to collectively manage their shared population of patients.

PGIP performance measurement initially focused on efficient use of health care resources (generic drug dispensing rate) and on chronic disease management (evidence-based care rates, based on HEDIS quality measures). The program has expanded to include a variety of "Initiatives" focused on multiple performance measures, developed in collaboration with provider partners, including, for example:

- ambulatory care sensitive condition admission rates
- emergency department use rates for primary care sensitive conditions
- high technology and low technology imaging rates
- cost and quality of cardiac care
- identification and management of chronic kidney disease patients re-hospitalization rates

A list of PGIP Initiatives follows:

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|---|---|---|
| Individual Care Management — PCMH | Core clinical processes | Ensure that patients with chronic conditions receive organized, planned care that empowers patients to take greater responsibility for their health. |
| Coordination of Care — PCMH | Core clinical processes | Coordinate patient care across the health system, through active collaboration and communication between providers, caregivers and patients. |
| Individual Care Management — PCMH | Core clinical processes | Ensure that patients with chronic conditions receive organized, planned care that empowers patients to take greater responsibility for their health. |
| Environmental Cancer | Core clinical processes | Identify patients with exposure to environmental toxins, correctly diagnose related illnesses, and treat or refer for treatment patients with conditions associated with exposure to these toxins. |
| Evidence Based Care to Reduce Gaps in Care | Core clinical processes | Implement effective systems of care designed to support outreach to populations of patients with identified primary and secondary prevention needs, and chronic illness management needs. |
| Extended Access — PCMH | Core clinical processes | Ensure that all patients have comprehensive and timely access to health care services that are patient-centered, culturally sensitive, and delivered in the least intensive and most appropriate setting based on patient needs. |
| Performance Reporting — PCMH | Core clinical processes | Implement performance-reporting technology that will allow physicians to receive feedback on their performance. |
| Lean Clinical Redesign for PCMH | Core clinical processes | A professional Collaborative Quality Initiative* to support and facilitate PGIP physician |

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|---|---|---|
| | | organizations to use lean thinking principles when developing strategies to implement components of the patient-centered medical home model. |
| Preventive Services — PCMH | Core clinical processes | Create a process of actively counseling, screening and educating patients on preventive care. |
| Patient-Provider Partnership — PCMH | Core clinical processes | Expand physician, health care team and patient awareness of and commitment to the patient-centered medical home model, and strengthen the bond between patients and their care-giving teams. |
| Linkage to Community Services — PCMH | Core clinical processes | Connect patients with community resources through a process of active coordination between the health system, community service agencies, family, caregivers and the patient. |
| Self-Management Support — PCMH | Core clinical processes | Offer support to patients as they learn to assume responsibility for daily management of their chronic conditions. |
| Specialist Referral Process — PCMH | Core clinical processes | Seamlessly coordinate the process of referring patients from primary care to specialty care, with both providers receiving timely access to the information they need to provide optimal care to the patient. |
| Test Tracking — PCMH | Core clinical processes | Implement a standardized, reliable system to ensure that patients receive appropriate tests, and that test results are communicated in a timely manner. Additionally, ensure that every step in the test-tracking process is properly documented. |
| Transitions of Care | Core clinical processes | Develop processes of care at discharge (from inpatient to outpatient care) to improve and systematize the discharge process. |
| Accelerating the Adoption and Use of Electronic Prescribing | Clinical information technology | Improve the safety, quality and cost-effectiveness of the prescription process through widespread adoption and increased use of electronic prescribing and clinical decision support tools. |
| Patient Web Portal — PCMH | Clinical information technology | Support optimal management of patients by using a web portal for electronic communication among patients and physicians, and provide greater access to medical information and technical tools. |
| Patient Registry — PCMH | Clinical information technology | Establish a comprehensive patient registry that can be used to optimally manage a population of patients. |
| Radiology Management | Service-focused | Moderate the increase in diagnostic imaging costs by reducing inappropriate use of diagnostic radiology procedures. |
| Emergency Department Utilization | Service-focused | Use relevant data to reduce primary care sensitive emergency department use. |
| Increase the Use of Generic Drugs | Service-focused | Reduce pharmacy drug costs by increasing the use of generic and over-the-counter drugs. |

| | | |
|---|---|---|
| Michigan Anticoagulation Quality Improvement (MAQI2) | Service-focused | A professional CQI to improve the quality of care for patients receiving maintenance anticoagulation under the guidance of anticoagulation services. |
| Inpatient Utilization | Service-focused | Patients will have access to timely and effective primary care with an emphasis on disease-state management, which can ward off disease progression, reduce preventable complications, and avoid unnecessary hospitalizations and emergency department visits. |
| Encouraging evidence-based utilization of labor induction | Condition-focused | An opportunity for Ob-Gyn physicians to use available data and improved care processes, as well as existing quality improvement efforts, to encourage evidence-based utilization of labor induction. |
| Michigan Oncology Clinical Treatment Pathways | Condition-focused | Establish and define evidence-based oncology treatment pathways for lung, breast and colon cancer, via a partnership between Blue Cross, the Michigan oncology community and P4Healthcare. |
| Oncology/ASCO Quality Oncology Practice Initiative | Condition-focused | Promote high-quality, cost-effective care for cancer patients, facilitated by participation in the American Society of Clinical Oncology's Quality Oncology Practice Initiative Health Plan Program. |
| Encouraging evidence-based utilization of hysterectomy | Condition-focused | An opportunity for Ob-Gyn physicians to use available data and improved care processes, as well as existing quality improvement efforts, to encourage evidence-based utilization of hysterectomy. |
| Cardiac Care | Condition-focused | Reduce the use of unnecessary cardiac diagnostic procedures, limit the associated cost trend, and enhance the quality of ambulatory cardiac care. |
| Chronic Kidney Disease — PCP Management | Condition-focused | Improve PCP identification and management of individuals with Chronic Kidney Disease, while strengthening the PCP-specialist relationship. |
| Encouraging evidence-based utilization of labor induction | Condition-focused | An opportunity for Ob-Gyn physicians to use available data and improved care processes, as well as existing quality improvement efforts, to encourage evidence-based utilization of labor induction. |

Physician Organizations can choose which Initiatives to engage in based on their current interests and capacities. This allows us to devote resources to supporting infrastructure building at the edges of the Physician Organizations' current capabilities and to reward improvement as well as net achievement. In this way we are using reimbursement to catalyze system transformation, moving physicians toward the creation of Organized Systems of Care. This incentive strategy motivates Physician Organizations to take on the most ambitious system transformation agenda possible rather than to do the least necessary as they have done in response to highly prescriptive and narrowly focused pay

for performance programs. The more PGIP Initiatives in which they participate, the more PCMH capabilities which they implement and the more they improve population level results, the more incentive payments they receive.

Physician Organizations have full latitude regarding how to spend the incentive money, but it is clear that success in PGIP is dependent in the long run on building effective systems and infrastructure, and on collectively taking responsibility for quality and efficiency at the population level, not on buying loyalty of physicians by paying bonuses directly to them.

**Building Patient-Centered Medical Homes**

As the concept of modernizing health care systems broadened to include well patients in addition to those who have chronic illness management and secondary prevention needs, the Chronic Care Model evolved into the Advanced Medical Home model and finally into the Patient Centered Medical Home (PCMH) Model. In 2007, in the wake of the growing interest in the Patient Centered Medical Home model, and in response to PGIP provider requests for more direction and structure, Blue Cross Blue Shield of Michigan collaborated with providers to develop a set of 12 PCMH Initiatives. Each Initiative focuses on a PCMH "domain of function", such as performance reporting or extended access, and provides incentive payments for the incremental implementation of PCMH infrastructure and care processes. Rather than trying to find (non-)existing full-fledged PCMH practices, pay them for care management on a per member per month basis, and hope to be able to prove the value of the model, the PGIP approach recognizes that achieving a fully transformed health care system informed and guided by the PCMH model will take years of "relentless incrementalism." Systems of care, including PCMH-based medical practices, have to be built before we can expect to see dramatic improvement in cost and quality performance at the practice and population levels. Recognizing this, approximately half of the incentive pool is allocated to support implementation of PCMH infrastructure and care processes.

In partnership with the provider community we have explicitly articulated 128 core capabilities within the 12 domains of the PCMH model. By tracking the development of these granular medical home capabilities in over 3,000 practices over time we have observed that very few have implemented more than 100 of these capabilities, and in the most advanced PCMH-based practices the average number of capabilities fully in place in 2011 was 88 (compared to an average of 56 capabilities in those practices which were nominated for recognition as PCMH-based practices but have not yet achieved it).

Practices which begin to implement PCMH capabilities quickly realize improvements in their level of engagement with patients and in their performance. But in the vast majority of practices the full potential of the PCMH model is yet to be fully realized, which is why we are committed to continued investment in supporting practice transformation at the same time as we reward population level performance on cost and quality measures.

In July 2009, with PGIP practices having made rapid strides in implementing PCMH capabilities, the PGIP PCMH Designation Program was initiated to provide additional financial support to those practices that have made the most progress in incorporating PCMH capabilities into routine practice and achieved acceptable results on quality and efficiency measures. Information about the PCMH designated physicians, who receive a 10% increase in their Evaluation and Management office visit fees, is disseminated to BCBSM members. By focusing payment increases on office visit services, we are intentionally directing an increasing proportion of physician payment toward relationship-based care and away from procedure-based care. Funding for the fee increases comes through the claims payment system, not from the PGIP incentive pool. The number of PCMH-designated practices has grown from 300 in 2009 to 780 in 2011, and the number of physicians in those practices has increased from 1300 to over 2500, as more Physician Organizations and their physician members have responded to incentives to transform systems of care.

Of the 780 PCMH Designated practices in PGIP, approximately 480 are participating in the CMS Advanced Medical Home demonstration project, called the Michigan Primary Care Transformation project in Michigan. These PCMH-based Michigan practices represent over half of all practices participating in the program in the 8 states accepted into the program. We expect this partnership between CMS, the State of Michigan, Physician Organizations and BCBSM to measurably increase the impact of PCMH-based practice on the cost and quality of care in Michigan.

**Incremental Reimbursement Reform**

Without having to eliminate the fee for service payment system, at great cost, against substantial inertia, and at the risk of losing access to granular data from claims regarding patients' conditions and services received, we are using PGIP as a mechanism for incremental reimbursement reform, redirecting a meaningful proportion of overall payment to physicians, and considerable physician effort, toward practice transformation and population level performance and away from volume-based practice. This approach, which can be thought of as Fee for Value-based payment (FFV), is practically and politically feasible: it does not require massive investment in claims systems overhaul or radical restructuring of health care benefits, and has the potential to contribute meaningfully to the viability of PCMH-based primary care practice and to practice transformation across the health care system. We recognize the negative aspects of the fee for service system, but don't want to wait for its downfall before we begin to transform how we pay.

In addition to the 10% increase in office visit fees for PCMH-designated practices, those designated practices that are members of Physician Organizations delivering optimally efficient care at a population level (based on per member per month cost and cost trend data) receive another 10% increase in their office visit fees, for a total increase of 20%.

We also reimburse PGIP participating practices for in-person or telephonic care management, care coordination, and self-management training/support provided by ancillary providers, including nurses, social workers, respiratory therapists and nutritionists who have received care management training through PGIP-approved programs. Physicians themselves do not typically have the time, or the skills, to provide care management services on their own, and, absent this payment, most practices could not afford to provide these essential PCMH team-based services.

Taken together, the incentive dollars, the care management payments and the PCMH Designation program provide substantial support for physicians who are devoted to transforming their practices and optimizing population level outcomes. This mixed-method reimbursement strategy also has the advantage of allowing us to retain access to granular detail about patients' diagnoses and service provision, which is necessary to evaluate performance (including detail about resource inputs), and to help assure that quality of care isn't short-changed. We intend to devote proportionately more reimbursement to communities of caregivers that offer high-value, system-based care and less to individual physicians on a service-specific basis. The net result we anticipate is that providers who come together to transform and modernize their own practices and the systems in which they work and integrate their systems and care processes with others in their community of caregivers will thrive, while those who don't, choosing to rely only on base fees without earning substantial incentive payments, will see their practices wither.

Beginning in February of 2012, starting with cardiologists, BCBSM will begin increasing office visit fees for specialists who are part of communities of caregivers which achieve benchmark performance on cost and quality measures at a population level. To be eligible for such fee increases, the specialists will have to be nominated by Physician Organizations whose attributed members represent at least 20% of the specialists' practice. This nomination will depend on the Physician Organization attesting to the active engagement of the specialist in system transformation efforts and in enhancing the coordination and management of care in concert with the primary care community. Eligibility for fee increases will depend on improvement in and optimization of cost and quality performance in the population of patients attributed to the primary care physicians with whom the specialists collaborate. In this way, incentives for specialists, and the future viability of specialists' practices, will be fully aligned with the incentives of primary care physicians and dependent on delivering high value at a population level. As with primary care physicians, this movement from Fee for Service to Fee for Value reimbursement serves as an incentive for specialists to move from a focus on volume-based practice toward a focus on collaborating with their primary care peers to achieve high value at a population level.

**Practice Transformation Assistance**

To accelerate the pace of change, Blue Cross Blue Shield of Michigan convenes about 350 PGIP Physician Organization leaders from across Michigan four times a year to

exchange information, collaborate on developing innovative solutions, and share best practices. Between these meetings, the Physician Organization community actively uses regional and statewide collaboratives to optimize mutual learning and accelerate dissemination of best practices.

Blue Cross Blue Shield of Michigan also supports specific projects aimed at fostering practice transformation. One example is a Lean Thinking Clinic-Reengineering Collaborative Quality Initiative, involving Physician Organizations across Michigan in a structured approach to office practice transformation which includes embedding Lean Thinking-trained change management facilitators into Physician Organizations. This approach has proven essential to enabling physicians' practices to implement new systems, re-organize practice teams and modernize care processes guided by the PCMH model, while still caring for their patients, which is a daunting challenge.

**The Role of Hospitals**

Beginning in 2012, hospital contracts, at the time of renewal, will be modernized to include very modest inflation increases to base payment, plus a component in support of building Organized Systems of Care infrastructure (clinically integrated information systems and care management processes) closely aligned with the systems of care being developed by the Physician Organizations whose physicians use their facilities. In addition, any substantial increase in payment rate, and in the long run the hope of achieving a positive margin, will depend on delivering high value (meaning moderation of the use of hospital services) at a population level, with the population measures based on the same population for which the primary care and specialist physicians are responsible. Special attention will be paid to performance on emergency department use rates, ambulatory care sensitive condition admission rates, readmission rates, discretionary procedure use rates and overall population payment trends. This will effectively align hospital incentives with those of physicians.

**Organized Systems of Care**

In 2011, PGIP launched two Organized Systems of Care Initiatives focused on catalyzing the development of clinically integrated information systems and performance measurement at a population level across all settings of care. These will be followed by additional Organized Systems of Care Initiatives in 2012 focused on clinically integrated care processes (care management, care coordination and systematized transitions of care) and on measuring and assuring optimal patient experience of care. To be eligible for participation in these Initiatives, communities of physician and facility providers must commit to actively partnering to deliver efficient, effective care to their population of patients. We are using the same incremental approach we've used for our PCMH program, beginning with initiatives that will support nascent OSCs in building shared information systems and care processes and working toward robust expectations regarding population level performance.

Relying on integrated information systems and care processes, wherever and whenever a patient seeks care across the continuum of care settings, providers will have access to the same, accurate clinical information in real time, helping to avoid redundancy in service provision and to assure safe, reliable and timely care.

There is no expectation that OSCs need to have common ownership. Affiliation agreements between independent entities (e.g., hospitals, physician organizations, other facilities) are all that is required to begin developing an Organized System of Care.

To date, 40 Physician Organizations have initiated 33 nascent OSCs in response to the Organized Systems of Care program. In contrast, 3 Physician Organizations and/or hospitals in Michigan have expressed intent to apply for the CMS Pioneer ACO program.

**Progress to Date**

The rapid growth of the PGIP program and the rising interest in the PCMH Initiatives and Designation Program are a testament both to the engagement of providers across the state in this experimental partnership, and to the recognition that health care, and primary care in particular, is in a period of crisis.

The Commonwealth Fund is supporting a comprehensive evaluation of PGIP led by Christy Harris Lemak, PhD at the University Of Michigan School Of Public Health. The quantitative portion of this evaluation is not finished, but the qualitative portion, based on stakeholder interviews across Michigan, is in draft form. The following is an excerpt of her findings from stakeholder interviews:

> "We describe respondent perspectives on the role of PGIP in Michigan's health care economy and its perceived impact on health care costs and quality.... The vast majority of respondents were generally positive in their remarks about PGIP. Nearly every stakeholder, Physician Organization leader, practicing physicians and even other payers (BCBSM competitors) expressed the view that PGIP is a very successful program that is working to improve primary care and health outcomes in the State of Michigan.
>
> Many respondents were proud of their specific, individual involvement in the program, even describing how they felt as if they were part of the program's development and success. With very few exceptions, respondents gave credit to BCBSM for its leadership to develop and implement PGIP and its role in the creation and support of a vibrant community of practice that now exists in many regions of the State. The best evidence of this community of practice can be observed in the quarterly PGIP meetings, where hundreds of primary care physicians, physician organization leaders, purchasers, and others come together to share best practices and work on solving the practice challenges.

> Most importantly, however, the vast majority of physicians we interviewed were energetic and motivated to improve their practice, to fully embrace patient centered medical home concepts, and to improve the health of their patients – respondents specifically tied many (though not all) of these changes to their active participation in PGIP."

Interview responses yielded numerous quotes such as these:

*"PGIP is the driving force for health care quality change in Michigan."*

*"Offices in the community help each other; we have group meetings. I used to [feel like I was competing with them] but not anymore. We're all moving in the same direction and we're helping each other get there"*

"*PGIP has challenged us to develop a broad population-focused model for clinical improvement for our patients.*"

"*PGIP has added value by helping to be the ignition piece. We had a culture of quality that pre-dated PGIP but PGIP did come in to push and cajole us to push that quality focus across the whole patient population.*"

With its intentional focus on harnessing physicians' intrinsic motivation, and recognizing the importance of fostering autonomy as an essential ingredient in inspiring full engagement in system change and outcome improvement efforts, BCBSM has encouraged a culture of collaboration among Physician Organizations, and between them and BCBSM. This is evidenced in the quarterly PGIP meetings, in regional clinic process re-engineering collaboratives, and in community-wide workgroups focused on challenges faced in common, such as registry implementation, data management and performance measurement. A unique effort known as the Care Management Resource Center emerged from collaborative discussions about the need for a central source of expertise and guidance for Physician Organizations engaged in implementing structured care management systems. PGIP serves as fertile ground for the development of such community-wide efforts which accelerate the pace of change, and elevate physicians' aspirations while providing practical support for realizing them. The sense of ownership and excitement among the PGIP participants is palpable and contagious.

Over 85% of PGIP providers are actively engaged in implementing PCMH capabilities, and significant progress has been made in transforming practices. For example, among PCMH-designated practices, over 95% now provide patients with 24 hour phone access to a clinical decision-maker, conduct medication review and management for all chronic condition patients, and have established a patient registry that incorporates evidence-based care guidelines.

As measured by available efficiency and quality metrics, this practice transformation work is leading to improved results: evidence-based care rates (quality measures) and generic drug dispensing rates are increasing at a faster rate for PGIP providers than for

non-PGIP providers, and the performance of PCMH-designated practices (selected in part based on quality and use performance) compared to non-designated primary care practices has grown stronger over time, even as we've expanded the program, including thousands of additional physicians. According to an analysis of 2010 BCBSM administrative claims data, adult members who received care from 2011 PCMH designees had 11.4% lower emergency department visits rates for primary care sensitive conditions (7.0% for 2010 designees), and 7.5% lower high tech radiology rates (6.3% for 2010 designees). PMCH designated practices also had 22% lower discharge rates for ambulatory care sensitive conditions, which was not a metric used in the selection process. (Table 1).

**Table 1:** 2010 Performance Statistics* for PCMH Designated Practices Compared to PGIP Primary Care non-Designated Practices -Adults

| Metric | PCMH Designees Compared to PGIP non-PCMH Practices | |
|---|---|---|
| Jan-Dec 2010 | 2010 Designees** (n=502) | 2011 Designees (n=774) |
| **Adults (18-64)** | | |
| Primary care sensitive emergency department visits (per 1,000)* | -7.0% | -11.4% |
| Ambulatory care sensitive inpatient discharges (per 1,000) | -11.1% | -22.0% |
| High tech radiology services (per 1,000)* | -6.3% | -7.5% |
| High tech radiology standard cost PMPM* | -3.0% | -4.9% |
| Low tech radiology services (per 1,000)* | -5.9% | -4.8% |
| Low tech radiology standard cost PMPM* | -5.9% | -5.0% |

*Adjusted for age, gender, and risk score. Statistics based on members attributed to Primary Care Practitioners.
**Data source for the 2010 Designees: 201001 P
*Metric used in selecting PCMH designees

For the twelve months ending in the third quarter of 2011, the overall cost trend for BCBSM PPO and Traditional business was 2.2%. This compares to an average of 4.3% for other Blue Plans nationally and to a similar rate of increase in cost for government programs. During this time period the professional cost trend (for physician payments) was 1.4%, with, remarkably, a negative 0.9% trend in the third quarter.

**Conclusion**

Like all important human endeavors, practice transformation is difficult, exhausting work. The underlying sense of urgency has only strengthened, however, as providers have taken ownership of these challenges as full, collaborative partners in PGIP and have begun to experience the fruits of their efforts: the beneficial impact on their patients of improved care management, group visits, increased access -- and on their practices from greater teamwork, increased efficiency, and a shared mission.

PGIP represents the kind of regional collaboration and experimentation which we hope Medicare delivery and payment reform will encourage, not hinder, given how little we know at this time about "what works" in regard to creating systems of care and payment mechanisms which yield optimal value.

Regional and local experimentation in system and performance transformation, and in incentivizing this work, will be essential in identifying and understanding best practices in payment reform. It is likely that in different communities, with different cultures and resources, the specific answers will vary, as do the circumstances which drive performance.

Through the PGIP payer-provider partnership, we are transforming the role of the payer from controller to catalyst, the role of the provider from responder to change agent, and the role of the patient from recipient to active partner. Imbued with energy and purpose, the PGIP approach represents incremental reform with dramatic impact.

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Chairman HERGER. Thank you.

Dr. Lewin is recognized.

**STATEMENT OF JACK LEWIN, M.D., CHIEF EXECUTIVE OFFICER, AMERICAN COLLEGE OF CARDIOLOGY, WASHINGTON, D.C.**

Dr. LEWIN. Thank you, Chairman Herger and Ranking Member Stark and——

Chairman HERGER. If you can hit your mike button, please.

Dr. LEWIN. Oh, yes. Thank you. There we go. Thank you, Chairman Herger, Ranking Member Stark, and committee members. I am Dr. Jack Lewin, representing the American College of Cardiology, 40,000 cardiologists, advanced practice nurses, pharmacists, and other clinicians.

Our purpose is to transform cardiovascular care and improve heart health, and we are doing that. In the last 10 years we have had a 30 percent reduction in morbidity and mortality across cardiovascular care in the United States. And the science in the pipeline is amazing. We are soon going to be replacing aortic valves without cracking the chest. We have got stem cell programs coming, miracle drugs in the pipeline. But the costs are out of control.

For 30 years, with the American Heart Association, the ACC has been developing guidelines and performance measures to bring better science to the point of care. Recently we have developed appropriate use criteria, new tools for diagnostic imaging, and for procedures that actually improve quality and lower cost at the same time.

This isn't cookbook medicine. Clinical judgment is still important. But getting science to the point of care more effectively improves quality and improves care for patients, and lowers costs. That is what is important. And physicians need to lead these processes.

Now, how does it work? Well, the clinical tools we have developed that actually bring science to the point of care include the national cardiovascular data registries. These are six hospital registries and one called Pinnacle, which is an outpatient register. Together, we have 20 million patient records, and we are providing outcomes results to hospitals and doctors all across America in cardiovascular care. And it is making a difference.

We have also developed a tool called FOCUS, which helps at the point of care—and it can be a mobile app—that helps choose the right image among a bewildering array of new technologies in these regards that can get the right test the first time and save significant dollars.

So going forward, we need payment reforms, with incentives, linked to these kinds of tools to make the kind of changes needed. In the testimony, you will see that in Wisconsin, we have a program called Safe Care, applying all these tools across a large number of medical groups and hospitals to really achieve some of these results. A similar program is going to happen in Florida under Safe Care.

We have got a clinical decision support system using the FOCUS tool to improve the appropriateness of imaging that is now across the entire State of Delaware. Very exciting. And the Cardiovascular

Performance Improvement Program, where we work with some of the insurance partners here like United, Blue Cross Blue Shield of Michigan, and others, actually rewards doctors for better outcomes and better performance. So we are moving in the right direction.

Is there any evidence that this can work, that these kinds of things actually reduce cost and improve quality? Let me tell you about the Door to Balloon Program. This is a program to speed up the treatment of heart attack, "Door" being the door to the emergency room, "Balloon" being angioplasty and stents to relieve the obstructed coronary artery in a serious kind of heart attack called a STEMI.

Using an educational program and our data in the United States, we have taken the time it took to treat a heart attack, averaging over two hours, down to what science tells us is necessary, under 90 minutes, or even better, under 60 minutes. Now, three years later, using this Door to Balloon Program, more than 90 percent of U.S. hospitals are under 90 minutes and half are under 60 minutes.

Here is the point. We have reduced the length of stay from five to three days, on average. We have reduced the cost by 30 percent. This is over 4- to $5 billion a year. This is important.

So we have even talked about a big idea of actually putting a challenge out to hospitals and cardiologists across the country to say, if you can reduce Medicare costs by 10 percent over 10 years—by the way, that would be about $300 billion—why don't we split the difference between the hospitals, doctors, and Medicare so that people can build these systems and make this happen. Imagine that kind of a win/win/win for patients and for doctors.

The conclusion for me would be to say that providing physicians and other health care providers with data on their performance and tools to improve their performance is going to improve quality and lower costs. To do this, to get it done, Medicare and private payers have got to encourage new incentives through the development of widespread use of clinical data registries that allow tracking and improvement of care systemically, along with payment reforms and incentives. Put those two together and we are going to see costs go down, quality go up. And we have got examples of it today.

Thanks for the opportunity to speak about several of these exciting improvement collaborations underway in cardiology, and we look forward to working with you to help solve America's problems in health care costs at the same time we improve patient care quality. Thank you.

[The prepared statement of Dr. Lewin follows:]

***THIS TESTIMONY IS EMBARGOED UNTIL 10:00 AM TUESDAY, FEBRUARY 7, 2012***

**Testimony of**

**Jack Lewin, MD**
**CEO, American College of Cardiology**

**Presented to the**

**UNITED STATES HOUSE OF REPRESENTATIVES**
**COMMITTEE ON WAYS AND MEANS**
**HEALTH SUBCOMMITTEE**

**Hearing on**

**Programs that Reward Physicians Who Deliver High Quality and Efficient Care**

**February 7, 2012**

Chairman Herger, Ranking Member Stark and members of the Subcommittee, thank you for holding this hearing today and for the opportunity to discuss initiatives that reward physicians who deliver high quality and efficient care.

I am the CEO of the American College of Cardiology (ACC), a professional medical society and teaching institution made up of 40,000 cardiovascular professionals from around the world – including over 90 percent of practicing cardiologists in the United States and a growing number of cardiovascular-focused registered nurses, clinical nurse specialists, nurse practitioners, physician assistants and clinical pharmacists.

Introduction

The United States (US) has benefited from stunning technological and therapeutic advances in health care in the past two decades, while at the same time Medicare and Medicaid costs are rising at an alarming rate. This is especially true for heart disease which has experienced a growth in health care costs and at the same time brought about a 30 percent reduction in mortality related to cardiovascular disease during the past decade. According to the CDC's Million Hearts Campaign, cardiovascular disease is the leading cause of death in the United States and cost more than $444 billion in health care expenditures and lost productivity in 2010 alone—and these costs are expected to rise given the aging of the population.

Cardiovascular medicine is responsible for managing the biggest source of morbidity, mortality, and cost in the current environment. The ACC possesses the best worldwide source of clinical data and scientifically validated clinical tools for care improvement. The College strongly believes we have an opportunity in cardiovascular disease to demonstrate a systematic, evidence and data driven approach to improving care that can simultaneously reduce unnecessary admissions, readmissions, complications, testing, and ineffective spending.

The Power of Data

The College has learned through years of experience that efforts to improve quality and efficiency must be grounded in the use of the best scientific evidence available, the collection of robust clinical data, measurement, and feedback on performance. Physicians must believe the data and trust it in order to act on it. The more confidence physicians can have in the underlying data, the more they will respond appropriately to the incentives. Rewarding physicians for providing the right care and using an appropriate amount of resources is essential to solving the long-term Medicare spending crisis. Clinical data registries should play a central role in this. Physicians and hospitals need to see how their own clinical outcomes data compares with their peers to systematically improve performance.

*The National Cardiovascular Data Registry*

Clinical data registries capture clinical information that is evidence based, derived from clinical guidelines, performance measures and appropriate use criteria in order to accurately measure patient outcomes and clinical practice. The ACC began development of the National Cardiovascular Data Registry (NCDR®) partnering with other medical specialty organizations in 1998 with a fervent determination to monitor and improve existing and new cardiovascular care technologies. Today, NCDR® is the most comprehensive, outcomes-based quality improvement program in the US encompassing six hospital-based registries and one outpatient physician office-based registry representing over 20 million patient records, 216 clinical abstracts and 70 published manuscripts. NCDR® is operational in over 2500 US hospitals, and the NCDR® PINNACLE Registry® is in over 1000 physician offices across the US. The College has for nearly three decades translated ever-evolving science into guidelines, performance measures, and recently appropriate use criteria. The NCDR registries measure the extent to which those scientific tools are actually applied across the nation, as well as measuring actual outcomes in cardiovascular care.

The NCDR® is uniquely positioned to help medical professionals – including cardiovascular and primary care professionals - and participating facilities identify and close gaps in quality of care; reduce wasteful and inefficient care variations; and implement effective, continuous quality improvement processes. The attached slides provide more information on the registries.

The ACC NCDR collaborates with numerous payers. WellPoint, Inc, United Healthcare Services, and Blue Cross Blue Shield of Michigan (by virtue of BMC2) formally require participation in NCDR as part of reimbursement or recognition programs. In addition, the Blue Cross Blue Shield Association includes NCDR participation as part of their national Blue Distinction Centers for Cardiac Care Program. Many states, including California, Florida, Maryland, Michigan, Missouri, Washington, West Virginia, are aligning regional monitoring efforts with NCDR. Health systems such as Hospital Corporation of America (HCA) and Kaiser Foundation Hospitals (of Kaiser Permanente) leverage NCDR to support QI efforts within their networks, as does the Veterans Administration. And, NCDR contains more NQF-endorsed performance measures than any other registry model---and NCDR data actually speeds the ability of the College and NQF to propose and formulate new measures as science progresses.

Two regional programs that have been receiving national recognition in publishing results for their use of data and "moving the dial" in improving care rely on the NCDR CathPCI Registry as their measurement tool for interventional procedures. These programs are the Northern New England Cardiovascular Disease Study Group and the Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2). Recently, The Leapfrog Group identified the NCDR CathPCI Registry as their preferred data source for PCI outcome reporting in their voluntary Hospital Survey aimed at encouraging health providers to publicly report their quality and outcomes so that consumers and purchasing organizations can make informed health care choices. This testimony also provides other examples of ACC collaborations on registry use to benefit the health care system.

While ACC is further along in the use of registries, other medical specialties have since developed clinical data registries or are now in the process of doing so. The ACC stands ready to assist other medical specialties with registry development.

*Decision Support Tools*

The ACC has developed appropriate use criteria (AUC) that define when and how often physicians should perform a given procedure or test in the context of scientific evidence, the health care environment, the patient's profile and the physician's judgment. The College has created point of order tools through which physicians can access the AUCs during a patient encounter with minimal workflow disruption.

Blue Cross Blue Shield of Delaware (BCBSD) is supporting use of the ACC's FOCUS: Cardiovascular Imaging Strategies tool by Delaware cardiologists to make more informed decisions about the appropriate use of certain diagnostic imaging tests this year. BCBSD will pay for cardiologists in the state to use the online tool, which allows for consistent application of AUCs to determine when and which cardiovascular imaging tests are needed. Other payers are also interested in the program. The program provides feedback reports on the patterns of appropriate use to physician practices and health plans. FOCUS participants then use the reports to complete action plans and share best practices.

A voluntary community of 50 sites using FOCUS saw a 50 percent decrease in inappropriate use of medical imaging over a 12 month time period. FOCUS not only improves patient care---it will greatly reduce unnecessary spending.

*The Cardiology Practice Improvement Pathway (CPIP)*

Payers approached the ACC to ask how to identify high quality cardiologists, leading to the College establish a program to recognize practices- the Cardiology Practice Improvement Pathway (CPIP). The College created a health plan advisory group and included them in program development to identify must-haves, nice to haves and deal breakers. The ACC sought their reaction and guidance at regular intervals.

CPIP provides an unbiased, transparent, comprehensive, self-reported, all-payer assessment of a practice's performance against national benchmarks to better and more consistently understand how we practice as a profession allowing us to demonstrate and quantify value while implementing practice improvements that

facilitate efficient workflows and drive effective patient care. CPIP is approved through the American Board of Internal Medicine's (ABIM) Approved Quality Improvement (AQI) Pathway and eligible for points towards the Self-Evaluation of Practice Performance requirement of Maintenance of Certification (MOC).

Practices can choose to have their baseline performance data sent to Bridges to Excellence (BTE) to apply for the Cardiology Practice Recognition (CPR), recognition awarded to practices that achieve quality thresholds established jointly by BTE and ACC. Numerous health plans are starting to provide incentives to practices that meet BTE CPR. For example, in 2012, practices in the BCBS Texas network who achieve CPR are eligible for financial rewards. In addition, in 2011, practices taking care of patients in the Pennsylvania Employee Benefit Trust Fund who achieved CPR were eligible for financial rewards. Also, recognized practices were eligible for Quality Designation in Aetna Aexcel, Anthem Blue Precision, and United Premium Designation programs in 2011. This standardized approach to assessing and recognizing quality in CV practice could go beyond incentives for achieving recognition; it could serve to facilitate performance-based contracting and proof of quality for integrated systems and bundled payments.

Putting the Data to Work

*The Door to Balloon Initiative*

D2B: An Alliance for Quality™ is a great example of how data collection and feedback can improve quality and outcomes. The Door to Balloon, or D2B, initiative challenged cardiovascular specialists to meet the national guidelines developed by the ACC and the American Heart Association (AHA) that state that hospitals treating heart attack patients with emergency percutaneous coronary intervention (PCI) should reliably achieve a door-to-balloon time of 90 minutes or less. "Door-to-balloon time" means the time it takes to diagnose a heart attack and restore blood flow to the heart by placing a stent in a blood vessel. Studies demonstrate strong associations between time to primary PCI and in-hospital mortality risk; however, accomplishing this level of performance was an organizational challenge. In 2006, the ACC partnered with many other organizations to address the challenge by sharing the key evidence-based strategies and supporting tools needed to reduce D2B times nationally. The program was incredibly successful, with widely published studies showing that D2B times dropped to under 90 minutes in over 90 percent of US hospitals, with many now having D2B times under one hour. This has reduced the average US length of stay for heart attack from five to three days, reducing average costs by 30 percent! This initiative significantly improved patient outcomes and lowered costs nationwide. The attached August 2011 *Circulation* article provides more detail on the success of D2B.

*The Hospital to Home Initiative*

Preventable hospital readmissions have been identified as a major source of avoidable health care spending as well as evidence of shortcomings in quality of care. The Hospital to Home (H2H) initiative, led by the ACC and the Institute for Healthcare Improvement, is a national quality improvement campaign to reduce cardiovascular-related hospital readmissions and improve the transition from inpatient to outpatient status for individuals hospitalized with cardiovascular disease. H2H is challenging practitioners to better understand and tackle readmission problems by trying specific tools and improvement strategies through the H2H Challenge Projects. In 2011 and 2012, H2H is offering tool kits, instructional webinars, and surveys to capture and share experiences with others.

*Shared Decision Making*

We know that health care decisions are not black and white. ACC believes engaging patients in decision making is crucial to achieving the best outcome for a patient, as determined by the clinical situation and the patient's preferences and values. More emphasis must be placed on shared decision making, the process by which a health care provider communicates to the patient personalized information about the options, outcomes, probabilities, and scientific uncertainties of available treatment options and the patient communicates his or her

values and the relative importance he or she places on benefits and harms. Through CardioSmart.org, ACC is providing content and tools to achieve this goal.

Moving Forward

The ACC has recently engaged on a project to combine all of these tools into a focused project to address documented clinical quality, resource use and cost variation in the treatment of stable ischemic heart disease (SIHD) called SMARTCare. In Wisconsin, the project has been driven by the American College of Cardiology Foundation (ACCF) State Chapter in collaboration with integrated health care systems, statewide, multi-stakeholder collaborative groups, including business coalitions, measurement and data collaborative groups, and a payment reform partnership. The parallel effort in Florida has been led by the ACCF State Chapter in collaboration with 6 provider organizations across the state.

SMARTCare will reduce complications, procedures not meeting current appropriate use standards, and episode cost; achieve high levels of patient engagement; improve quality of life; and increase the number of patients at risk reduction goals. The project will accomplish these changes by impacting three key decision points:

1) appropriateness of noninvasive cardiac imaging; 2) treatment decision between medical therapy, stenting, and bypass surgery; and 3) optimizing medication and lifestyle interventions. Combining these tools will provide customized patient benefit and risk information based on evidence and registry data in real time. Information provided in these tools and registries will then be used to assess patterns of care. Feedback about impact on overall clinical care and cost will be made available through an interactive dashboard and analysis tool. Ongoing tracking using NCDR and PINNACLE registries will allow sites to modify use of their tools over time to enhance impact. The information also will be used to support an episode of care shared savings/bundled payment model and quality incentive payments.

The ACC has seen the incredible excitement that has arisen from the participation of so many healthcare stakeholders in this project and we believe such efforts can be expanded throughout the nation. In addition to the aforementioned initiatives, ACC is developing plans to launch a national demonstration project with Medicare and private insurers in 2013 to systematically reduce projected cardiovascular spending over the next 10 years by at least 10 percent. If fully deployed with proposed new payment reform incentives for hospitals and physicians, this ambitious project could save over $300 billion in the next decade in Medicare alone, while further reducing morbidity and mortality.

Conclusion

Providing physicians and other healthcare providers with data on their performance and tools to improve their performance will result in improved quality and efficiency and lower costs. To establish the infrastructure and data necessary, Medicare and private payers should encourage, through incentives, the development and widespread use of clinical data registries that allow the tracking and improvement of healthcare quality in concert with payment programs that encourage higher quality. The pathway to reducing the rate of growth of US health care spending and its alarming contribution to the national deficit will require that we align payment incentives with improved data-driven outcomes---the task requires *improving* care rather than *cutting* care. Physician leadership, working together with other clinicians, hospitals, insurers, and Medicare, will be necessary to effect these needed improvements in our health care system. Thank you for the opportunity to speak today about several of the exciting quality improvement collaborations underway in cardiology and what lessons can be applied to improve quality and lower cost across the health care system.

# What is National Cardiovascular Data Registry?

- Most comprehensive, outcomes-based quality improvement program in the U.S.
- The premiere source of clinical outcomes data
- Encompasses both hospital-based registries and a practice-based program.
- Trusted, patient-centered resource
- Helps participating facilities:
  - Identify and close gaps in quality of care
  - Reduce wasteful and inefficient care variations
  - Implement effective, continuous quality improvement processes

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# How many hospitals participate in NCDR?

***Nearly all EP Labs and 70% of Cath Labs submit data to NCDR***

| Name | Disease or Device | Facility Services | Sites | Patient Records |
|---|---|---|---|---|
| CathPCI | Percutaneous coronary interventions | Cath Lab | 1500 | 13,000,000 |
| ICD | Implantable cardioverter defibrillators | EP Lab | 1600 | 600,000 |
| ACTION-GWTG | Acute coronary syndrome | Emergency | 700 | 300,000 |
| CARE | Carotid artery revascularization | Cath Lab<br>Surgical | 170 | 15,000 |
| IMPACT | Congenital heart disease | Cath Labs w/ Congenital Service | 50 | 7000 |
| PINNACLE | Coronary artery disease, heart failure, atrial fibrillation, hypertension | Outpatient | 800 physicians | 3,000,000 |

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**Total 2,500 Hospitals and Nearly 20 Million Patient Records!**

# NCDR – a generation of quality care

PINNACLE Registry™

ACTION Registry-GWTG™

CathPCI Registry

Registry

CARE Registry

ICD Registry™

STS/ACC TVT Registry

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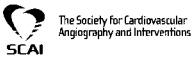
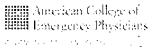
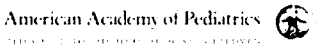
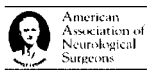
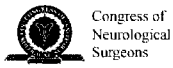
***NCDR registries bring together medical experts***











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## That was then...

Launched 1997

1 registry

Focused on quality patient care

## This is now...

More than 2,500 hospitals and 1,000 practices

Health plans and government regulator adoption

Industry uses for market research, clinical research, and to support best practice treatments

FDA uses NCDR data for post market assessment

## This is our future...

Patient centric

International collaboration

Platform for clinical trials and CER

More post market assessment studies

Implement physician reports to support MOC and MOL

EHR Integration

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# The PINNACLE Registry

- First office-based QI program in U.S.
- Data collection system
- Assessments and continuous feedback
- Clinical decision support tools
- Opportunity for recognition as ‘high quality’
- EHR interoperable module or web-based
- Data extraction by “system integrator”
- Is being used in India!

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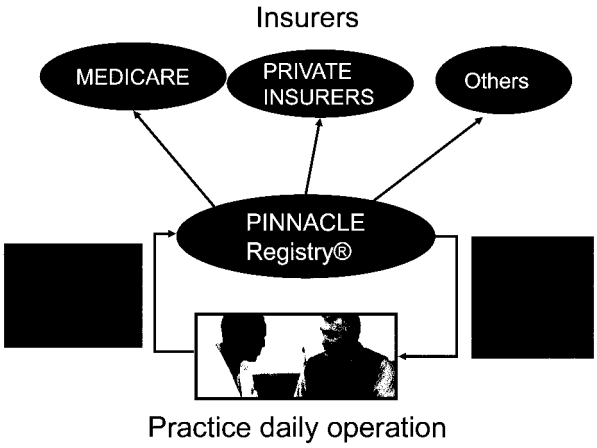
# PINNACLE and Data Collection

Data collection example:
CAD performance

- BP measurement
- Symptom and activity assessment
- Smoking assessment
- Anti-platelet therapy
- Lipid profile
- Use of lipid therapy
- β-blocker post-MI
- ACE/ARB in EF[4] and DM[4]
- Screening for diabetes



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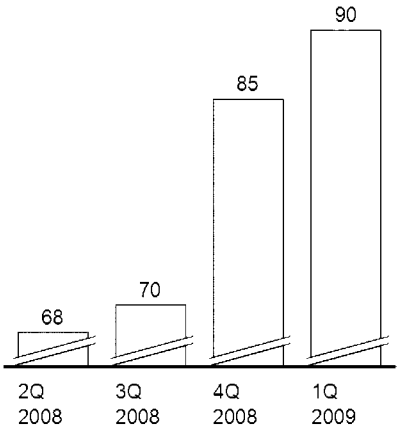
**Antiplatelet prescription after MI**
Percent of eligible patients seen at member practices



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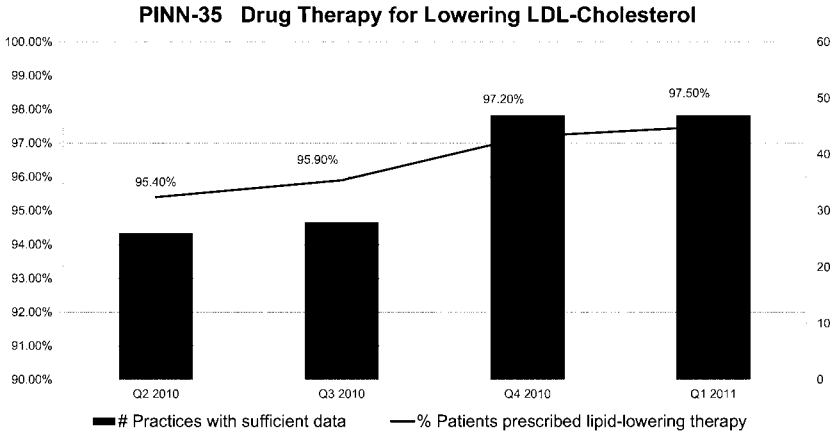
## LDL Rx performance keeps climbing, even as new practices come online



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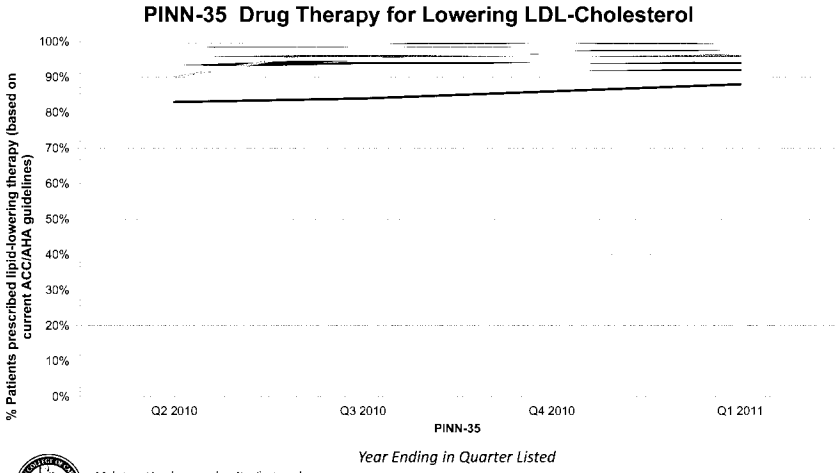
A job well done across all practices



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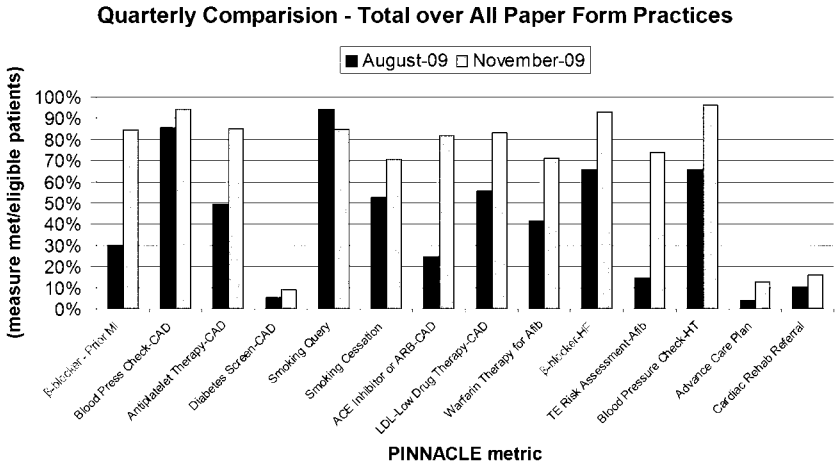
# Encouraging Early Indicators



# Variation Opportunities in Cardiology:

Imaging in FOCUS: CV Imaging Strategies:

*New ACC product for health plans focuses on appropriate patient selection through:*

- physician-developed Appropriate Use Criteria
- point of order clinical decision support
- benchmarking to target education and quality improvement

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# FOCUS: [illegible]

[illegible]

- Collaborative learning model
- Rolling admissions
- Grassroots centered and open across medical specialty
- Performance Improvement Modules (PIMs)/Online Data Collection to track AUC

[illegible]

- Contribute lessons learned
- Preparing for laboratory accreditation
- MOC Part IV

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# FOCUS:

- Implement tool at point of order
- Provide feedback on patterns to ordering physicians
- Focus on common inappropriate; provide education and reminder cards
- Local peer to peer discussions

in inappropriate ordering by practices equals within one year

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August 30, 2011

Embargoed for 4 PM ET/3 PM CT, Monday, Aug. 22, 2011

# Improvements in Door-to-Balloon Time in the United States, 2005 to 2010

Harlan M. Krumholz, MD, SM; Jeph Herrin, PhD; Lauren E. Miller, MS; Elizabeth E. Drye, MD, SM; Shari M. Ling, MD; Lein F. Han, PhD; Michael T. Rapp, MD, JD; Elizabeth H. Bradley, PhD; Brahmajee K. Nallamothu, MD, MPH; Wato Nsa, MD, PhD; Dale W. Bratzler, DO, MPH; Jeptha P. Curtis, MD

AQ:2

P1-foo

***Background***—Registry studies have suggested improvements in door-to-balloon times, but a national assessment of the trends in door-to-balloon times is lacking. Moreover, we do not know whether improvements in door-to-balloon times were shared equally among patient and hospital groups.

***Methods and Results***—This analysis includes all patients reported by hospitals to the Centers for Medicare & Medicaid Services for inclusion in the time to percutaneous coronary intervention acute myocardial infarction-8 inpatient measure from January 1, 2005, through September 30, 2010. For each calendar year, we summarized the characteristics of patients reported for the measure, including the number and percentage in each group, the median time to primary percutaneous coronary intervention, and the percentage with time to primary percutaneous coronary intervention within 75 minutes and within 90 minutes. Door-to-balloon time declined from a median of 96 minutes in the year ending December 31, 2005, to a median of 64 minutes in the 3 quarters ending September 30, 2010. There were corresponding increases in the percentage of patients who had times <90 minutes (44.2% to 91.4%) and <75 minutes (27.3% to 70.4%). The declines in median times were greatest among groups that had the highest median times during the first period: patients >75 years of age (median decline, 38 minutes), women (35 minutes), and blacks (42 minutes).

***Conclusion***—National progress has been achieved in the treatment of patients with ST-segment–elevation myocardial infarction who undergo primary percutaneous coronary intervention. **(*Circulation*. 2011;124:00-00.)**

AQ:3

**Key Words:** balloon dilation ■ myocardial infarction ■ percutaneous coronary intervention ■ reperfusion

The effectiveness of primary percutaneous coronary intervention (PCI) is highly dependent on its timeliness.[1–4] Clinical practice guidelines and practice guidelines recommend that the time from hospital arrival to mechanical reperfusion, the door-to-balloon (D2B) time, should be as short as possible and should not exceed 90 minutes.[5,6] In 2002, only a third of patients received primary PCI within 90 minutes, and a third underwent the procedure >2 hours after arriving at the hospital.[7] These lackluster times led to a national response; in September 2005, the Centers for Medicare & Medicaid Services (CMS) began to report publicly the percent of patients treated within recommended times. At the same time, federally funded research identified strategies and organizational factors that were strongly associated with shorter D2B times.[8–11] In November 2006, the American College of Cardiology (ACC), with national partners, launched the D2B Alliance, a national campaign to improve D2B times by advocating the adoption of key strategies that had been shown to reduce delays based on a study funded by the National Heart, Lung, and Blood Institute.[12] In May 2007, the American Heart Association (AHA) launched Mission: Lifeline, another national initiative to improve systems of care for patients with ST-segment–elevation myocardial infarction.[13]

**Clinical Perspective on p ●●●**

Although studies have reported improvements in D2B times during this period of national focus on improving the

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timeliness of primary PCI,[14,15] these reports, which assessed performance through the first quarter of 2008, were derived from hospitals participating in registries that represent a selected sample of the nation's hospitals. There has been no national assessment of the trends in D2B times, nor do we know whether improvements in D2B times were shared equally among patient and hospital groups.

Accordingly, we evaluated data submitted to CMS as part of its initiative to report indicators of quality for patients with an acute myocardial infarction. The latest published report from the CMS data included data up until the second quarter of 2004.[16] We sought to determine how performance on this measure had changed from 2005 through 2010, with a focus on D2B times and the percent of patients who were treated in <90 minutes and in <75 minutes. We also evaluated the trends among hospitals defined by their bed size, geographic region, ownership, urban or rural location, and volume of patients with PCI that they reported for this measure. This study represents the most contemporary, comprehensive, nationally representative investigation of the changes in D2B times in the United States.

## Methods

### Patient Population

This analysis includes all patients reported by hospitals to CMS for inclusion in the time to PCI (acute myocardial infarction-8) inpatient measure from January 1, 2005, through September 30, 2010. Hospitals with at least 5 acute myocardial infarction inpatient admissions during a quarter must report to CMS or face a financial penalty. Hospitals may exclude patients through sampling, depending on the number of patients eligible, and the minimum number required to be reported has changed over time. Sampling is mandated by CMS to be either simple random or sequential random, and hospitals that sample for at least 1 quarter must report that they sampled for that year; this is enforced through an additional mandate to use a measurement system certified by The Joint Commission.[17] The percentage of hospitals that sampled was generally stable over the study period, with the largest number (percentage) being 252 of 4085 (6.2%) in 2005 and the smallest number being 173 of 3780 (4.6%) in 2010. The inclusion and exclusion criteria for this measure and the sampling and reporting criteria are publicly available.[17] During the period of the study, there were some changes in the measure regarding exclusion criteria; the major change occurred in 2006 when patients were allowed to be excluded if there was a nonclinical reason for the delay (acute myocardial infarction-8 exclusions; see the online-only Data Supplement). To increase the likelihood that we were assessing patients receiving primary PCI, we excluded patients with times >6 hours.

### Patient Variables

For each patient included in the measure, there is information about age, sex, and racial/ethnic group (white, black, other, unknown).

### Hospital Variables

We classified each hospital that reported at least 25 patients during any year for the measure according to size (number of beds), Census region, ownership (government, for profit, and nonprofit), location (rural or urban), and number of patients treated with PCI, as submitted by the hospital. For 2010, we repeated the analysis with hospitals that reported at least 20 patients because we only had 3 quarters of data. Information about hospitals was taken from the Program Resource System, a national provider database maintained by CMS and the Quality Improvement Organizations.

### Analysis

For each year, we summarized the characteristics of patients, including the number and percentage in each group, the median time to primary PCI, and the percentage with time to primary PCI within 75 minutes and within 90 minutes for each group.

For each year, we summarized hospital characteristics, number of patients reported, and percentage of hospitals in each group. For each year, we also calculated the median and range of hospital median time to PCI, average of hospital percentage of patients treated within 90 minutes and within 75 minutes, and the interquartile range for each of these. We graphed the summary measure of percent <90 minutes and <75 minutes over the 6-year period for all patients included in the study.

We conducted the analyses with SAS version 9.1.3 (2004; SAS Institute Inc, Cary, NC) and Stata version 11.1 (2010; Stata Corp, College Station, TX). The Human Investigation Committee at the Yale University School of Medicine approved an exemption for the authors to use CMS claims and enrollment data for research analyses and publication; informed consent was not required.

## Results

During the 6-year period, the number of patients was fairly constant, ranging between 48 977 and 53 682 (Table 1), with 42 150 reported during the 3 quarters of 2010. The number of hospitals that reported at least 25 patients increased slightly from 896 to 973, with 764 reporting 25 patients for the first 3 quarters of 2010 (Table 2). T1AQ:4 T2

### Patient Door-to-Balloon Times

Median D2B times declined 32 minutes over the 6-year period from a median of 96 minutes in the year ending December 31, 2005, to a median of 64 minutes in the year ending September 30, 2010 (Table 1). The declines in median times were greatest among groups that had the highest median times during the first period: patients >75 years of age (median decline, 38 minutes), women (35 minutes), and blacks (42 minutes). There were corresponding increases in the percentage of patients who had D2B times of <90 minutes (44.2% to 91.4%) and <75 minutes (27.3% to 70.4%; Figures 1 and 2). F1–2

### Hospital Median Door-to-Balloon Times

Hospital median D2B times declined over the 6-year period from a median of 97 minutes in 2005 to a median of 64 minutes in 2010 (Table 2). The declines were greatest among groups of hospitals that had the longest times in the first year: hospitals with ≥500 beds (median hospital time declined 34 minutes), for-profit hospitals (declined 38 minutes), and hospitals in the East South Central and Mid Atlantic Census regions (40- and 35-minute declines, respectively). There was a corresponding increase in the hospital average percent of patient D2B times <90 minutes (from 44% to 92%) and <75 minutes (from 27% to 71%). The results from 2010 were similar if we restricted the required number of cases to 20.

## Discussion

The study demonstrates the national progress in the treatment of patients with ST-segment–elevation myocardial infarction who undergo primary PCI. Median patient D2B times decreased substantially from 96 to 64 minutes, a drop of 32 minutes, over the 6 years ending in mid-2010.

**Table 1. Median Time to Percutaneous Coronary Intervention and Percent Treated Within 90 and 75 Minutes for Patients Reported to Centers for Medicare & Medicaid Services From January 1, 2005, to September 30, 2010, by Patient Characteristics**

| | 2005 | | | | 2006 | | | |
|---|---|---|---|---|---|---|---|---|
| | n (%) | Median (IQR) | <90 min, % | <75 min, % | n (%) | Median (IQR) | <90 min, % | <75 min, % |
| Total | 48 977 (100) | 96 (73–126) | 44.2 | 27.3 | 52 028 (100) | 86 (67–113) | 55.2 | 35.7 |
| Age, y | | | | | | | | |
| 18–35 | 684 (1.4) | 99 (77–131) | 40.9 | 23.5 | 763 (1.5) | 92 (73–125) | 48.6 | 29.0 |
| 36–45 | 5133 (10.5) | 93 (72–121) | 47.0 | 28.5 | 5346 (10.3) | 85 (66–110) | 56.6 | 36.5 |
| 46–55 | 12 686 (25.9) | 93 (71–120) | 47.3 | 29.5 | 13 864 (26.6) | 84 (65–108) | 58.8 | 38.5 |
| 56–65 | 13 576 (27.7) | 94 (72–122) | 46.2 | 28.8 | 14 803 (28.5) | 85 (65–110) | 57.2 | 37.3 |
| 66–75 | 9205 (18.8) | 98 (74–130) | 42.3 | 26.2 | 9372 (18.0) | 88 (67–116) | 53.2 | 34.8 |
| ≥76 | 7693 (15.7) | 105 (79–139) | 36.0 | 21.8 | 7880 (15.1) | 93 (72–123) | 47.2 | 28.8 |
| Sex | | | | | | | | |
| Female | 14 039 (28.7) | 102 (77–135) | 38.6 | 23.3 | 14 611 (28.1) | 91 (71–120) | 49.5 | 30.3 |
| Male | 34 935 (71.3) | 94 (72–122) | 46.4 | 28.9 | 37 410 (71.9) | 85 (65–110) | 57.4 | 37.8 |
| Unknown | 3 (0.0) | 63 (24–94) | 66.7 | 66.7 | 7 (0.0) | 70 (55–102) | 71.4 | 57.1 |
| Race | | | | | | | | |
| Black | 3543 (7.2) | 111 (83–148) | 31.4 | 18.2 | 3819 (7.3) | 97 (75–130) | 44.3 | 25.9 |
| Other | 2430 (5.0) | 103 (77–136) | 38.5 | 23.4 | 1184 (2.3) | 90 (67–121) | 50.8 | 35.3 |
| Unknown | 3292 (6.7) | 91 (67–121) | 49.4 | 33.0 | 3133 (6.0) | 84 (63–111) | 58.4 | 39.7 |
| White | 39 712 (81.1) | 95 (73–124) | 45.2 | 27.9 | 43 892 (84.4) | 86 (66–111) | 56.1 | 36.2 |
| | **2007** | | | | **2008** | | | |
| | n (%) | Median (IQR) | <90 min, % | <75 min, % | n (%) | Median (IQR) | <90 min, % | <75 min, % |
| Total | 51 298 (100) | 76 (59–93) | 72.6 | 49.8 | 53 032 (100) | 71 (55–86) | 82.0 | 58.7 |
| Age, y | | | | | | | | |
| 18–35 | 690 (1.3) | 81 (64–107) | 64.6 | 40.0 | 737 (1.4) | 73 (57–89) | 76.8 | 53.9 |
| 36–45 | 5197 (10.1) | 75 (58–92) | 73.5 | 51.0 | 5292 (10.0) | 70 (56–85) | 82.8 | 59.4 |
| 46–55 | 13 965 (27.2) | 74 (58–90) | 75.6 | 52.4 | 14 140 (26.7) | 69 (54–84) | 84.1 | 61.3 |
| 56–65 | 14 762 (28.8) | 75 (58–91) | 74.4 | 51.6 | 15 517 (29.3) | 69 (54–85) | 83.4 | 60.4 |
| 66–75 | 9179 (17.9) | 77 (60–96) | 70.5 | 47.7 | 9490 (17.9) | 71 (55–87) | 80.2 | 57.3 |
| ≥76 | 7505 (14.6) | 80 (62–101) | 66.3 | 43.9 | 7856 (14.8) | 74 (58–89) | 77.5 | 52.5 |
| Sex | | | | | | | | |
| Female | 14 099 (27.5) | 79 (62–99) | 68.1 | 44.8 | 14 456 (27.3) | 73 (58–88) | 78.4 | 54.1 |
| Male | 37 196 (72.5) | 74 (58–91) | 74.3 | 51.7 | 38 574 (72.7) | 70 (54–85) | 83.3 | 60.4 |
| Unknown | 3 (0.0) | 84 (36–87) | 100.0 | 33.3 | 2 (0.0) | 52 (45–58) | 100.0 | 100.0 |
| Race | | | | | | | | |
| Black | 3875 (7.6) | 82 (65–106) | 63.5 | 39.8 | 4137 (7.8) | 76 (61–90) | 75.5 | 49.1 |
| Other | 1257 (2.5) | 78 (60–97) | 69.3 | 48.1 | 1338 (2.5) | 72 (57–86) | 80.6 | 56.4 |
| Unknown | 3089 (6.0) | 74 (57–91) | 74.8 | 52.2 | 3166 (6.0) | 69 (53–84) | 83.3 | 61.2 |
| White | 43 077 (84.0) | 75 (58–93) | 73.4 | 50.6 | 44 391 (83.7) | 70 (55–85) | 82.5 | 59.5 |
| | **2009** | | | | **2010*** | | | |
| | n (%) | Median (IQR) | <90 min, % | <75 min, % | n (%) | Median (IQR) | <90 min, % | <75 min, % |
| Total | 53 682 (100) | 67 (52–81) | 87.9 | 65.8 | 42 150 (100) | 64 (50–78) | 91.4 | 70.4 |
| Age, y | | | | | | | | |
| 18–35 | 717 (1.3) | 70 (56–87) | 79.9 | 57.7 | 592 (1.4) | 69 (53–84) | 85.5 | 63.2 |
| 36–45 | 5103 (9.5) | 67 (52–81) | 89.3 | 66.5 | 3821 (9.1) | 64 (51–78) | 91.1 | 71.1 |
| 46–55 | 14 546 (27.1) | 66 (51–80) | 89.6 | 68.2 | 10 991 (26.1) | 63 (49–77) | 92.5 | 72.5 |
| 56–65 | 15 648 (29.1) | 66 (51–80) | 88.9 | 68.1 | 12 639 (30.0) | 63 (49–77) | 92.1 | 72.0 |
| 66–75 | 9727 (18.1) | 68 (52–82) | 86.6 | 63.9 | 7794 (18.5) | 65 (50–79) | 91.2 | 69.7 |
| ≥76 | 7941 (14.8) | 70 (55–85) | 84.1 | 59.1 | 6313 (15.0) | 67 (53–82) | 88.8 | 64.7 |

(Continued)

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**Table 1. Continued**

| | 2005 | | | | 2006 | | | |
|---|---|---|---|---|---|---|---|---|
| | n (%) | Median (IQR) | <90 min, % | <75 min, % | n (%) | Median (IQR) | <90 min, % | <75 min, % |
| Sex | | | | | | | | |
| Female | 14 586 (27.2) | 69 (55–84) | 84.8 | 61.3 | 11 531 (27.4) | 67 (52–81) | 89.1 | 66.3 |
| Male | 39 094 (72.8) | 66 (51–80) | 89.0 | 67.4 | 30 618 (72.6) | 63 (49–77) | 92.2 | 71.9 |
| Unknown | 2 (0.0) | 75 (58–91) | 50.0 | 50.0 | 1 (0.0) | 55 (55–55) | 100.0 | 100.0 |
| Race | | | | | | | | |
| Black | 4153 (7.7) | 71 (56–86) | 82.4 | 57.5 | 3203 (7.6) | 69 (55–83) | 86.6 | 61.7 |
| Other | 1440 (2.7) | 68 (53–82) | 87.4 | 63.6 | 1169 (2.8) | 65 (52–79) | 91.4 | 69.9 |
| Unknown | 3209 (6.0) | 66 (51–81) | 88.0 | 67.0 | 2530 (6.0) | 65 (51–79) | 90.9 | 70.8 |
| White | 44 880 (83.6) | 66 (52–81) | 88.4 | 66.5 | 35 248 (83.6) | 64 (50–78) | 91.8 | 71.2 |

IQR indicates interquartile range

*For 2010, only the first 3 quarters (discharges from January through September) were available at the time of analysis.

representing a >30% relative decline. This improvement, experienced across the country and across different types of hospitals, represents a remarkable elevation in practice that was achieved over a relatively short period of time and in the absence of financial incentive. The accomplishment is truly a tribute to interventional cardiologists, emergency medicine physicians, nurses, technologists, and other team members nationwide who were dedicated to improving D2B times.

The perspective on D2B times changed dramatically over this period. The 2004 ST-segment–elevation myocardial infarction guidelines recommended that patients be treated with primary PCI within 90±30 minutes.[18] The caveat of the additional 30 minutes was included as a compromise in response to controversy about whether it was possible for hospitals to routinely treat patients with ST-segment–elevation myocardial infarction within 90 minutes. The publication of the 2004 guidelines was followed by a shift toward the 90-minute standard. Nallamothu and colleagues[1] published a study based on trials of the relationship between D2B time and the advantage of primary PCI over fibrinolytic therapy. They found that if primary PCI was delayed >1 hour beyond the time that fibrinolytic therapy could be provided, the advantage was lost. Thus, if fibrinolytic therapy was recommended to be given within 30 minutes, then the provision of primary PCI within 90 minutes was supported by evidence from the trials. In the guideline update published in 2007, the additional 30 minutes was removed, altering the recommendation for D2B time to <90 minutes.[6] The CMS measure, which initially reported the percent of patients treated within 120 minutes, was subsequently reduced to 90 minutes in 2006 to align the performance measure with the new guideline recommendation.[17]

The improvement in D2B times that we observed cannot be definitively attributed to any single action; many activities likely contributed. During this period, multiple national efforts focused attention on timeliness of D2B and supported quality improvement. Published articles that revealed gaps in care and indicated strategies that were associated with faster times contributed to clinical changes in performance. A study sponsored by the National Institutes of Health used a mixed-methods approach to examine exceptional performers and then test hypotheses that derived from their experience.[7–10,19] The CMS developed contracts with Quality Improvement Organizations that contributed to the increasing focus on improving various aspects of acute myocardial infarction care, including D2B times. Hospital groups and consortia focused on improving D2B times. The performance of the nation's hospitals in treating patients with ST-segment–elevation myocardial infarction was further highlighted by the release of the publicly reported D2B time measures by CMS, and the D2B Alliance and Mission: Lifeline, national campaigns by the ACC and the AHA, enlisted clinicians and hospitals in a broad-based effort to reduce delays.[12,13]

Improvement in D2B times demonstrates how emerging science on improving care can be rapidly integrated into practice. The ACC campaign was launched simultaneously with the publication of an article in the *New England Journal of Medicine* that described strategies associated with faster times.[9] The ACC campaign promoted the adoption of such strategies, which were shown to be underused nationally. Recent reports demonstrated the marked integration of these strategies into practice that occurred during the period of the campaign.[14] Moreover, a recent qualitative study showed that the credibility of the campaign was related to the strength of the science and the clarity of the recommendations.[20]

Despite the recent gains, additional opportunities for improvement in D2B times remain. The most outstanding institutions are now regularly achieving exceptional times of ≈60 minutes through strategies including coordination with Emergency Medical Services and the collection and dissemination of a prehospital ECG.[21–23] This level of performance may become the new standard.

Another opportunity for improvement is related to the care of transfer patients. Prior studies have shown that many patients who are transferred from a hospital without PCI capability to a PCI-capable institution experience long delays in treatment.[24,25] To address this concern, CMS is collecting a measure, with potential to be publicly re-

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**Table 2. Acute Myocardial Infarction-8: Median Hospital Door-to-Balloon Time and Mean Hospital Percent <90 and <75 Minutes by Hospital Characteristics**

| | 2005 | | | | 2006 | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Mean (IQR) | | | | Mean (IQR) | |
| | n (%) | Median (IQR) | <90 min, % | <75 min, % | n (%) | Median (IQR) | <90 min, % | <75 min, % |
| Total | 896 (100.0) | 97 (87–108) | 44 (31–56) | 27 (15–35) | 934 (100.0) | 87 (77–98) | 55 (41–69) | 35 (21–47) |
| Bed size, n | | | | | | | | |
| <300 | 282 (31.5) | 94 (84–105) | 46 (33–58) | 29 (17–38) | 306 (32.8) | 85 (76–97) | 57 (42–72) | 37 (22–50) |
| 300–499 | 327 (36.5) | 97 (88–108) | 43 (30–53) | 26 (15–32) | 354 (37.9) | 88 (79–99) | 53 (41–67) | 33 (21–45) |
| ≥500 | 287 (32.0) | 98 (87–111) | 43 (29–56) | 27 (14–35) | 274 (29.3) | 87 (77–99) | 54 (39–68) | 36 (22–48) |
| Census region | | | | | | | | |
| East North Central | 161 (18.0) | 95 (85–106) | 46 (33–58) | 28 (17–35) | 169 (18.1) | 85 (76–95) | 58 (43–72) | 37 (24–49) |
| East South Central | 66 (7.4) | 104 (92–114) | 40 (29–50) | 25 (12–32) | 66 (7.1) | 89 (82–99) | 51 (39–62) | 33 (23–41) |
| Middle Atlantic | 104 (11.6) | 102 (88–112) | 40 (27–53) | 24 (14–33) | 114 (12.2) | 90 (81–100) | 52 (39–66) | 33 (21–42) |
| Mountain | 76 (8.5) | 93 (82–107) | 45 (31–59) | 29 (13–41) | 81 (8.7) | 86 (76–101) | 54 (39–71) | 35 (17–51) |
| New England | 31 (3.5) | 96 (82–101) | 47 (36–58) | 30 (19–40) | 36 (3.9) | 83 (77–93) | 59 (47–71) | 39 (27–49) |
| Pacific | 121 (13.5) | 95 (83–107) | 45 (30–58) | 29 (15–40) | 119 (12.7) | 85 (76–99) | 55 (42–70) | 35 (19–49) |
| South Atlantic | 145 (16.2) | 99 (91–109) | 41 (31–49) | 25 (15–32) | 152 (16.3) | 89 (79–100) | 53 (40–66) | 33 (21–44) |
| West North Central | 78 (8.7) | 90 (79–99) | 53 (40–68) | 34 (19–45) | 79 (8.5) | 79 (70–88) | 65 (53–79) | 44 (25–58) |
| West South Central | 113 (12.6) | 99 (92–112) | 40 (27–49) | 24 (14–31) | 118 (12.6) | 91 (81–104) | 49 (33–65) | 30 (16–43) |
| US territories | 1 (0.1) | 166 (166–166) | 5 (5–5) | 5 (5–5) | 0 (0.0) | NA | NA | NA |
| Ownership | | | | | | | | |
| Government | 119 (13.3) | 98 (86–109) | 43 (32–57) | 27 (16–37) | 113 (12.1) | 86 (76–96) | 55 (44–71) | 36 (22–49) |
| For profit | 127 (14.2) | 100 (91–113) | 39 (27–50) | 23 (13–31) | 134 (14.3) | 91 (80–102) | 50 (36–65) | 31 (17–43) |
| Nonprofit | 650 (72.5) | 96 (85–107) | 45 (31–57) | 28 (15–36) | 687 (73.6) | 86 (77–97) | 56 (41–69) | 36 (22–48) |
| Location | | | | | | | | |
| Rural | 61 (6.8) | 93 (83–104) | 47 (35–61) | 30 (18–39) | 64 (6.9) | 83 (76–95) | 58 (46–70) | 40 (30–50) |
| Urban | 834 (93.1) | 97 (87–109) | 43 (31–56) | 27 (15–35) | 869 (93.0) | 87 (77–98) | 54 (40–69) | 35 (21–47) |
| Unknown | 1 (0.1) | 68 (68–68) | 72 (72–72) | 57 (57–57) | 1 (0.1) | 63 (63–63) | 74 (74–74) | 64 (64–64) |
| Reported cases, n | | | | | | | | |
| 25–35 | 266 (29.7) | 101 (88–116) | 40 (27–53) | 25 (13–33) | 285 (30.5) | 91 (80–106) | 50 (33–66) | 31 (17–43) |
| 36–50 | 276 (30.8) | 95 (87–106) | 44 (32–55) | 28 (16–35) | 306 (32.8) | 88 (79–97) | 54 (41–67) | 34 (21–45) |
| >50 | 354 (39.5) | 96 (84–106) | 46 (33–58) | 28 (16–39) | 343 (36.7) | 83 (76–93) | 60 (47–73) | 40 (27–50) |

| | 2007 | | | | 2008 | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Mean (IQR) | | | | Mean (IQR) | |
| | n (%) | Median (IQR) | <90 min, % | <75 min, % | n (%) | Median (IQR) | <90 min, % | <75 min, % |
| Total | 936 (100.0) | 75 (69–83) | 73 (63–85) | 50 (36–63) | 956 (100.0) | 71 (64–77) | 82 (75–92) | 59 (48–71) |
| Bed size, n | | | | | | | | |
| <300 | 310 (33.1) | 75 (69–84) | 73 (62–86) | 49 (36–63) | 329 (34.4) | 71 (65–79) | 81 (73–92) | 57 (44–71) |
| 300–499 | 358 (38.2) | 76 (69–83) | 73 (64–85) | 49 (37–62) | 357 (37.3) | 71 (64–76) | 83 (76–93) | 59 (48–71) |
| ≥500 | 268 (28.6) | 75 (67–83) | 73 (63–85) | 50 (38–63) | 270 (28.2) | 70 (64–76) | 82 (76–92) | 60 (49–71) |
| Census region | | | | | | | | |
| East North Central | 164 (17.5) | 75 (68–82) | 73 (65–85) | 51 (38–64) | 175 (18.3) | 71 (64–77) | 82 (75–93) | 59 (47–72) |
| East South Central | 71 (7.6) | 79 (72–84) | 71 (64–81) | 46 (33–57) | 66 (6.9) | 71 (66–78) | 83 (78–93) | 58 (49–69) |
| Middle Atlantic | 112 (12.0) | 77 (71–84) | 71 (59–83) | 47 (36–58) | 121 (12.7) | 72 (66–76) | 81 (73–90) | 57 (50–67) |
| Mountain | 80 (8.5) | 75 (68–86) | 72 (59–87) | 48 (33–62) | 85 (8.9) | 74 (66–80) | 80 (71–90) | 54 (43–67) |
| New England | 41 (4.4) | 71 (64–79) | 78 (66–86) | 56 (42–63) | 39 (4.1) | 66 (62–74) | 84 (79–94) | 63 (56–74) |
| Pacific | 121 (12.9) | 73 (67–80) | 75 (68–85) | 52 (40–66) | 130 (13.6) | 71 (64–75) | 84 (78–92) | 60 (51–73) |
| South Atlantic | 159 (17.0) | 76 (71–84) | 73 (63–86) | 49 (36–61) | 166 (17.4) | 71 (64–77) | 83 (76–92) | 59 (47–70) |
| West North Central | 75 (8.0) | 70 (62–76) | 82 (75–92) | 60 (48–72) | 70 (7.3) | 65 (59–71) | 88 (84–94) | 69 (60–81) |
| West South Central | 113 (12.1) | 78 (72–88) | 68 (56–84) | 44 (30–56) | 104 (10.9) | 73 (66–80) | 79 (71–90) | 55 (42–66) |
| US territories | 0 (0.0) | NA | NA | NA | 0 (0.0) | NA | NA | NA |

*(Continued)*

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**Table 2. Continued**

| | 2005 | | | | 2006 | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Mean (IQR) | | | | Mean (IQR) | |
| | n (%) | Median (IQR) | <90 min, % | <75 min, % | n (%) | Median (IQR) | <90 min, % | <75 min, % |
| Ownership | | | | | | | | |
| Government | 119 (12.7) | 77 (69–86) | 70 (61–84) | 47 (33–61) | 125 (13.1) | 71 (64–77) | 81 (73–93) | 59 (45–73) |
| For profit | 129 (13.8) | 76 (70–86) | 72 (58–85) | 47 (32–61) | 139 (14.5) | 71 (65–79) | 83 (77–93) | 58 (44–70) |
| Nonprofit | 688 (73.5) | 75 (69–82) | 74 (64–86) | 51 (38–63) | 692 (72.4) | 70 (64–76) | 82 (76–92) | 59 (49–71) |
| Location | | | | | | | | |
| Rural | 74 (7.9) | 75 (71–82) | 73 (64–83) | 49 (38–61) | 75 (7.8) | 69 (65–73) | 82 (76–92) | 61 (52–75) |
| Urban | 862 (92.1) | 75 (69–84) | 73 (63–85) | 50 (36–63) | 881 (92.2) | 71 (64–77) | 82 (75–92) | 59 (47–71) |
| Unknown | 0 (0.0) | NA | NA | NA | 0 (0.0) | NA | NA | NA |
| Reported cases, n | | | | | | | | |
| 25–35 | 295 (31.5) | 77 (70–87) | 70 (59–85) | 46 (31–60) | 299 (31.3) | 73 (65–79) | 80 (72–92) | 55 (43–68) |
| 36–50 | 331 (35.4) | 77 (69–85) | 72 (62–85) | 49 (36–62) | 323 (33.8) | 71 (65–77) | 82 (74–92) | 58 (48–70) |
| >50 | 310 (33.1) | 73 (67–79) | 77 (68–86) | 54 (43–65) | 334 (34.9) | 68 (63–74) | 85 (80–93) | 62 (52–73) |

| | 2009 | | | | 2010* | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Mean (IQR) | | | | Mean (IQR) | |
| | n (%) | Median (IQR) | <90 min, % | <75 min, % | n (%) | Median (IQR) | <90 min, % | <75 min, % |
| Total | 973 (100.0) | 67 (61–73) | 88 (84–96) | 66 (56–76) | 764 (100.0) | 64 (58–70) | 92 (89–98) | 71 (63–82) |
| Bed size, n | | | | | | | | |
| <300 | 347 (35.7) | 67 (62–72) | 88 (84–96) | 65 (57–76) | 250 (32.7) | 64 (59–70) | 92 (89–98) | 71 (63–81) |
| 300–499 | 357 (36.7) | 67 (61–73) | 88 (84–96) | 66 (56–76) | 289 (37.8) | 65 (59–70) | 92 (89–98) | 71 (63–81) |
| ≥500 | 269 (27.6) | 66 (61–72) | 88 (83–95) | 66 (56–77) | 225 (29.5) | 64 (58–69) | 92 (88–98) | 72 (63–82) |
| Census region | | | | | | | | |
| East North Central | 169 (17.4) | 68 (62–72) | 89 (85–96) | 67 (57–76) | 137 (17.9) | 65 (58–70) | 92 (89–97) | 72 (64–84) |
| East South Central | 63 (6.5) | 68 (62–72) | 88 (84–96) | 65 (54–77) | 52 (6.8) | 64 (58–68) | 94 (91–98) | 74 (68–81) |
| Middle Atlantic | 127 (13.1) | 69 (64–75) | 86 (80–92) | 61 (52–71) | 96 (12.6) | 67 (61–72) | 90 (86–95) | 67 (60–76) |
| Mountain | 85 (8.7) | 69 (64–74) | 87 (83–95) | 62 (55–71) | 63 (8.2) | 63 (57–70) | 92 (89–97) | 71 (62–82) |
| New England | 37 (3.8) | 62 (58–71) | 90 (87–96) | 71 (62–81) | 27 (3.5) | 62 (58–66) | 93 (89–97) | 72 (65–79) |
| Pacific | 131 (13.5) | 66 (62–72) | 88 (83–95) | 67 (58–76) | 100 (13.1) | 64 (59–69) | 93 (89–99) | 72 (64–81) |
| South Atlantic | 175 (18.0) | 66 (60–72) | 88 (85–97) | 67 (57–78) | 152 (19.9) | 63 (58–68) | 92 (88–99) | 73 (64–82) |
| West North Central | 75 (7.7) | 63 (58–69) | 92 (88–97) | 73 (63–84) | 54 (7.1) | 60 (55–65) | 93 (89–100) | 76 (68–84) |
| West South Central | 110 (11.3) | 68 (63–74) | 87 (81–96) | 63 (54–74) | 83 (10.9) | 66 (61–73) | 92 (88–100) | 68 (59–80) |
| US territories | 1 (0.1) | 102 (102–102) | 38 (38–38) | 17 (17–17) | 0 (0.0) | NA | NA | NA |
| Ownership | | | | | | | | |
| Government | 136 (14.0) | 68 (62–74) | 86 (80–94) | 64 (54–76) | 101 (13.2) | 65 (59–70) | 91 (86–97) | 71 (62–82) |
| For profit | 138 (14.2) | 65 (61–72) | 91 (87–98) | 67 (58–78) | 109 (14.3) | 62 (58–69) | 95 (94–100) | 75 (67–85) |
| Nonprofit | 699 (71.8) | 67 (61–73) | 88 (84–95) | 66 (56–76) | 554 (72.5) | 65 (58–70) | 92 (88–98) | 71 (63–81) |
| Location | | | | | | | | |
| Rural | 83 (8.5) | 66 (60–70) | 86 (81–96) | 67 (60–78) | 57 (7.5) | 63 (58–69) | 92 (88–97) | 73 (64–84) |
| Urban | 890 (91.5) | 67 (61–73) | 88 (84–96) | 66 (56–76) | 707 (92.5) | 64 (58–70) | 92 (89–98) | 71 (63–81) |
| Unknown | 0 (0.0) | NA | NA | NA | 0 (0.0) | NA | NA | NA |
| Reported cases, n | | | | | | | | |
| 25–35 | 300 (30.8) | 69 (64–75) | 87 (81–96) | 63 (52–73) | 358 (46.9) | 65 (59–72) | 92 (88–100) | 70 (60–81) |
| 36–50 | 355 (36.5) | 67 (62–73) | 88 (84–96) | 65 (55–76) | 244 (31.9) | 64 (59–69) | 92 (88–98) | 71 (64–80) |
| >50 | 318 (32.7) | 65 (59–70) | 89 (85–96) | 69 (61–79) | 162 (21.2) | 61 (55–67) | 94 (91–98) | 76 (68–85) |

IQR indicates interquartile range.

*For 2010, only the first 3 quarters (discharges from January through September) were available at the time of analysis.

ported, that assesses the time required to transfer such patients.[17] More important, current research shows that these times can be reduced through greater coordination between hospitals.[26,27]

A limitation of this assessment is the evolution of the measure over the study period, with modifications related primarily to the exclusion criteria. The most notable change occurred in 2006 and allowed hospitals to exclude

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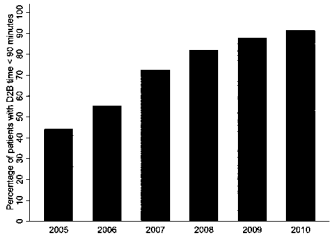


**Figure 1.** Trend in percentage of patients with door-to-balloon (D2B) time <90 minutes over 6 years.

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patients on the basis of the judgment that a D2B time >90 minutes was the result of a delay incurred by patient preference or clinical condition. Subsequent changes included minor alterations in the codes or slight expansions in the exclusion criteria. However, the dramatic decline in D2B times that was observed over the study period is unlikely to have resulted from changes in the measure. Moreover, the greatest decline occurred between 2006 and 2007, a period corresponding to the initiation of national campaigns to improve D2B times. Finally, our results are aligned with those of registries that documented trends in D2B times and applied consistent criteria over time.

## Conclusions

We document remarkable improvement in D2B times from 2005 through 2010. The improvement demonstrates the results that can be produced by collaboration among healthcare professionals, hospitals, federal research agencies, and national organizations interested in patient care toward the achievement of a shared goal. The focus on improving the way in which care is delivered—improving the systems—has yielded more timely care for patients and serves as a template for similar contemporary and future efforts in areas such as readmission.

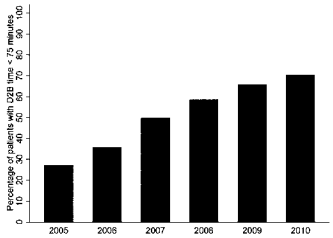


**Figure 2.** Trend in percentage of patients with door-to-balloon (D2B) time <75 minutes over 6 years.

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## Disclosures

Dr Krumholz reports that he chairs a cardiac scientific advisory board for UnitedHealth. The other authors report no conflicts.

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## CLINICAL PERSPECTIVE

In the United States, many groups, including the federal government, the American College of Cardiology, the American Heart Association, healthcare professionals, hospitals, emergency medical services, and the research community, have focused on improving door-to-balloon times for patients with ST-segment elevation myocardial infarction who are referred for an emergency percutaneous coronary intervention. We report the national experience in door-to-balloon times based on the Centers for Medicare & Medicaid Services' measure, which includes all patients of all ages. The door-to-balloon time declined from a median of 96 minutes in the year ending December 31, 2005, to a median of 64 minutes in the 3 quarters ending September 30, 2010. There were corresponding increases in the percentage of patients who had times <90 minutes (44.2% to 91.4%) and <75 minutes (27.3% to 70.4%). This improvement, experienced across the country and across different types of hospitals, represents a remarkable elevation in practice that was achieved over a relatively short period of time and in the absence of financial incentive. The improvement demonstrates the results that can be produced by collaboration among healthcare professionals, hospitals, and national organizations toward the achievement of a shared goal.

Chairman HERGER. Thank you.

Dr. Bender is recognized for five minutes.

**STATEMENT OF JOHN L. BENDER, M.D., PRESIDENT AND CEO, MIRAMONT FAMILY MEDICINE, FORT COLLINS, COLORADO**

Dr. BENDER. Thank you, Chairman Herger and distinguished Members of the Subcommittee on Health. I am Dr. John Bender. I am a family physician in Fort Collins, Colorado, and I am CEO of Miramont Family Medicine, which is a network of patient-centered medical homes.

Now, in 2002, my wife Therese and I moved back to Larimer County, where we were from, and we purchased one of the oldest practices in Fort Collins, Colorado. They had been there for over 40 years, and were basically doing things the same as they had in the 1970s. They left me one computer and one employee. That was 10 years ago.

Today we have over 50 employees, 14 providers, including 8 physicians; we have over 80 computers and a centralized data center, serving four different parts of our state. And we have about 27,000 patients.

Now, during this same period of time in Larimer County, 34 primary care physicians closed their doors or stopped providing primary care services. Eight of these were actual bankruptcies. And yet at the same time, we saw a doubling in the number of emergency room beds and an increase by the number of emergency room physicians by 50 percent, suggesting that if patients didn't have a patient-centered medical home like myself, they were going to the emergency room at a later stage of their illness for a higher cost, increasing health care premiums for everyone across the state.

Now, how is it that Miramont was able to double in size, grow at 34 percent per year to the size that we achieved, in this economy while other family physicians were saying, I give up, and walking away? Well, part of it was, in 2007, we made the conscious decision that we were no longer going to just focus on volume.

We were going to make sure that we had a high-quality product that was safe and efficient, and believed that if we built the best product in the marketplace, that consumers would vote with their feet and we would be able to maintain our solvency—because, after all, I didn't want to be the 35th practice to close or the ninth physician to bankrupt.

So we pursued NCQA patient-centered medical home recognition. That is the National Committee of Quality Assurance. We achieved level 3, which is the highest level of patient-centered medical home. It basically meant that we, after a six-month audit period, were able to show improvements in our work flow and the way we retooled things so that we could deliver team-approached care.

We also had, for example, a patient portal, where patients could go online, look up their labs, see their clinic record. They could send me a HIPAA-compliant email, or they could schedule appointments. And we also conducted care coordination through the transitions of care, as people went from hospitals to nursing homes, et cetera.

Our next big break came in 2008 with the multi-payer patient-centered medical home pilot. This was the brainchild of Dr. Paul

Grundy and others at IBM, who had compelled the top payers in the United States, WellPoint, UnitedHealth Group, CIGNA, Aetna, and Humana, to test the patient-centered medical home model. It was based on some of the beliefs and work that Dr. Barbara Starfield had published 10 years earlier, suggesting that if we put an emphasis on primary care, we could bend the health cost curve.

So 17 pilots were selected. Miramont was one of them. It was convened under a group called the Health TeamWorks, and it was basically an alliance of payers, including insurers, employers, and physicians. We agreed on the quality metrics that we were going to track to show improvement on, and we also agreed on a three-tiered payment system based on fee-for-service, per-member-per-month fees, and pay for performance.

Now, fee-for-service was included, and I will tell you why. There was an understanding that volumes in primary care were actually too low, and if we were going to pull people out of emergency rooms and urgent care and other high-cost centers, we would have to incentivize primary care physicians in order to help them to build the capacity to see the increased volumes.

Per-member-per-month fees ensured that I was able to provide what was other non-revenue-generating activity such as having a diabetic nurse educator in-house, or a psychologist, and doing care coordination.

Then finally, pay-for-performance bonuses made certain that we just didn't report our metrics to a centralized data registry, but we were actually working to try to reach certain target goals to help improve our delivery of evidence-based medicine.

The results are in, and they are fabulous. UnitedHealth Group has told us that Miramont reduced hospital readmission rates by 83 percent compared with our peers. A year ago, the State Medicaid program joined the pilot, and they said that we have an ER utilization rate that is a negative 219 percent—negative 219 percent—compared with our peers.

So I call on the Subcommittee on Health of the Ways and Means Committee of the House of Representatives to compel the Department of Health and Human Services to immediately deploy the patient-centered medical home payment standard nationally in order to conserve the strength of the primary care workforce, in order to increase the quality of health care delivered to entitlement beneficiaries, and to also reverse the escalating costs that are burdening the American taxpayer by using a payment method, a payment standard, that has been proven and is now being adopted in the private sector.

Thank you.

[The prepared statement of Dr. Bender follows:]

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February 6, 2012

## Written Statement to the Health Subcommittee of the House of Representatives Ways and Means Committee, as requested by subcommittee Chairman Wally Herger

Thank you, Chairman Herger, Congressman Stark, and Members of the Subcommittee for this invitation to testify on programs that reward physicians who deliver high quality and efficient care.

**Section 1. Background on John L Bender, Miramont Family Medicine, and NCQA**

I, **John L. Bender, M.D., FAAFP** am a board-certified family medicine physician, a Fellow of the American Academy of Family Physicians, and the senior partner at Miramont Family Medicine based in Fort Collins, Colorado.

**Miramont Family Medicine** www.miramont.us is a network of four **Patient Centered Medical Homes** in northern Colorado delivering full spectrum primary care services in suburban and rural communities. Since 2002, Miramont has grown from one physician, one employee, and one computer in one location to 14 providers, 50 employees, 4 locations and over 80 computer workstations networked through an integrated data center, serving over 27,000 patients.

In 2008 Miramont received **NCQA** level III recognition for its Patient Centered Medical Home model and in 2010 won a national HiMSS Nicholas E. Davies Award of Excellence for outstanding achievement in the implementation and value from health information technology. In 2011, The Colorado Academy of Family Physicians Foundation named Miramont the Patient Centered Medical Home of the Year.

The **National Committee for Quality Assurance** is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality founded in 1990. The process for achieving NCQA level III required Miramont to devote significant time and capital investment in 2008, including the extensive documentation of having met 9 separate Standards each broken down into numerous separate Elements graded on a point system with a 100 total possible points. The Standards for being an NCQA recognized Patient Centered Medical Home at the time included such domains as patient tracking and database registry functionality, care management, patient self-management support, electronic prescribing, test tracking, and performance reporting of various evidence-based health care metrics (see attachment 1).

**Section 2. Background on the Multi-Payer Patient Centered Medical Home Pilot study.**

Interest by the private sector in the Patient Centered Medical Home delivery model began to grow at the beginning of the decade. As early as 2000, **Dr Paul Grundy, IBM Corporation's Global Director for IBM Healthcare Transformation,** recognized that the ongoing costs of health care for IBM's employees, including the legacy costs to its retirees, were the key driver to labor cost differentials between IBM's less competitive work force in the United States and its workforce abroad. Dr Grundy became a champion of the Patient Centered Medical Home at that time, and my information that follows is from personal conversations with him and attendance at speeches he gave. He realized that the cost of health care delivery to IBM's US workforce was close to $8,000 per person per year, nearly double what IBM was incurring in health care costs for developing nations and other nations abroad where it employed labor. At the same time, the World Health Organization was releasing data suggesting that the United States was only 37th in the world for important health care outcomes such as neonatal mortality and longevity. Dr Grundy used the health care purchasing power of IBM to compel a group of five large national commercial health insurers, (WellPoint/Anthem/Blue Cross Blue Shield, United Health Group, Humana, Cigna, and Aetna) to agree to test the Patient Centered Medical Home model in two statewide pilots. Dr Grundy believed that the profound erosion of the primary care workforce in America was the key driver to escalating costs confounded by poorer quality. He was also influenced by the work of **Barbara Starfield, MD, MPH, Distinguished Professor at John Hopkins University Schools of Public Health and Medicine,** whose landmarks studies demonstrated the cost containment abilities of properly designed primary care delivery systems.

The commercial health insurers agreed to participate in short term multi-payer pilots in two states, Colorado and Ohio (chosen as IBM has larger concentrations of employees here). Colorado's pilot launched first, convened under the title of **The Colorado Multi-Payer Patient Centered Medical Home Pilot project.** The convening organization, the Colorado Clinical Guidelines Collaborative (now known as **HealthTeamWorks** www.healthteamworks.org ), functioned as an alliance of employers, primary care physicians and commercial payers. The Collaborative reached an accord for incentives and payment structuring early on, and then followed the formula recommended by Dr Grundy, that is the three-legged model of Fee for Service (FFS), Per Member Per Month Fees (PMPM) and Pay for Performance (P4P).

**Fee For Service** was retained in deference to the understanding that volumes in primary care were lacking, and volumes incentives were needed to keep consumers out of high cost centers such as Emergency Departments by motivating Patient Centered Medical Homes to develop capacity to see these patients. **Per Member Per Month** fees were necessary to pay for the infrastructure needed in the Patient Centered Medical Home to deliver what is otherwise non—revenue generating activity, such as information technology (IT) enhancements like online patient portals that allow

consumers to access their own health information outside the physician's office, and care coordinators who could work deficiency lists and individually coordinate care with patients to get them to goal without a physician visit. **Pay For Performance** (P4P) payments were made to incentivize the PCMH to not only track and report metrics to a centralized registry, but to ensure motivation to improve quality over time. The self-reported data was chosen over historical claims data, which is fraught with error, yet prior to the pilot was the standard for commercial payers to rate physicians nationally. The payers agreed to let the PCMH pilots collect and report their own data, and over time the pilots learned workflow redesign that produced steady improvement in practice metrics. The metrics were tabulated monthly, then reported back to the practice alongside the other pilot practices, giving the PCMH feedback not only about their own progress, but peer comparison data. Higher performers were then allowed to share success strategies through a number of forums including quarterly collaboratives, where the payers, employers and PCMH representatives could meet face to face for a day or two to exchange information, and also bimonthly telephone conference calls. Finally, HealthTeamWorks used grant funding to provide onsite coaches who would meet weekly with staff onsite at the PCMH clinic to teach and develop workflow redesign strategies. These included implementing Toyota Production Model and PDSA (plan, do, study, act) type innovations as used in other industries. The shared activities between PCMH competitors were always conducted in accordance with Federal Trade Commission anti-trust rules, meaning there was no price fixing, etc. among suppliers, but rather only academic exchanges focused on quality rather than profits. Even the exact amounts paid as PMPM and P4P were kept confidential between the various PCMH pilots, and all contracts were awarded by individual Taxpayer Identification Number (TIN) by the commercial payers. There was never collective negotiating of rates by the physicians.

Over time, the pilots were able to demonstrate improvements in safety and efficiency as well as improved patient outcomes for various metrics, especially chronic disease management such as diabetes and heart/stroke patients. But what really made the Colorado pilot a success was its ability to demonstrate significant cost controls during the same two year period. This data, released privately by the payers to the pilots, now appears to have influenced the commercial payers in the way Dr Grundy and Dr Starfield envisioned. First, was the announcement that the payers would agree to extend the Colorado pilot rather than terminate it April 2012, as originally constructed. Second, was the national announcement by WellPoint, as reported in the Wall Street Journal, Friday January 27th, 2012, that "it will offer primary-care doctors a fee increase of around 10%, with the possibility of additional payments that could boost what they get for treating the patients it covers by as much as 50%". Aetna also committed in the same article to roll out payments later this year to primary care physicians who become certified as Patient Centered Medical Homes, botb payers evidently influenced by the results of the Colorado pilot (attachment 2).

**Section 3. Miramont Family Medicine – A case study of Workflow Redesign and Practice transformation in the Patient Centered Medical Home model.**

In 2002, Teresa and John Bender returned to Larimer County Colorado and purchased one of the oldest Family Medicine practices in Fort Collins. The selling sole proprietor, HG Carlson MD and his wife Jean, had run the practice much as they had since the 1970's. They had one additional employee who served as medical assistant, had several thousand paper charts but fewer and fewer active patients, and a single 386 IBM computer used only for billing purposes. John and Teresa found themselves offering a poor product in the health care marketplace. Problems included test results with slow turnaround times, high labor costs with much non-revenue generating activity and waste, no open appointments with little ability to respond to elasticity in demand, no clinical data management, barely any financial data management, high variability in patient experiences from day to day, illegible documentation, and a growing inability to compete with retail clinics, urgent care, emergency departments, etc.

Over the next 10 years, 34 primary care physicians would abandon providing primary care services in Larimer County, 8 of these being actual bankruptcies. During this same time the number of Emergency Department beds in Larimer County would double, and the number of Emergency Room physicians increased by 50%. Further economic pressures in the last two years would compel 169 physicians to abandon private practice and become part of a brand new hospital medical group, created by the local hospital system as their ACO health care delivery strategy that would rely on employed physicians, not independent physician groups.

Yet over the last 10 years, Miramont was able to grow at a rate of 30-34% per year, doubling in size every two years, to four locations in three separate communities with expanded hours including evenings and weekends, labor expansions to fourteen providers (8 physicians, 5 physician assistants, 1 nurse practitioner), fifty total employees, electronic charting, an online Patient Portal, NCQA III PCMH recognition, over 80 company computers operating in a terminal service environment with a centralized data center and 27,000 patients. Because Miramont produced growth while at the same time improving quality, efficiency and outcomes, the **Healthcare Information and Management Systems Society (HiMSS)** bestowed on Miramont a Nicholas E. Davies Award of Excellence for outstanding achievement in the implementation and value from health information technology in 2010.

The obvious question is how did Miramont achieve a rate of growth to be named the fourth fastest growing company in Northern Colorado in 2008 and 2010, while in the same economy virtually no other primary care physician group saw growth in Larimer County other than the hospital owned enterprises?

Miramont started with a leadership and a courage proposition. The leadership proposition was that the physician partners would focus their energies on new models of health care delivery, positioning themselves in the local economy as the choice that offered the most convenience and the highest value in the marketplace. Second, Miramont would function as a true business, not to "profiteer" off of our patients, but in recognizing that if we became the 35th office to shutter our doors or the 9th primary care physician to bankrupt in Larimer County, that we would not be able to truly meet our most important duty to our patients, which is the value of a long

term sustainable relationship with a family physician they trust. To do so, took courage, because it meant taking on risk and, taking on debt in the form of capital leases to build an expensive IT infrastructure from scratch while still initially operating in a cottage industry nearing the end of its product life cycle. At the time, there were no guarantees of Meaningful Use dollars, as the HITEC Act was not yet even signed.

In 2007 as I gave my inaugural speech as the incoming President of the Colorado Academy of Family Physicians, I compared the scenario to the restaurant business. At the Stanley Hotel in Estes Park, I told a group of 150 physicians, that like Paul Grundy who had likened the product he was buying as "garbage" that we in family medicine were analogous to a restaurant with "bad food". "What are you doing differently today in 2007 than was being done in your office in 1970?" I then asked them to imagine that if we were in the restaurant business, that we could not just raise the prices on our bad food to generate the investment capital to purchase new cooking equipment or to recruit a fancy Chef from out of state.

Miramont decided it would take money to make money and that the process starts with investing. We pledged that we would make Miramont safer, more efficient, and up to date and we would ensure our own profitability at all times in order that we could be there for our patients for many years to come. We would eliminate as much as possible non-revenue generating activity up until a time that the PCMH model would pay for us to do so. We would find ways to provide needed services in our house, in the free market health care system that we are given. We would find the best Electronic Health Record (EHR) and attain NCQA recognition for a Patient Centered Medical Home. We would build the best product we could in the marketplace such that consumers would choose us regardless of payer source. We would build systems of care that could survive and be profitable regardless of the uncertainty of new health care reform regulations at the state and national level, regardless of SGR threats, because those were not things we could control anyway.

In order to bring about workflow redesign, Miramont pursued multiple quality improvement resources. The first was to apply for and be accepted into the Colorado Multi-Payer Pilot project. Many more physician practices applied to the Colorado Clinical Guidelines Collaborative than there were seats available, but because Miramont had started on the NCQA journey one year earlier, we found ourselves properly positioned to be selected. In May of 2008 we achieved 96 of 100 possible NCQA recognition points and were awarded the highest level of PCMH recognition, level III, by NCQA. We adapted the full tenants of the Patient Centered Medical Home model, including team based approach to care, pre-visit planning (team huddles), registry reporting and review, and after-visit care coordination and test tracking. The work flow redesign was not easy. Some staff were not comfortable with computers, and resigned or were terminated after failing in house training programs. Physicians who did not adopt the new workflows had to be encouraged or later financially curtailed if metrics failed to improve, or if new workflows were not adopted. Customer satisfaction waned at times, as the new workflows oftentimes came with learning curves that initially interfered with wait times. Customers also would at times simply resent the change, especially if they were long term patients. Over time the culture change has led to proper expectation from

staff and patients about what digital medical records mean, and how best to use the technology to achieve goals. More and more customers and staff are now enamored with the progress that has become Miramont, rather than be wearied by the constant change.

**Section 4. Miramont Family Medicine – two years of metrics prove better patient outcomes and the ability to deflect the health care cost curve down.**

Attachment 3 is a sample of the monthly reports that Miramont creates and reports to HealthTeamWorks. There are 364 diabetic patients cared for as Miramont patients as of December 2011, only some of whom were seen in clinic or the hospital that month. In the third table, one can see that Miramont initially was only able to prove that a little over 40% of its diabetic patients had a current A1C laboratory test on file. Over time the metric improved to the target threshold of over 85%. Improving the metric required Miramont to manage population health, which in paper records was nearly impossible. By leveraging the ability to produce and monitor metrics over time, Miramont developed innovative strategies of its own such as adding in-house A1C testing, as well as adapting innovative recommendations from the consensus of other physicians participating in the PCMH pilot, like having standing orders whereby the medical assistant could order the A1C test under physician license as a part of an "order set" if a computer alert notified the medical assistant at check in that the patient was overdue for testing.

Workflow redesign also led Miramont to deploy a medical assistant checklist (Attachment 4). The checklist is color coded, so that if one of the items in red is missed, it can lead to an adverse patient outcome such as hospitalization or death. Blue coloring indicates that skipping the step will lead to inefficiencies later in the day. Green color coding indicates that recording the step is necessary for meeting quality standards that are paid for under the PCMH pilot program. The checklist was developed over a period of a couple of years. If a potentially avoidable poor patient outcome occurred, such as hospitalization or death, a workgroup would discuss the issue, and the checklist would then be revised to include additional or modified steps to help prevent a recurrence, much like an airline pilot would revise a checklist based on feedback from the National Transportation Safety Board.

Global cost reduction data was provided back to the PCMH pilots from the commercial payers in a manner previously unknown to the individual physicians. Although the "claims data silo" enabled some primary care physicians to know whether they cost a payer more, claims data did not disclose global patient care costs, nor could it tell if the extra medical losses a payer incurred by a specific PCMH translated to positive return on investment (ROI) for the global costs of care, especially in the form of decreased hospital or specialist utilization. The new global reports allowed for such analysis.

Attachment 5 is an example of a pilot composite report. By sharing data between groups, individual physicians and practices could be motivated more fully to improve weak metrics and sustain strong ones. Initially groups were hesitant to share data, citing concerns of how it might be portrayed or

even published. Other concerns included Federal Trade Commission violations for pooling and sharing data that might be perceived as collusion. Over time these fears were overcome, and the reality of having actual grades that the PCMH could review themselves and act upon translated into real improvements in quality for health care delivery at the local level.

Global costs for 523 Medicaid patients attributed to Miramont from Sept 2010 to Aug 2011 were provided to Miramont by the Colorado State Medicaid program. In Attachment 6, the total Global costs for the 523 beneficiaries was $6,084,478 or $11,633 per person, which is higher than the national average for all citizens, but less than the average for Medicaid beneficiaries. Note that ER utilization for Miramont patients was 178 total visits for the cohort, which is roughly 340 visits per 1,000 Medicaid beneficiaries. In comparison this is 219% below the state average for Medicaid (figure provided by Treo Analytics).

Attachment 7 demonstrates that the average Clinical Risk Grouping (CRG) for Miramont is around 1.4, meaning that despite the fact that Miramont patients are sicker than average, they cost the system less, and have better outcomes. In other words, Miramont's better numbers are not merely from having healthier patients, in fact Miramont appears to attract and retain sicker patients, but Miramont is able to create more health value for this same group over time compared with their peers.

Additional data from United Health Group shown privately to Miramont revealed that for the United Health Care beneficiaries attributed to Miramont, Miramont provided an 83% reduction in hospital readmission rates. Although relative data such as this was provided from time to time by the commercial payers to the pilots, it was generally done so as a slide presentation or some other method to prevent the data from being recorded or externally reported, in part out of the necessity of the commercial health insurer to maintain trade secret status. In general, the data showed Miramont that it decreased Emergency Room and Urgent Care utilization, reduced readmission rates, reduced global costs of care, and improved metrics over time. Individual commercial insurers would need to be contacted separately to provide this testimony to the subcommittee.

**Section 5 – Rural Health Care sustainability - scalability**

In 2008, a regional hospital system lost over $500,000 in one year maintaining a small clinic in the rural community of Wellington Colorado. The clinic was closed without almost any notice, and attempts to garner support for a replacement clinic from other multibillion dollar hospital health care systems in the region failed. No plans were forthcoming for state or Federal deployment of a community health center of Federally Qualified Health Center (FQHC). Within 48 hours of the clinics closing, however, Miramont was able as a small private sector enterprise to open a clinic just blocks from the old facility. Utilizing the workflow changes it was developing in the pilot, and scaling the technology of its centralized data center, within the first year the clinic was profitable, and by the end of year two construction was completed on a Small Business Administration (SBA) financed building complete with in-house laboratory, X-ray and drive through pharmacy. Patient centered services included a visiting Psychologist, Physical Therapist and Audiologist, as well as the addition of a

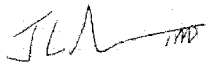
visiting Pediatrician and Obstetrician-Gynecologist. The clinic serves nearly 40% of the community's residents, and represents the only medical services within a 40 minute round trip drive to the community. Like all Miramont locations, it serves new Medicare and new Medicaid patients, and participates in the reporting of metrics to the PCMH Multi-payer Pilot Program. Miramont Wellington has one full time physician, and two physician assistants.

**Section 6- Summary**

In summary, the process of NCQA recognition and workflow redesign coaching made it possible for Miramont to develop the foundation necessary to improve safety, efficiency, patient outcomes and profitability in the ambulatory care environment. Other benefits of workflow process improvement included a successful Meaningful Use implementation strategy and recognition by the Office of the National Coordinator and HiMSS. Improved clinical quality flowed from measuring population health at the primary care level, and by reporting these metrics to commercial and government payers via a central registry. **This created a business case for continuous quality improvement in the ambulatory care environment that only worked by virtue of being coupled with Patient Centered Medical Home payment reforms such as Per Member Per Month fees and Pay for Performance bonuses, as well as adequate Fee For Service payment to Primary Care. Cost reductions more than offset the increased payments to the individual PCMHs, and private sector health insurance now publically recognizes the value of contracting with PCMHs for health care delivery. Return on investment (ROI) appears to be immediate, within 1 to 2 years, and the workflow changes demonstrated in the pilot are scalable to urban, suburban and rural areas, with practice transformation consistently possible in under 2 years.**

I call on the Health Subcommittee of the Ways and Means Committee of the United States House of Representatives to compel the Department of Health and Human Services to deploy the Patient Centered Medical Home payment model at the national level immediately in the broad interest of conserving our primary care workforce, improving the quality of health care for entitlement program beneficiaries, and reversing the burden of rising health care cost expenditures on the American taxpayer with a system that is proven and is already being adapted in the private sector.

Respectfully Submitted,



John L Bender, M.D., FAAFP
Diplomat, American Board of Family Medicine
President and CEO, Miramont Family Medicine
Secretary-Treasurer, Physician's Quality Network, Inc.
Board and Past President, Colorado Academy of Family Physicians
Board, Colorado Medical Society
Board and Past President, Larimer County Medical Society
Past President, Northern Colorado IPA

Chairman HERGER. Thank you.

Mr. Nichols is recognized for five minutes.

**STATEMENT OF LEN M. NICHOLS, DIRECTOR, CENTER FOR HEALTH POLICY RESEARCH AND ETHICS, FAIRFAX, VIRGINIA**

Mr. NICHOLS. Thank you, Chairman Herger. Thank you, Ranking Member Stark, and other Members of the Committee and subcommittee. I am honored to offer my thoughts on incentive realignment today.

My name is Len Nichols. I am a health economist. I direct the Center for Health Policy Research and Ethics at George Mason University. I am also the editor-in-chief of a new online journal, the Community on Payment Innovation, jointly sponsored by the ACC and the American Journal of Managed Care, which, by the way, has already published a report by colleagues of Dr. Share on his innovative PGIP program. I am on the board of the NCQA, which devised the patient-centered medical home criteria Dr. Bender just spoke about. And I was recently selected as the innovation advisor to CMS.

But I do want to make crystal clear at the outset my written testimony and spoken views are mine and mine alone. I do not speak for any organization, public or private, nor for any other person, living or dead.

Let me start with some good news. Health care stakeholders around the country get it, and they are responding to the incentive realignment signals now embedded in the Affordable Care Act. They are devising private initiatives, some of which you have just heard about; but even more importantly, they are devising public-private partnerships that are our best hope for improving health, improving care, and lowering costs for all of us over time.

It seems to me we face two broad alternative pathways to achieve our goals. One path entails severely reducing coverage, eligibility, and prices paid in public programs, or even eliminating them altogether. In other words, we could cut our way to fiscal balance, and in so doing, reduce access to care for millions of Americans. I fear this pathway would likely fail, for the ensuing cost shift to the private sector would drive up premiums and cost us yet more high-wage jobs in a never-ending cycle of decline.

Alternatively, we could align incentives so thoroughly that we actually link the self-interest of clinicians with our common interest in cost growth reduction and quality improvement while covering all Americans. This is by far the most humane way to our shared objective. Quite simply, we need value-based payment systems where value has three dimensions: clinical quality, patient experience, and efficiency.

I will emphasize three points. Number one: While fee-for-service is part of the problem, in the real world fee-for-service is also ubiquitous and therefore it cannot be jettisoned overnight. We must develop transition business models to enable clinician groups to move from fee-for-service alone to more sustainable incentive structures without going bankrupt.

Point number two: The ACA has signaled to the country that business as usual is over, and business as usual is over because we can't afford it. Every one of the initiatives you have heard about

today and that Karen Ignagni of AHIP reported on a fascinating conference in October, referenced in my written statement. Patient-centered medical homes, bundling, accountable care organizations, or organized systems of care in Dr. Share's terminology, all have a conceptual counterpart in the ACA.

The growing private sector interest in care innovation emerging from the CMMI is the proof that ideas and efforts in the public and private sector are converging, which is extremely good news because every single clinician I have ever met, and I am old enough to have met quite a few, wants one set of incentives, one set of quality metrics from payers, one set of patient acuity adjusters, rather than the Byzantine plethora they labor under today.

Number three: Neither private nor public sector payers can do this by themselves. Private payers sometimes need public payers to help with local provider market power, and as Dr. Sandy said, public payers can benefit from adopting the supple nuance with which private payers tailor incentives for different marketplaces.

I will close with three observations that I think are relevant. As an editor-in-chief focused on payment innovation, I have learned that many practicing physicians are skeptical of new payment models that don't have quality or patient acuity components.

Second, as an informal advisor to three different applications to the recent Innovation Challenge grant initiative from CMMI, I saw the immense value of having a vision of a community health system. In each case, leadership originated in a different place—a consumer-oriented health system agency in one case, a local nonprofit health plan with a history of collaboration in another, a forward-thinking single specialty group armed with data and a commitment to quality.

But in each case, local employers, hospitals, plans, and of course, other clinicians and community voices we recruited, in two cases including the state Medicaid program, until by the end only Medicare had not yet joined these promising local incentive arrangements that are squarely aimed at a sustainable version of the three-part aim. The point of the applications and this initiative is to entice Medicare to join the party that the private sector devises, and others like it.

Finally, as a participant in CMMI's new Innovation Advisors program, I recently spent two and a half days in a hotel near Baltimore with 72 of my new best friends. CMMI hopes to deepen our skills in innovation and quality improvement while we bring them new ideas from the real world outside the Beltway. But the best part of this was in seeing the energy and talent from across the country that is now committed to achieving the three-part aim in a wide array of institutions and settings.

I would suggest to you that the Innovation Advisors program is proof that there is now broad recognition that top-down payment and delivery changes will not work, that frontline clinicians and managers and nurses and plans and patients all have to work out the details that will work for them where they live and work, and that we all need all the tools we can muster, from the public sector, the private sector, the recent reform law, and the God we worship in our own ways, to get this done in time for our health care system and our country.

Thank you very much.
[The prepared statement of Mr. Nichols follows:]

***THIS TESTIMONY IS EMBARGOED UNTIL 10:00 AM, TUESDAY FEBRUARY 7, 2012***

**Programs that Reward Physicians**

**that Deliver High Quality and Efficient Care**

**Statement of**

**Len M. Nichols, Ph.D.**

**Professor of Health Policy and Director,**

**Center for Health Policy Research and Ethics**

**College of Health and Human Services**

**George Mason University**

**Fairfax, VA 22030**

**For the Health Subcommittee of**

**The Committee on Ways and Means**

**February 7, 2012**

**Washington, DC**

Programs that Reward Physicians that Deliver High Quality and Efficient Care

Len M. Nichols, Ph.D.

February 7, 2012

Chairman Herger, ranking Member Stark, other distinguished members of the Committee and Sub-Committee, it is an honor and a privilege to join this panel today and offer my thoughts as you consider different types of incentive realignments within our health care delivery system. My name is Len M. Nichols. I am a health economist, Professor of Health Policy, and Director of the Center for Health Policy Research and Ethics in the College of Health and Human Services at George Mason University in Fairfax, Virginia. My other affiliations relevant to the subject of today's hearing include: Editor-in-Chief of the online Payment Innovation Community, a project jointly sponsored by the American College of Cardiology and the American Journal of Managed Care[1]; Board member of the National Committee on Quality Assurance,[2] Academy Health,[3] and the Arkansas Center for Health Improvement;[4] member of the National Committee on Vital Health Statistics;[5] and recently I was selected, along with 72 other health professionals from around the country (out of 920 applicants), to be an Innovation Advisor to the Center for Medicare and Medicaid Innovation.[6] I do want to make crystal clear at the outset, however, my written testimony and spoken views are mine and mine alone and that I do not speak for any organization, public or private, nor for any other person, living or dead.

I am certain there is no need to belabor my first point on this subject for this Committee: we simply must lower health care cost growth to ensure continued access to high quality care for all Americans, including the currently insured and the (hopefully) soon-to-be insured. And while the sense of urgency is great in any student of our health care system or our economy, I want to tell you why I am more optimistic today about our chances than at any time in the past 20 years: health care stakeholders around the country are responding to the incentive realignment signals in the Patient Protection and Affordable Care Act (ACA) and stepping up to the plate to device

[1]http://paymentinnovations.cardiosource.org
[2]http://www.ncqa.org
[3]http://www.academyhealth.org
[4]http://www.achi.net/index.asp
[5]http://www.ncvhs.hhs.gov
[6]http://innovations.cms.gov/innovation-advisors-program

private sector initiatives, some of which you just heard about, and public-private partnerships that together are our best hope for improving health, improving care, and lowering cost over time.

Despite our serious budget realities, it is important to not panic, to take stock of initiatives that are working well and to spread them, to improve on those that need some work, and to take note of our successes, including the recent slowdown in Medicare spending growth to only 2.5% per beneficiary from 2009-2010.[7]

Now the contemporaneous slowdown in the private health spending (out of pocket plus private health insurance benefit payments) growth to 2.2% in 2010,[8] is most likely due to the twin effects of the Great Recession, for millions of newly uninsured cut back on needed services as they lost COBRA coverage, either because they could no longer afford it any longer or because their time limits were reached, and of higher cost-sharing requirements relative to reduced family incomes (overall out-of-pocket spending grew only 1.8%).[9] This last effect would also explain why insurers like Aetna[10] saw large profit increases from way less than anticipated use by the still insured. But the same "coverage loss/higher-cost sharing" rationale cannot explain the Medicare cost growth reduction.

A number of interpretations have been offered, and it is certainly too early for definitive judgments, but the one I find most compelling is that the Patient Protection and Affordable Care Act (ACA) savings provisions, specifically the reductions in overpayment to Medicare Advantage plans and the reductions in automatic increases to the market basket update factor for hospitals, are working as well or better than the Congressional Budget Office (CBO) expected when it scored them in 2010. This is good news in general, and sets us up for even more success as the payment reform pilots and demos coming out of CMMI and the private sector alike work to transform care and improve patient health and quality even as they lower total cost of care, at least off baseline, for all Americans.[11]

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[7] Martin, Anne B., et al. "Growth in US Health Spending Remained Low in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009," *Health Affairs* 31 No. 1 (2012):208-219

[8] Computed from data in Martin et al, Ibid.

[9] Martin et al.

[10] http://www.foxbusiness.com/industries/2012/02/01/aetna-profit-gets-boost-from-low-claim-costs/

[11] http://www.innovation.cms.gov/documents/pdf/CMMIreport_508.pdf

The urgency of sustaining lower health care cost growth in the face of our demographic challenges is widely accepted, and we are going to need every arrow in the quiver, public sector, private sector, and preferably turbo-charged partnerships among the two. It seems to me we face two broad alternative pathways or "doors" to accomplishing this political, economic and budgetary imperative.

One path entails severely reducing coverage, eligibility and prices paid in public programs[12] or even eliminating the programs altogether.[13] Presumably this path would also eventually include logically related reductions in the generosity of benefits in the private sector and/or eliminating our current almost $400B tax expenditure[14] from shielding employer and employee premium contributions from federal taxation. In other words, we could cut our way to fiscal balance, and in so doing reduce access to care for millions of Americans. I fear this pathway would also likely fail to preserve the high value added private sector jobs we need to retain in this country, since hospitals would have no choice but to cost-shift to the private sector, to make up for the public sector underpayment and the growing uninsured population. This would raise private insurance premiums to even more unsustainable levels. In others words, this pathway would likely not even succeed in its narrow goal of balancing public health care budgets, for revenue from a weakening economy would continue to fall.

The alternative pathway is to realign health and health care delivery incentives so thoroughly that we link the self-interest of clinicians, hospitals and all patients with the social interest in cost growth reduction while covering all Americans. Now I admit to a possible conflict of interest here, since incentive realignment across 1/6th of our economy virtually guarantees full employment for health economists and others of our ilk, but I will also state unequivocally and as forcefully as I can, "door number two" is by far the more humane pathway to our shared objective.

To realign incentives with appropriate speed and efficiency, we need new value-based payment systems to be adopted by public and private payers alike. Value, by the way, is increasingly taking on three dimensions: clinical quality, patient experience, and efficiency (or overall

[12] http://cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf
[13] Volack, Jason M. http://abcnews.go.com/blogs/politics/2011/12/ron-paul-attacked-for-views-on-health-care
[14] http://www.ebri.org/pdf/publications/facts/FS-209_Mar10_Bens-Rev-Loss.pdf

resource use). This value construct is also consistent with the new three part aim of CMS and CMMI: better health, better care, and lower cost.

The very good news is there is truly a tremendous amount of ferment across the country on incentive realignment, for most health system stakeholders have come to recognize its importance as the preferred and only real alternative to draconian cuts in access and equity that would result from door #1 above. You've heard about some of that interesting work today from my fellow panelists.

I want to emphasize three points in the remainder of this testimony.

Number 1: While there is a (thankfully) growing recognition that our historical over-reliance on fee-for-service (FFS) payment mechanisms is part of the problem and sometimes creates strong disincentives to improving health and efficiency-enhancing delivery system redesign, FFS payment is also ubiquitous and therefore it cannot be jettisoned wholesale overnight. Indeed, one of the most important tasks for economists, CFOs, practice managers, and clinicians themselves is to develop new business models that will align the self-interest of providers with the social interest in lower cost, better care, and better health. Some new payment models are taking shape and being tested, as you have no doubt heard before and I will describe below, but they are still a long way from being granular and flexible enough to work in the many different contexts of the US health delivery system. And more than likely, we will decide to keep some version of FFS for many and perhaps all providers for at least some patients. Therefore, there is an even more urgent task of developing "transition" business models to enable clinician groups and hospitals to move from FFS alone to better and more sustainable incentive structures and overall quality and efficiency performance without going bankrupt in the bargain. This is a task I and others are now focused on like a laser beam. So stay tuned.

Number 2: The ACA has had a number of salient effects already, in addition to slowing Medicare spending growth. It has signaled to the country that the US Congress has gotten the main point about our health care system; business as usual is over because we cannot afford it, even though we are not now serving all our citizens as well as we should. The Ryan budget, since it included all of the Medicare savings provisions of the ACA, as well as the ensuing and ongoing deficit reduction debate, also contributed to the signal being received throughout our

health care delivery system, but I would argue that the ACA is the major reason behind the private sector incentive realignment efforts that are encouraging us all.

The proof I offer today of the ACA's central role comes from two sources: one, a recent summit conference that America's Health Insurance Plans sponsored on shared accountability, and the other, the growing interest in care innovation initiatives emerging from the CMMI.

In October of Karen Ignangi and colleagues reported the results of a survey of AHIP members that was completed in late summer 2011.[15] At that time there were already 151 patient centered medical home partnerships between physician practices and private health plans, 30 "Accountable care model" arrangements, 16 bundled payment/episode or care partnerships, and 3 full patient-acuity-adjusted global caps, wherein the provider groups bear full or partial financial risk for the care of a defined population and for a specific amount of time.[16] The very organization of her presentation shows how the private sector is mirroring and sprinting ahead with the types of payment reform that CMMI is encouraging pursuant to the ACA: accountable care organizations, primary care transformation, and bundled payment arrangements emphasizing Medicare enrollees. }

The reason I am excited by this dovetailing in model development and payment innovation is that every clinician and clinician manager I have ever met, and I am old enough and have given enough hospital association and medical society keynote addresses to have met quite a few over the years, every single one always expressed a strong preference for one set of incentives from payers, one set of quality metrics, one set of patient acuity adjusters and feedback loops, etc., rather than the byzantine plethora they labor under today. Indeed, without new incentives in place for a majority of patients in a given practice or hospital, it is highly unlikely that care delivery will change from the current focus on volume and uncoordinated care.

And while the ACA may be responsible for the type and scope of interest in payment and delivery reform models being tried now in the 49 states which AHIP reported on, similarly the

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[15] http://www.ahipcoverage.com/2011/10/20/materials-from-ahip%E2%80%99s-summit-on-shared-accountability/

[16] AHIP updates these counts regularly, for they continue to expand. For more on AHIP's work in this area, see: Higgins, Aparna et al, "Early Lessons from Accountable Care Models in the Private Sector: Partnerships Between Health Plans and Providers," *Health Affairs* 30, No. 9 (2011):1718-27; and "Transforming Care Delivery," *AHIP Issue Brief* January 2012.

spread of these initiatives within the private sector is surely also driving more plans and provider groups to consider the public-private partnerships that CMMI is trying to create around the Comprehensive Primary Care Initiative,[17] the Multi-Payer Advanced Primary Care Practice Demonstration,[18] and through both Pioneer and Advanced Payment ACOs.[19] When providers see the federal government, state government programs, and private payers all focused like a laser beam on reducing costs while better measuring and improving care quality, patient experiences and outcomes, old barrier attitudes like "this fad will go away with the next election," fade quickly, and suddenly it seems like a very good idea to invest in learning new care coordination techniques and business models.

It is fair to say that many were disappointed with the initial shared savings ACO proposed rule,[20] but since then interest in CMMI pilots has been increasing, from 32 full speed Pioneer ACOs to 8 states coordinating large multi-payer collaborations to transform physician practices into patient centered medical homes, 5-7 sets of private plans providing incentives to transform primary care with 75 physician practices each within defined local markets and the as yet unreported but expected (and rumored throughout delivery system circles) very high interest in both the 4 bundled payment models about to be tested and the open ended innovation challenge grants which were just submitted 10 days ago.[21] Based on what I'm hearing from applicants to that grant opportunity from around the country, interest is very high in this unique opportunity to tell CMMI/CMS what new payment and care delivery arrangements make sense to particulars set of providers, plans, and employers who are indeed willing to pursue the three part aim (better health, better care, lower cost) on the ground in the real world. This is not your father's "one size fits all" Medicare demo from decades past.

Number 3: Neither public nor private sector payers can remake sustainable incentive structures by themselves. While it has not gotten enough policy attention yet, there is growing awareness

[17] http://innovation.cms.gov/initiatives/cpci
[18] https://www.cms.gov/DemoProjectsEvalRpts/MD/ItemDetail.asp?ItemID=CMS1230016
[19] http://innovations.cms.gov/initiatives/aco/pioneer; and http://innovations.cms.gov/initiatives/aco/advance-payment/

[20] http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2011/May/May-9-2011/Model-ACO-Health-Centers-Skeptical.aspx
[21] These initiatives are all described and the counts of participants if underway as of yet are contained in the document referenced in footnote 11.

that a serious problem private insurers face in many markets is local provider market power.[22] The best hope for effective incentive realignment in those markets is far more supple private-public payer cooperation, for only Medicare has enough market share to engage some providers in balanced negotiation and only federal antitrust authorities can create appropriately monitored safe harbors to negotiate community-wide incentive arrangements that will achieve the three part aim for all.

At the same time, public sector programs can benefit from increasing their own flexibility to match and support inherently more flexible private sector arrangements. The ACA included long overdue provisions that will finally enable states and communities to acquire and use certain Medicare data alongside what state Medicaid programs, state employee programs, and local private plans may be willing to provide to support common approaches to target delivery and payment reform efforts to the highest value local uses. In addition, discretionary authority that would enable Medicare to piggyback on locally agreed upon private sector incentive arrangements that pursue the three part aim for all patients, providers, and payers would be a very good tool to add to the CMS toolbox. The creativity and focus coming out of and into recent CMMI initiatives, especially the Pioneer ACOs, the CPCI and the Innovation Challenge grants, which are more open ended, provider led and individually tailored than many previous opportunities, are likely to reveal a number of different incentive realignment strategies that may make perfect sense in different parts of the country but not everywhere. As are the private sector initiatives like the ones recently highlighted by AHIP. It would be wise to enable Medicare and the private sector to spread these kinds of innovations in similar if not identical ways, so that more and more clinicians face similar incentives to achieve the three part aim for all patients.

I will close with lessons learned in three of my recent roles. Each has given me a bird's eye view of some of this innovative ferment that spans public and private sectors and that may be useful for you to consider ways to improve the Medicare program while benefitting all Americans.

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[22] Nichols, Len M. "Making Health Markets Work Better With Targeted Doses of Competition, Regulation, and Collaboration," *St. Louis University Journal of Health Law and Policy* 5(7):7-26; Paul B. Ginsburg, http://hschange.org/CONTENT/1162/1162.pdf ; Nichols et al, "Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning," *Health Affairs* March/April 2004. *Competition in the Healthcare Marketplace: Hearing Before the Subcomm. on Consumer Prot., Product Safety, and Ins. of the Comm. on Commerce, Science, and Transp.*, 111th Cong. 85-99 (2009) (statement by Len M. Nichols).

First, as Editor in Chief of the new online Community on Payment Innovation,[23] I have learned that good patient registry data can drive awareness and behavior to higher value diagnostic and therapeutic choices by patients and clinicians *together*. And given the general tumult in the health care system, there is considerable interest in new arrangements among and for physicians, ranging from employment by hospitals rather than private practice to direct physician contracting with employer and by-passing health plans altogether. I have also learned, however, that many physicians are simply not aware of key details of the current incentive structures they are paid by today, and therefore it is not surprising they are having a hard time analyzing proposed new models. They have no frame of reference or trusted method of comparison of how they would fare under different scenarios. Therefore much useful teaching, awareness building, and model development must precede wholesale incentive realignment in our country.

Second, as an informal and upaid advisor to three different communities' applications to the CMMI Innovation Challenge grant initiative, I saw the immense value of having a vision of a true community health system shape the partners that were ultimately recruited to join the efforts. In each case, leadership originated in a different place; a health system agency with a consumer-oriented focus in one case, a local non-profit health plan with a history of collaboration in another, and a forward thinking single specialty group armed with data and commitment in a third. But in each separate case, local employers, hospitals, plans, and of course other clinicians and community voices were recruited (and in two cases, the state Medicaid program), until by the end only Medicare has not yet joined promising local incentive arrangements that are squarely aimed at a sustainable version of the three part aim. The point of the applications and this initiative is to entice Medicare to join the party and others like it.

Third, as a participant in CMMI's new Innovation Advisors Program (IAP), I recently spent 2.5 days in a hotel near Baltimore with 72 of my new best friends. CMMI hopes to deepen our skills in innovation and quality improvement while we bring them new ideas from around the country. Innovation theory and tools are useful and interesting, but the best parts of the meeting were when we talked with each other, sometimes structured sometimes now, about challenges and promising ways to overcome them in different settings and for different types of patients. The very best part was in seeing the energy and talent that is now committed to achieving the

[23] See the link in footnote 6.

three part aim in a wide array of institutions and settings. I would suggest that the IAP is proof there is broad recognition that top down payment and delivery changes will not work, that frontline clinicians and managers and plans and patients all have to work out the details that will work for them where they live and work, and that we need all the tools we can muster, from the public sector, the private sector, the recent reform law, and the God we worship in our own ways, to get this done in time for our health system and our country.

I thank you again for the privilege of offering these thoughts today, and would now be glad to answer any questions my testimony, written or spoken, may spark, today or at your leisure.

Chairman HERGER. Thank you.

Dr. Sandy, I understand that your company's network includes approximately 650,000 physicians, a number nearly equal to the number of doctors who participate in Medicare. As your quality and efficiency program touches many of these physicians, and considering that other private payers have similar programs, would you say that a good number of Medicare participating physicians have exposure to a program such as yours?

Dr. SANDY. Well, thank you, Mr. Chairman. We do have close to 650,000 physicians and other health care professionals, including nurses, chiropractors, mental health workers, and so on in our broad network across the country. The premium program that I mentioned in my testimony encompasses, at current scale and scope, close to 250,000 physicians across 21 different specialty areas of medicine.

So given that scope, I don't know the exact answer, but I would venture to say that the vast majority of those physicians, aside from those that don't typically take care of Medicare patients such as pediatricians, have had exposure to our program and probably similar programs by others in the private sector, and those physicians also take care of Medicare beneficiaries.

Chairman HERGER. Thank you.

Dr. Share, the number of Michigan physicians participating in your program is very impressive, and that they group together in the physician organization is an interesting feature. As someone who represents a very rural district in Northern California, I know it has always been a difficult challenge to develop integrated delivery systems in rural areas. Can you describe the level of physician participation in the rural or more remote parts of Michigan as well as the size of organizations in those areas?

Dr. SHARE. Certainly. The incentive program that we have is intentionally designed to be inclusive of both sophisticated, vertically integrated delivery systems and small one- and two-physician practices, and also to get all of them, regardless of their size and structure, to come together collectively to share responsibility for a population in common.

So there are physician organizations in nearly every county in the state, and there are many, many rural physicians who are involved in these physician organizations. Some of them, interestingly, have come together under an umbrella organization run by the state medical society that provides comprehensive administrative and technical structure to support the smaller practices who join in confederations of private practices, one? and two-person doctor offices, so that they don't have to create the analytic infrastructure and the information systems all by themselves.

This has empowered them to be full partners in this program, equally engaged, equally exciting. There are individual physicians in one-person offices who have stunning stories to tell about how they have transformed their practice, including way up in the upper reaches, far reaches of the Upper Peninsula.

So I think this program has touched nearly every community and every type of practice, including rural practices, absolutely.

Chairman HERGER. Thank you. That is exciting.

Dr. Bender, your story of transformation is remarkable. You note that your practice made these investments without regard to health care overhaul and without regard to SGR because these were things you couldn't control. You also note that it would take other small practices two years or less to complete such transformation.

What advice would you offer to other physicians who struggle to make major practice changes, given the constant pressure placed on them by the reimbursement system?

Dr. BENDER. Well, thank you, Chairman Herger. They need two things, leadership and courage. Leadership means, to get involved in a patient-centered medical home, they have to tell their staff, hey, we are going to do this. They have to believe in it. The group has to eat, sleep, and drink the model.

This requires delegation. I couldn't have done this without the superior HR structure that we have at Miramont, with excellent employees who are committed to this process. Because it is brain damage. It is very difficult to go through change. People hate change, but they love progress, and to get to the point where we are excited about what is new at Miramont as opposed to, my goodness, we are doing thing differently.

The other part, courage: Physicians are scared. They don't know what is going to happen with the health care overhaul. They are worried about regulations, malpractice, et cetera, et cetera, SGR threats. And really what I tell them is, the opposite of careless is not always—or, I am sorry, the opposite of cautious is not always careless, but sometimes the opposite of cautious is courage.

Are they choosing not to do it just because they think that it is going to be careless? Or are they choosing not to do it because they are afraid?

Chairman HERGER. Thank you.

Mr. Stark is recognized.

Mr. STARK. Thank you, Mr. Chairman. I thank the witnesses for participating with us today.

Mr. Nichols, you talked about why public and private payers must work together to align incentives. So while this hearing has been informative, it seems to me that the focus just on private sector initiatives misses a larger picture. Could you talk some more about the need to combine the public and private sectors to see if we can get those stars in alignment?

Mr. NICHOLS. Be glad to, Congressman Stark. Basically, the simple reason they have to cooperate is because most clinicians treat all kinds of patients. And it turns out in lots of specialty cases and in some locales, a majority of a clinician's patients might be public, so they are the biggest market share. They are typically the biggest market share for hospitals, and they are often also so for specialists, including cardiology, I might point out.

So if you don't get the sectors aligned, if you don't get the incentives aligned, clinicians are going to be both confused and, as Dr. Bender might say, unhappy about it. And so the best way to transform patient care is to get them aligned.

That does not mean they all have to pay the exact same level. I certainly believe in the private enterprise system. I certainly believe in competition. But I also think it makes sense for the clini-

cians to face the very same set of incentives, the very same set of feedback loops, the very same set of metrics.

The very idea that United would have one set of metrics and Aetna a different one and CIGNA a third and Medicare a fourth and Medicaid and yada yada yada—by the end of the day, what is the clinician going to do? What they think is best independent of what they are being paid by.

So the smartest thing to do is to get the incentives aligned. Now, there are lots of reasons that is difficult to do, but there are about 300 million reasons it is a good idea to do as soon as possible.

Mr. STARK. Thank you. Also, it is my understanding that we are probably the only industrialized nation that does not use a comparative effectiveness measure. And I hasten to point out that all the comparative effectiveness programs, whether they are for pharmaceuticals or medical procedures, don't include cost. And of course, there is this—for some reason; I think it is mostly political fodder, but people are suggesting that using comparative effectiveness would lead to rationing.

I wondered, both Dr. Sandy and Dr. Share, what is your reaction to that? Comparative effectiveness, if you had that available to you across the board—some professions or segments, thoracic surgeons, for instance, have done their own. For about five or seven years, they have collected data on every procedure that every member of the club or college, whatever you call it, has provided to a patient, and the outcome, and they have tracked the patients. But that is a small group in the firmament of medical providers.

What do you think about the rationing issue?

Dr. SANDY. Well, thank you, Congressman Stark. The comment I would say around comparative effectiveness research is, it is absolutely essential that there be investments in understanding of the differences in clinical effectiveness between different treatments so that physicians can have the best science and information to help inform the choices in their care, and that patients then can have that information as well so that they can make their informed choices.

I think what I really would underscore and echo and support is the phrase that Dr. Lewin laid out. He used the term bringing science to the point of care, and I would strongly support that. And I think organizations such as the American College of Cardiology, the Society for Thoracic Surgery that you mentioned, these medical specialty societies are really at the forefront of doing that.

One of the things that in my opinion would be helpful is that these societies are at the forefront, but there are other societies that would like to move in this direction to develop detailed clinical registry information, to help inform the physicians that are part of that specialty area to collect that information. That has been a challenge.

It is gratifying—there is a fledgling effort, by the way, called the NQRN, the National Quality Registry Network, a multi-stakeholder coalition, to advance this frontier. And we think that would be a very important development to support.

Mr. STARK. If I may just have another second, Mr. Chairman, wouldn't the requirement for keeping electronic records, which now

everybody is supposed to do, help toward building this comparative effectiveness study?

Dr. SANDY. Well, again, one of the things that your question points out is the issue of the challenges of administrative simplification and the fact that many physicians do not have electronic health records. While electronic health records sometimes aren't architected to collect detailed information, it is an important start to help promote that kind of data collection for the purposes that I have outlined.

Mr. STARK. Thank you.

Dr. SHARE. Mr. Chairman, could I just add a brief note in response to Mr. Stark's question?

Chairman HERGER. Very quickly.

Dr. SHARE. Yes. So we have actually embarked on a very ambitious approach to empowering the provider community, in the spirit of our partnership approach, with the workings of comparative effectiveness research, putting them into the hands of the provider community.

We have 17 distinct hospital-based, multi-institutional, data registry-driven, collaborative quality improvement programs that have dramatically decreased the rate of mortality and morbidity, and saved money while doing so. And we are now in the process of linking claims data to the quality data across the state to empower CFOs, CEOs, and physician leaders to use that integrated data set to improve value in hospital care.

Mr. STARK. Thank you.

Chairman HERGER. Mr. Johnson is recognized for five minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

Dr. Share, it is interesting to learn the improvements you are making in Michigan. Do you ever talk to Blue Cross in Dallas?

Dr. SHARE. Do we talk to Blue Cross in Dallas? We talk to the Health Care Service Corporation, which I believe is a nonprofit. It is a Blue licensee, so it is a Blue plan. And it is multi-state. It is in Texas, Illinois, and I am not sure where else.

We have talked to them a good bit about this collaborative quality improvement approach using comparative effectiveness research in daily practice across an entire state, and they are beginning to adopt that model. We haven't talked to them about our physician group incentive program yet.

Mr. JOHNSON. So the Blues aren't united across the country?

Dr. SHARE. The Blues are united across the country in terms of having really rich relationships at the local and regional level with the provider community, and each developing payment transformation and practice transformation approaches that fit the needs and the circumstances of those communities. And we share experience and knowledge about what works across the Blue association.

We are now actually working towards developing a set of tiered incentive programs, tiered in the sense of benefits being—the out-of-pocket costs for members being lower if you are using a medical home doctor, for example, to try and bring our approaches into more alignment while still respecting local circumstances.

Mr. JOHNSON. And what are your ideas? Do you all have some innovations that you are trying to share with Medicare?

Dr. SHARE. We are actually partnering with Medicare in the context of the advanced medical home demonstration project. And in keeping with Mr. Nichols' comments, we have aligned incentives where we have 480 of our patient-centered medical home-designated practices involved in an incentive program that includes Medicare and Medicaid funding as well as Blue Cross funding.

It has actually significantly enhanced the focus on a common set of quality measures, a common set of efficiency measures, and a common approach to care management across all of these 480 practices. So working with CMS in this way, bringing them into our regional innovative approach, has amplified what we are able to do.

As an example, though, of how sometimes CMS has a bit of a hard time fully embracing and trusting a local or regional effort, one of our approaches is to provide the incentive payments to the physician organization, as I mentioned, for their collective success at achieving value for a population of patients. The physician organization can then invest the money in better care management systems, information systems, et cetera. CMS has required that its incentive money must be paid 80 percent to the individual medical home practices. That makes it harder for them to band together and create common systems with aggregated resources.

So tremendous opportunities to partner with CMS. More opportunity, I think, to do so in ways that aren't constraining, that free the local community to do its best.

Mr. JOHNSON. Yes. But what I am hearing you saying is CMS isn't listening to you.

Dr. SHARE. No, they listen. They are an active partner, and they are trying to think through the best way to do it also. And as a partner, they naturally have an instinct to say, well, we really think it will be best if we tested an incentive models, where the doctors get reimbursement or an incentive payment made directly to them. So that is important to us. We didn't come to yes on exactly how approach that.

Mr. JOHNSON. Thank you.

Dr. Lewin, you know, as we explore new systems for Medicare physician payment, in your experience what are some of the key points we need to keep in mind? And what does Congress need to do to apply these programs to Medicare?

Dr. LEWIN. Well, the faster Congress really moves forward with payment incentives, I think we will see progress. We know that we have to be able to measure our way to success, so we do need registries. And registries work with electronic health records.

So you have the electronic health record; a registry tracks a whole set of conditions and gives feedback to the hospitals and the doctors in terms of how they are doing so that they can begin to compete with themselves and with their peers on producing better and better results. Ultimately that is going to get reported back to consumers so that people will be able to choose where they get their health care based on improved outcomes.

The extent to which Medicare can move more swiftly to payment reforms, I think we would see progress there. I love the CMMI grant program, but we will probably take three years or four years before we can see the results of those programs and apply them. Meanwhile, our deficit keeps increasing as a nation.

I would hope that we would begin to do some national demonstration projects coming right up in 2013 that would split the difference of savings between Medicare and the hospital and physician partners. So if we end up ferreting out unnecessary stents and unnecessary defibrillators, or choosing the right image and reducing the cost of imaging, and reducing the number of admissions and readmissions to hospitals by improving the treatment of heart failure—that is going to reduce the income to the hospitals. Right? Because they won't have as many admissions. They won't have as many procedures and images.

So to help offset that, splitting the savings between Medicare and the provider community of doctors and hospitals is a way you could get people to move much faster. But we would need to require that while they are doing that, they are measuring how much progress they are making in a way that is effective and scientifically valid, and report that back so that we can see what we are doing.

Chairman HERGER. The gentleman's time has expired.

Mr. JOHNSON. Thank you, sir.

Chairman HERGER. Mr. Thompson from California is recognized for five minutes.

Mr. THOMPSON. Thank you, Mr. Chairman, and thank you for holding the hearing.

I would like to just piggyback on something that the chairman and the ranking member both spoke on, and that is the importance of fixing the SGR program. I have got to tell you, in my district that is what I hear about most—from the medical profession, from patients, people on Medicare.

They have long forgotten all the manufactured crisis that was sent out on the talking points for the health care reform stuff. They want to make sure that they are going to get paid for the medical services that they provide, and Medicare patients want to make sure they are going to have a doctor to go to. And it stops right about there.

I have not had one Medicare person stop me on the street and say, hey, I think electronic records are good, bad, or otherwise; the Affordable Care Act is doing this, that, or the other thing. But the SGR is critically important, and I don't think it is enough to say if the Senate Democrats didn't do this or the House Republicans didn't do that. We have dropped the ball on this thing.

I think Mr. Stark nailed it when he said that it is the cost, $300 billion to fix this thing. Well, the bad news is if we wait another five years, it is over $600 billion. And I applaud my colleague and ranking member for raising a proposal as to how it can be paid for.

We need to come together as Members of Congress, party stripe notwithstanding, and figure out how we come up with the dollars to fix this because right now—Mr. Nichols talked about the importance of partnerships. This is not a partnership. It is not happening. The Congress is not doing its fair share. If you use the breakfast analogy, we are bringing the eggs. And that is just not good enough, and I think we need to move quickly on that.

Mr. Nichols, on the Affordable Care Act, this has in fact moved towards—some of these programs have moved towards payment reforms. And I think that is an important part of this bill on the part of a lot of us, and so I am glad to see this happening.

Can you talk about how the ACA reforms are moving private sector providers to develop and explore new forms of health care delivery that encourage efficient delivery and quality care?

Mr. NICHOLS. I would be glad to, Congressman Thompson, and let me start with the program which I think is the most comprehensive, and that is the Comprehensive Primary Care Initiative, which you may know was actually offered to health plans so that they would indeed apply for the grant.

Then, once selected, what they are looking for is five to seven markets around the country where they have a sufficient market share to really reach a large number of practices. And they will go back and jointly recruit physician practices to join the program, to join the party, and to devise payment arrangements that will work for those local communities.

As every member of this panel has said to you, America is a big old diverse country. The idea that we can make one set of rules apply everywhere is just a little bit, well, last century. So here we are, and what is great about CPCI is indeed you are getting the plans and the government to work together to find a way to get to exactly what Dr. Share was talking about, what makes it work in Michigan versus Virginia versus California. That is among the more interesting ones.

But I also want to emphasize the most recent innovation challenge grant, which basically was an open-ended invitation to provider groups, plans, people around the country. And while CMMI has not released the final numbers that have come in on applications because the grants have not been made, I know, from the people that I know who applied, very large numbers of people were very interested in this program—I mean thousands around the country. And we know this because when you apply, you get an email back that says, you are the 400-whatever.

So over 6,000 people exhibited letters of interest. Over 2,000, we think, actually submitted proposals. That tells you something about the scale of people around the country who are hungry to do exactly what Dr. Bender talked about, and that is, how do you make incentives work where we are? And they are trying to tell the government, this is the best way to work for us. I can think of no better way to encourage the kind of partnership we all agree on.

Mr. THOMPSON. Thank you.

Dr. Share, one of the programs, the multi-payer advanced primary care initiative—and I think Blue Cross Blue Shield in Michigan is part of that—do you agree with CMS that CMS can be a catalyst in increased innovation in a health care system? And does this participation in this program lend to that?

Dr. SHARE. Yes, I do agree. As it happens, in Michigan—and by the way, I mentioned earlier, we have 480 medical home practices in the demonstration project, which represent over half of the medical home practices in the eight states in the demo nationally—we actually had our physician group incentive program several years before in place, so we had a structure. We had engagement. We had made tremendous strides in developing medical homes and improving performance.

So in our context, CMS came in and actively partnered with us, piggybacking on the work, building on the foundation we had laid.

In other communities, they are beginning. They are starting with 10 medical home practices, with intention to grow that number. And the influx of support and focused attention and commonality of measurement approach by CMS has really jump-started their effort, has amplified their interest and their ability.

So I think in different communities it will play out differently. But there is no question the answer is yes.

Mr. THOMPSON. Thank you.

Chairman HERGER. The gentleman's time is expired.

Mr. Kind is recognized for five minutes.

Mr. KIND. Thank you, Mr. Chairman, and thank you for holding this very important hearing. Again, we have an excellent panel and your testimony here today is very appreciate and quite inspirational.

I mean, what I have heard you in your testimony, reading through your written submission as well, it is hard to find any inconsistency in what is happening in the private world versus what reforms are being advocated in the Affordable Care Act. And Dr. Nichols, I couldn't agree with you more. There has to be a convergence or harmony in delivery system and essentially payment reform between both the private and the public spheres or it is not going to work very well.

I am proud that I hail from a state, Wisconsin, that seems to be out ahead of the cost curve. And Dr. Lewin, I am going to go to you shortly here to talk about the Smart Care project that you have submitted to CMMI for an update on that.

But you look at certain models of care that are proving very effective, from the Mayo system to Gundersen, to Marshfield, to Aurora, to Dean, to Theta Care—highly integrated, coordinated, patient-focused, which provide models of where we need to drive the health care delivery system, and hopefully, ultimately—and I think this is going to be the verdict on any type of health care reform in this country—the payment reform that is desperately needed.

We have got direct control over Medicare, and I would love to see fee-for-service die as quickly as possible so we can get to a value- or quality-based reimbursement system, which sounds to me what you guys are all working on right now with the type of initiatives and the type of projects and demonstrations that you are involved in.

Dr. Lewin mentioned the Smart Care project in Wisconsin. You are teaming up with the Mayo System of La Crosse, my hometown, but also UW Health Systems in Aurora in the state. Could you explain a little bit more what the goal is, how it is going to assist physicians, how it is going to lead to better quality outcomes for the patients, and how you see that working?

Dr. Lewin. Great. Well, it really is a physician-mediated approach, and it uses really all the tools that we have developed in cardiovascular medicine to achieve a result of better outcomes, better patient care at a lower cost.

So a good example will be the use of the Pinnacle registry in the outpatient setting to better and more consistently manage high blood pressure, dyslipidemia—you know, cholesterol and so forth—anticoagulation, and heart failure, to reduce the number of heart attack admissions, strokes, and heart failure admissions.

Now, this is billions of dollars nationally, billions and billions. And in Wisconsin, it is going to be a lot of money. And even with the integration that you have got there, there is still a lot of progress that we know can be made.

In addition to that, we are going to be applying the FOCUS tool on the inpatient side as well to choose the right image. There is a bewildering array of images now. There are dozen kinds of echo tests, a dozen kinds of nuclear tests, CT, MR, positron emission, and the science just keeps growing faster and faster.

How do you choose the right test for the right patient? Or does the patient even need the test? Well, staying up with that science is awfully difficult. So using the FOCUS tool helps you, with six clicks at the point of care, make sure that either you are ordering a test or you don't need to order a test, figuring it out right away, far better than a radiology benefit manager approach, where you are calling a number and asking for permission.

They are going to apply that across Wisconsin; also going to apply appropriate use with shared decision-making to help prepare patients who have coronary artery disease, determine whether in their future which pathway they are likely to go down—medical therapy, angioplasty and stents, or bypass surgery.

Now, a lot of times people end up in the cath lab on the table, partly sedated, where they are going to make a decision about whether they need a stent or not. That is not when you want to ask that question. You need the shared decision-making early on. You need to explain to the patient what the options are, what the complications might be of procedures, and then, if the anatomy finally says it is a grey zone, you would have prepared the patient who would have said, I would rather go the stent in that circumstance, or I would rather take the medical therapy.

That needs to be done early. And if we do that early, a lot of people will move toward less intense care. They would try the medicine, or they would try the stent rather than the surgery.

So I think applying all these tools across the board and then using the registries, both inpatient and outpatient, to give the hospitals, the medical groups, feedback on their performance——

Mr. KIND. I love your phrase, bring science to the point of care.

Dr. Lewin. Yes.

Mr. KIND. Another way of saying it is, let's find out what works and what doesn't and drive that information into the hands of our providers and patients through share decision-making. So I don't know why there is all this angst and concern about comparative effectiveness research. That seems to be the whole point of driving science into the point of care and into the hands who need it the most.

Dr. Lewin. Yes.

Mr. KIND. And Dr. Sandy, this sounds very consistent, what UnitedHealth has been doing with imaging services and trying to use clinical studies and support tools for physicians in order to deal with it. We may not have time this round to get your response, but I would like to follow up a little bit more on what UnitedHealth has done in that area, too.

Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

Mr. Reichert from Washington is recognized for five minutes.

Mr. REICHERT. Thank you, Mr. Chairman. Thank all of you for the hard work that you are doing in this field. I know it is not an easy answer, as we have been struggling with this as a nation for many, many years.

We have some doctors on the Ways and Means Committee, as you know. Most of us are not doctors, so we are wading through the information that you have all given us. But I want to focus on coordinated care as it relates to chronic care and how that plays into the doctor reimbursement issue.

We all agree that everyone's goal here is quality care, efficient care, access, and reduced cost. You have all talked about cooperation, the culture of cooperation, collecting data, information, and facts. You have talked about health IT and clinical data registry.

Well, even in our own government system, the VA we know has a great health IT system, but the Department of Defense, pretty much nothing. So how do they even—they can't even communicate. How do we expect them to reach outside into the private sector? And it gets more complicated, I know.

So all of this is tied together. It needs to be, I agree with all of you, a physician-driven, patient-driven solution to all this. And you are all making progress. But there are a couple of things that bother me.

I think, first of all, I liked Mr. Nichols' comment about we need to have Medicare join the party that the private sector is throwing. I think that is a good point. And this leads me to my two questions, and I will ask them together.

So we know that the average 75-year-old suffers pretty much from three chronic health conditions out of five chronic diseases that most of you have been dealing with—heart disease, cancer, stroke, COPD, and diabetes. In your opinion, does the original fee-for-service model in Medicare work going forward? I am going to guess I know what the answer is on that. And how do we work together to build this coordinated care for these seniors who are trying to live with and manage these three chronic diseases?

The second question, and more specific, is to the issue of a group that I met with not too long ago, and it is regarding the illness of lymphedema, sometimes brought on by cancer treatment, sometimes as a birth illness. Lymphedema is covered by some insurance companies. The treatments are sometimes long and drawn out, and you probably all know some of the side effects when the treatment is not given. And some of the compression garments, for example, are covered by some insurance companies but not covered by Medicare.

How do you bring this together? These folks, if they are not treated correctly, they end up with these compression garments prematurely. It doesn't do the job. They need to have massage therapy. They need to have some followup. How do you tie in Medicare with the chronic diseases that I have talked to and follow up with those folks that are dealing with chronic illnesses? Because eventually, this lymphedema issue can result in infections and even death, as you know.

Anyone who wishes to address the question. Dr. Share?

Dr. SHARE. So you had two questions, the first being that I think it is essential to align the incentives of the physicians so that a meaningful proportion of their reimbursement becomes dependent upon them doing the right thing, not just with an individual patient but at the population level; also, dependent with patients with common chronic or multiple chronic illnesses, which are challenging to address.

It is not as if we can simply successfully address that within the context of one physician's office because primary care doctors and specialists and doctors in hospitals tend to wind up seeing these same patients at different points in time. So we really need an organized system of care, the language we are using, where there are clinically integrated systems and also sophisticated, organized care management approaches that help providers across settings manage a group of patients. And it needs to be patient-centric.

So while the work of the cardiologist is really seminal and important, patients with cardiac illness don't just get treated by cardiologists. So you have to have a system where the primary care folks have the same data and the same scientific evidence at the point of care. So that is one answer.

The second question that you asked had to do with the frustration that patients and families experience when difficult medical illnesses have different types of coverage depending upon the insurer they have. And especially if you are switching insurers over time, the same person with the same problem may not have access to the same services.

So I would just say there that the key is to define or really breathe life into the notion of medical necessity because most insurers say medically necessary care is covered, but then we don't have enough evidence to always define what is medically necessary.

So that is where I think comparative effectiveness research comes in because it can help to really rigorously define answers to those key questions.

Mr. REICHERT. Thank you.

Chairman HERGER. The gentleman's time is expired.

Mr. Blumenauer is recognized for five minutes.

Mr. BLUMENAUER. Thank you very much, Mr. Chairman.

Dr. Lewin, I want to go back to where you left off with my colleague, Congressman Kind. Your testimony spoke to shared decision-making, the reference here to giving everybody more choices and having conversations where they will be the most productive and useful.

I would say, parenthetically, I have legislation based on what we had previously with the Ways and Means Committee; despite a little kerfuffle, it actually was unanimously supported by Members of the Committee and one of the few areas of broad agreement, that we need to strengthen not just the information for patients, but the guarantees that their wishes would be respected.

You made a reference there that I think is important. Some people think of this as just end of life. But patients more frequently are subjected—the patient and the patient's family are subjected to very challenging circumstances, often when they are not perhaps in the frame of mind that is clear. They may be clouded with pain or medication, anxiety, and quick decision.

I wondered if you could just elaborate on this notion of shared decision-making, how you envision it moving forward, and things that the Federal Government might be able to do either within the ambit of the legislation that is standing or changes that we should make.

Dr. LEWIN. Thank you, Congressman Blumenauer. It is an incredibly good question.

We feel like, with cardiologists and physicians in general, we have these guidelines and performance measures to help us guide the science. We still use clinical judgment. If patients had guidelines, I think what they would have is they would know—we would give them some ability to understand what questions they should be asking their clinician when they come in.

So we have developed, at Cardiology, figuring we need the patients as partners in care with us if we are going to reduce costs, something called CardioSmart. It is a website, but it is interactive. It has mobile applications. It allows patients, when they come in to either their primary care doctor or their cardiologist, to know enough about their condition to ask the right questions, and to be able to ask whether, am I really a better candidate for medicines, or should I be thinking about angioplasty and stents, or do I need a defibrillator?

Those kinds of questions are not things patients are typically challenged to think about ahead of time. So we would like the patient to come in with the questions they need to ask and work with their doctor, and then truly participate in deciding how that care is going to go in the future, whether they really need this test or whether they really need this procedure or how, in fact—whether they need a generic medicine or the most expensive medicine on the market.

Those kinds of decisions, if we could get those to be shared, I think patients would engage in a positive way to reduce costs and improve outcomes. So we think that this is a critical part of the overall picture of improving quality and lowering costs.

Mr. BLUMENAUER. Thank you very much. I appreciate that, Doctor, and I am hopeful that this is something that we can have a broader conversation. I will give to you a piece of legislation that we are working on, but would welcome an opportunity for further feedback.

Mr. Chairman, I will just say, you recall that we were all concerned—when we were debating health care reform, we all were concerned to make sure that patients had the information, that they could make decisions, and those decisions would be respected.

You will recall we had some actually touching testimony from committee members. I think of Geoff Davis from Kentucky, who talked about a problem that he had with his mother at a late stage. And I would like to see if this might be an area that the committee could review.

I will share with each of you legislation to try and—we call it Personalize Your Health Care, to make sure that we do everything we can, whether it is Medicare or other mechanisms, that physicians are encouraged and maybe even paid to have a conversation like this.

One of the problems that a number of people here have talked about is that physicians are usually paid when they do something to somebody. But to sit down and talk to them, to empower them and to learn, that is off the—that is kind of either a different code or it doesn't happen.

Mr. Chairman, I would look forward with you and the subcommittee that maybe we could have a little conversation about this before our work is done.

Chairman HERGER. I think the point is well made. I look forward to working with the gentleman and the committee on this very important issue.

The gentleman from Washington, Mr. McDermott, is recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Willie Sutton was once asked, "Why do you rob banks?" And he said, "Well, that is where the money is." And it seems to me that what I am listening to you talk and reading all of this is that chronic illness is where the money is spent.

Playing off of what Mr. Blumenauer just said, several years ago, Sandy Levin and I put an amendment into the Medicare legislation requiring that everybody who applies be given a set of final directives that they can fill out so that they can decide a little bit about what will happen to them in the future. We went back a year later to find out how many had actually done so, and less than 20 percent had filled them out.

One of the questions I have is, the issue of how an is going to ever control costs if we don't get the patient involved early on thinking about what the final process is. When you get to 65, the wheels are starting to fall off, so at that point at least you know that you have an end in sight. When you are 30, it is very hard to get anybody to think about this stuff at all.

But I am interested, Mr. Nichols or Dr. Nichols. You have been at the Boeing Clinic and you have been at the Virginia Mason experience, in my state I know about, and we have heard about your experience with some other places.

How do they deal with this whole question—and maybe, Dr. Lewin, you want to join in on this—how do you deal with the question of getting patients to think about this before they are in the cath lab, sedated, and then you ask them, do you want a stent? I mean, how are they doing this to make it work?

Mr. NICHOLS. Well, I can tell you, Congressman, there are a couple of really fascinating examples around the world, actually. One class of things is getting people engaged in assessing their own health. I know of a program in South Africa where an insurance company actually pays people to do the health risk assessment. So you get rewarded for doing it.

But then when you do it, you have to go take it to your primary care doc, and you work with that physician about what is right for you. And, you know, I have a pretty bad family history in heart, and my secretary does not, and she is a whole lot younger, so we have very different pathways. But the clinician will work out with us what is the best pathway for you to be healthy. That is the key, sir. How do you want to manage your trajectory in life?

It turns out this program gets people incentivized. They start doing the things. They basically give them what you and I would

call green stamps, rewards for doing the right stuff along the way. This program, they are filling up three airplanes a day with people taking vacations on the green stamps they have earned. They are spending 2 percent of the premium on the promotion. They are saving 5 percent off trend three years in a row.

So it has to do with incentivizing the patient to begin to engage in managing their own health with a clinician. It has to do with hooking them up with a real live doc you know and trust and takes care of you, who lays out a pathway for you, and then you get incentivized.

Now, at the end of one's lifespan, one might think about having that conversation in lots of different ways. But you probably know of Mt. Sinai in New York, Diane Meier, the person who invented the—I think it is called the Center for Advancement of Palliative Care.

What she has is a team that basically—and I know you are a physician—teaches clinicians how to talk to families because, as you know, sir, we don't teach them that all that well in medical school. And most clinicians think about, what I am supposed to do is save, protect, keep them alive. In fact, what families and patients often want nearer the end are, what are my options? What are my choices? What is going to happen to me? What is it going to be like? What do I really have to choose among?

That is where those conversations teaching the clinicians how to talk to families and the patients can often have a heck of a lot of what I would call effective shared decision-making down the road, where people tend to take the least invasive option because they want to spend as much quality time with their families as they can.

I will turn it to Jack.

Dr. LEWIN. I think that there are some people with heart failure, for example. We are trying to pull together videos to help people look on that CardioSmart site at somebody who is in the same circumstance that they are in and hear about their story over the next six months.

For many people, the end stage, a class 4, New York Heart Association class 4 heart failure, the patient needs to know that they are limited to end stage here, and they can become comfortable and start doing things to make themselves feel better and be with their families rather than heading to the intensive care unit for multiple procedures.

There is also another little element of this we shouldn't forget, and that is the medical malpractice piece. It is back to the patient laying in the cath lab. The physician is really worried there, if the patient hasn't clearly understood that they would rather go medical therapy if they could. They are very worried about not doing the procedure because they don't know whether the patient is going to take the meds.

So I think that there are a bunch of elements there. But we can do so much better at helping people make their own better decisions and working with them.

Mr. MCDERMOTT. Is there any evidence—Mr. Chairman, may I ask one question to follow that?

Chairman HERGER. Maybe to be followed up in writing. Time is expired.

Mr. MCDERMOTT. Okay. I want to ask you about how you get physicians to get patients to sit and talk about it.

Chairman HERGER. I thank the gentleman.

Now the gentleman from Florida, Mr. Buchanan, is recognized for five minutes.

Mr. BUCHANAN. Thank you, Mr. Chairman. And I also want to thank our witnesses for taking the time today.

In Florida, like my district, I have 180,000 seniors 65 and older. And I am very concerned about the quality of care our seniors are getting. In terms of the way doctors are being reimbursed, I hear it every single day, many of them that practice for 20 years—they are afraid to leave their practice because there might not be someone else to take their practice. There is not the enthusiasm.

They said every year it gets more uncertain in terms of the payment plan or how they get reimbursed. It is a very big issue. I know our cardiologists in one of our big practices in our area just lost 30 percent. That came out of nowhere for them.

So I guess, Dr. Lewin, why don't you give us your thoughts on what is happening with the reimbursement or the unpredictable pay that doctors are getting reimbursed all over the country, but especially in Florida, where you have heavy, heavy Medicare patients.

Dr. LEWIN. Well, as you probably know, Congressman Buchanan, Medicare changed the payments for diagnostic services in the private practice setting for cardiologists in 2010, and they reduced by about 30 percent the modern day stethoscope tools of the cardiologist in the office, which are stress testing and nuclear testing and other ways that we use to diagnose patients.

The result of that was we had almost a wildebeest migration of cardiologists moving from private practices to hospital employment. And in fact, five years ago when I first came to the American College of Cardiology, 70 percent of the cardiologists were in private practice, 30 percent were in academic or hospital practice.

Today it has completely flipped. We now have 70 percent in hospital-based practice or employment and 30 percent in private practice, and those remaining 30 percent are struggling because—and it is difficult because we pay the hospital outpatient portion of that at a much higher rate than the private practice. And the patient, obviously, pays a higher copay.

So what has happened to cardiology practices, really, is the economics—and it is largely Medicare economics—have forced them to move toward hospital employment.

Mr. BUCHANAN. That is what I hear every day.

Dr. Bender, let me ask you, I am just talking with a lot of doctors that we have in our area. But I don't know how—as a business person myself for 30 years, I don't know how people make decisions in terms of capital improvements however we have got one large firm looking at trying to add facilities or in terms of hiring. I got here in 2007 and there has been probably five or six times where we have had to adjust or deal with the SGR doc fix.

As someone that has built a successful practice, and obviously you are also running a business, how does that affect you in terms

of looking to the future, in terms of providing service to patients and everything?

Dr. BENDER. Thank you, Congressman Buchanan. So I do not have a part-time patient-centered medical home, as you can imagine. We offer services regardless of payer source. So right now, maybe the good news is Medicare is getting my patient-centered medical home for free because WellPoint, UnitedHealth Care, and the other groups that are funding it through the pilot are basically paying for it.

Whether that is sustainable long-term, probably not, particularly since I am 40 percent Medicare. SGR threats are——

Mr. BUCHANAN. In our case in Florida, we are 80, 90 percent Medicare for a lot of these doctors.

Dr. BENDER. Yes. So it would be much more difficult to have a patient-centered medical home pilot. And so, for example, four years ago, when SGR did not get repealed on time and my Medicare patients were delayed for like 30 days, I called my bank and I took a $70,000 signature loan, and that is how I covered my payroll.

Now, since that time we have had the derivative markets and the Wall Street excesses, and the banking regulations have changed. I can't call my banker now and ask for a $70,000 signature loan. If SGR is not repealed, we would be bankrupt.

Mr. BUCHANAN. Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

Dr. Bender, you state that your practice is providing better quality to patients with diabetes and other common conditions. How big a role did embracing the concept of being measured on key accepted quality measures play in facilitating the quality improvements?

Dr. BENDER. Thank you, Chairman Herger. It is huge. When I was in paper, I had no idea how many diabetics I had, much less how many of them were at goal. Now I get a report every month that basically tells me now just how my individual practice is doing but how I compare to others in my region.

So, for example, if we are at 80 percent for a certain metric, that might be good, but it is in a vacuum. Once I learn that the others in the state are at 95 percent, then I realize, wow, I need to work on it. Or maybe everyone else is at 40 percent and I am the thought leader. And then they are calling me, and we discuss in a way that is FTC-proof. You know, there is no price fixing; it is academic and collegial. But we all work together to improve our quality in the pilot.

Chairman HERGER. Thank you.

Dr. Lewin, did you have something to add to that?

Dr. LEWIN. Well, I just want to say that it is measure to manage. You have got to give doctors and hospitals continuous feedback on outcomes and performance, and when you do, we just have it built into us. We want to improve.

So making that part of what we do in the future as part of our whole system is going to make the whole difference in moving us toward higher-quality care. And if you put payment incentives with it, then you double the incentive and the progress.

Chairman HERGER. Thank you.

Mr. STARK. Mr. Chairman.

Chairman HERGER. Yes?

Mr. STARK. Just a moment for a——

Chairman HERGER. Yes.

Mr. STARK. I just wanted to ask Dr. Bender if he knows what tomorrow is.

Dr. BENDER. Other than Wednesday, I am uncertain.

[Laughter.]

Mr. STARK. Uh-oh. Lewin, you are not doing your job. Do you know what tomorrow is? Tomorrow is National Heart Day, and my 10-year-old is going to school in fifth grade to jump rope for Heart Day. Get with it, you guys. You have got to get your PR machine going here.

Dr. LEWIN. We have got the whole month, sir.

Mr. STARK. If you don't know that tomorrow is——

Dr. LEWIN. It is National Heart Month and National Heart Week.

Mr. STARK. I expect you all to jump rope.

Thank you, Mr. Chairman.

Chairman HERGER. You are welcome.

Mr. STARK. Thank the witnesses for excellent——

Chairman HERGER. Everyone in this room will know what tomorrow is now, so I thank you.

I want to thank each of our witnesses for your testimony today. Your private sector experience with rewarding physicians for quality efficiency is of keen interest as we seek to reform Medicare physician payments. The fact that the different stakeholders are working together, in many cases, on this endeavor gives me increasing hope that Medicare can learn from these efforts so we can find a long-term solution that has been so elusive.

I appreciate the physician leadership exemplified by our witnesses because we need the physician community to be active participants in our reform effort. Together we must find a better way. The stakes are high. The current rate of growth in Medicare spending is unsustainable. And the congressional habit of short-term fixes is creating a great deal of uncertainty for physicians and beneficiaries.

Further, the program will go bankrupt if changes are not made. This is our reality. While I, along with many on the Republican side, believe we ultimately need to bring competition and market forces into the Medicare program in order to reduce costs, we will also continue to move forward on finding the best way to eliminate the SGR and replace it with responsible reform.

Any member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, I ask the witnesses to respond in a timely manner.

With that, the subcommittee is adjourned.

[Whereupon, at 11:33 a.m., the subcommittee was adjourned.]

## Public Submissions For The Record

### American College of Gastroenterology

February 21, 2012

The Honorable Wally Herger
Chairman, Health Subcommittee
House Committee on Ways & Means
The U.S. House of Representatives
Washington, DC 20515

Dear Chairman Herger,

The American College of Gastroenterology (ACG) and the American Society for Gastrointestinal Endoscopy (ASGE) appreciate the opportunity to submit for the record comments on the recently held hearing entitled "*Programs that Reward Physicians who Deliver High Quality and Efficient Care*" (February 7, 2012). Our societies appreciate the Committee holding this important hearing as Congress hopefully transitions away from a Medicare reimbursement model based upon the sustainable growth rate (SGR) formula to a reimbursement system that accurately pays providers and also rewards providers based on the quality of care they provide patients.

The GI Quality Improvement Consortium, or GIQuIC, is an educational and scientific organization led by the ACG and ASGE that help gastroenterologists improve quality of care and could also be used to further this objective.

The growth in physician specialty societies establishing data registries will allow for more successful ways to achieve the goal of demonstrating quality of care. As noted above, one such data collection and quality of care initiative is GIQuIC. GIQuIC is a clinical registry and collaborative effort by our societies that allows gastrointestinal specialists to collect and submit quality measures to a data repository, including measures endorsed by the National Quality Forum (NQF), the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI), and adopted by the AQA alliance. These providers receive outcome data on the procedures they provide which, in turn, they can use to improve patient care delivery. Feedback reports are provided on a group practice level or at the individual physician level, per the choice of the participants. GIQuIC allows gastrointestinal specialists to submit data that is specific to our specialty and provides them with the means to receive comparative outcome data based on other participants reporting the same measures. GIQuIC already includes more than 40,000 cases in just its first year of operation. It is worth noting that GI physicians participating in GIQuIC are doing so at their own expense in an effort to deliver the best possible care, and we believe that Congress should encourage the development and growth of these registries through its policies in reforming the Medicare reimbursement system.

ACG and ASGE welcome the opportunity to work with the Committee in developing a Medicare payment system that rewards physicians for providing high quality health care to Medicare beneficiaries

and patients. If we may provide any additional information, please contact Brad Conway, Vice President of Public Policy, ACG, at 301-263-9000, or bconway@acg.gi.org; or Camille Bonta, consultant to ASGE, at 202-320-3658 or cbonta@summithealthconsulting.com.

Sincerely,

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**American Society of Clinical Oncology**

Written Testimony of Allen S. Lichter, MD

on behalf of

The American Society of Clinical Oncology

before the

Health Subcommittee

of the

Ways and Means Committee

February 7, 2012

Thank you for the opportunity to submit written testimony for consideration by the House Ways and Means Health Subcommittee on programs that reward physicians for delivering high quality and efficient care. My name is Allen Lichter. I am Chief Executive Officer of the American Society of Clinical Oncology (ASCO) headquartered in Alexandria, Virginia. As a clinician and leader of the professional organization for physicians who treat people with cancer, I am submitting comments about Medicare payment reform in the context of cancer care and the critical link between such efforts and robust quality assessment systems. ASCO and our members have been active over the past decade in developing, supporting and participating in a robust quality assessment program that promotes high quality, high value cancer care.

If current trends continue, the nation will face ongoing, unsustainable increases in the costs of cancer care. There will be an estimated 2.3 million new cancer cases each year in the United States by 2030, and the National Cancer Institute has projected the population of cancer survivors—numbering 13.8 million in 2010—will grow to over 18 million by 2020. The care needs of cancer patients and survivors will likely exceed the capacity of the oncology workforce, which is projected to experience a nearly 30% shortfall in the supply of oncologists by 2020. All health care payers will confront the consequences of increasing cancer prevalence and costs, but as the dominant payer for elderly Americans with cancer diagnoses, Medicare faces perhaps the greatest challenge. Over half of all new cases of cancer are diagnosed in individuals who are 65 years or older.

Payers obviously are not the only group concerned about the cost of cancer care. Our patients, even those with insurance, are faced with burdensome out-of-pocket expenses. A national survey of cancer patients and family members showed that, among those with insurance, 25% reported that they

consumed all or most of their savings dealing with cancer, and 33% reported a problem paying cancer bills. A majority of oncologists report concerns regarding patients' out-of-pocket spending. In the face of projected increases, the financial burden placed on cancer patients and their families is unacceptable and unsustainable.

The increasingly challenging economic environment—and a flawed payment system—have also strained the nation's network of community based oncology practices, where the majority of cancer care occurs. Over 200 practices have either closed their doors or reduced service because they are unable to absorb the escalating cost of providing services in the context of a payment system that inadvertently penalizes those who invest in providing high quality, cost-effective care. The administrative burdens placed on these practices by the health system are growing exponentially, although typically these burdens do not result in meaningful enhancements in patient care or efficiency. Community based oncology practices provide critical access points where vulnerable cancer patients can obtain the care they need, and at the same time, community based oncology practices are extremely cost-effective in the delivery of this care. Over the past four decades, we have built an outpatient delivery system for cancer that is the envy of the world, and now as a nation, we need to act quickly to ensure that we do not lose this valuable resource.

In light of these challenges, ASCO and the oncology community have been working over the past decade to gather scientific evidence and develop strategies for improving the quality, value and efficiency of cancer care. In the remainder of these comments, I would like to describe the insights we have gained in working to address these important issues.

We have learned that significant improvements in cancer care delivery can be achieved by building upon the strengths of our existing delivery system, which relies on care provided in both the community-based physician office setting and the hospital-based outpatient setting. Policy changes that provide meaningful support for the provision of high quality, comprehensive care in these outpatient settings can bring immediate positive impacts on clinical outcomes and quality of life for cancer patients.

In taking systemic steps to improve cancer care, both patients and payers can benefit from significant efficiencies. In the area of cancer care, ASCO and our members are working with private payers and other stakeholders to pioneer approaches for treating cancer patients in the outpatient setting that avoid unnecessary emergency department visits, reduce unscheduled hospitalizations, smooth variation in care and place greater emphasis on selecting the most cost-effective drug therapies. Early results from these initial pilots—which marry practice efficiency and a strong emphasis on quality monitoring and assessment—have demonstrated significant potential for both savings and enhanced patient experiences.

To achieve the national goals of better health, enhanced quality of care, and lower costs within the uniquely complex context of patients with cancer, it is imperative that we implement a robust quality assessment system. Under virtually every type of payment reform designed to reward efficiencies in health care, it is critically important to provide safeguards that assure efforts to lower health care costs do not jeopardize access to high quality, high value care for elderly Americans with cancer. A strong, cancer-focused quality assessment program is vital to achieving this protection and must play a pivotal role in any payment reforms of the health care delivery system for cancer care.

Since 1999, efforts to enhance quality improvement have become central to ASCO's work; most notably in the development and expansion of the Quality Oncology Practice Initiative (QOPI). This effort, designed to facilitate quality measurement and continuous improvement, is the only comprehensive, national database for oncology care in ambulatory settings, where the vast majority of cancer services are provided. Begun in 2002 by ASCO as a pilot project, QOPI became available to all ASCO member medical oncologists and their practices in 2006 as a free member benefit. Over the past decade, QOPI has grown from a pilot to a national initiative with over 700 registered practices submitting data on more than 25,000 patient records every six months. ASCO has developed, tested, and implemented more than 100 cancer-specific quality measures through the program. The process is designed to be nimble, allowing for rapid integration of quality measures based on new scientific guideline recommendations, IOM reports and other sources.

ASCO's experience with QOPI has revealed that, even in the absence of incentives beyond the opportunity to improve care, a significant number of medical oncologists are able and willing to devote time and resources to participate in a system that is designed to create meaningful improvements in th quality of cancer care. Participating practices report that QOPI has caused them to re-examine their work flow and policies, improve safety measures and focus on areas that demonstrate an opportunity for improvement. For example, when compared to newly enrolled practices, those completing multiple cycles of QOPI data collection demonstrated meaningful improvements in performance on measures involving pain management, which is one of the primary drivers for unplanned emergency department visits.

A growing number of private health plans have recognized the power of programs like QOPI. In 2007, Blue Cross Blue Shield of Michigan began a program to subsidize practice participation in QOPI. Other

plans have included special recognition in provider directories for QOPI practices and still others have offered other forms of recognition for QOPI participation, including increased economic rewards and relief from certain administrative requirements such as preauthorization.

ASCO's dedication to QOPI continues, as does the program's expansion. Additional disease modules and measures are in development. Tests of data reporting from electronic health records systems are underway. And most importantly, our members and their practices continue to sign on.

Quality measurement and improvement can only work to improve value if it is meaningful and relevant to providers in their efforts to provide the highest level of care to their patients—and does not simply represent one more administrative burden. Over the past few years, ASCO has reached out to national payers and to Medicare to urge adoption of programs and measures already developed by experts in relevant diseases. ASCO is increasingly concerned about the proliferation of disconnected programs arising from multiple payers—each with their own requirements and conditions. Not only is this unlikely to improve quality, it has a strong chance of harming it. Organizations like ASCO have invested in development of programs that have strong physician support—because they are part of building it—while at the same time providing the most challenging quality assessment program for oncology practitioners. Meaningful quality measurement in cancer requires a comprehensive set of clinically-meaningful and evidence-based measures. We understand that CMS has invested in PQRS; however, the complexity and rapidly evolving science around more than 100 diseases that comprise cancer require measurement that goes beyond that can be achieved through PQRS alone. We need a system that:

- Captures the full patient experience, from diagnosis and treatment to survivorship;

- Provides rapid insight into patient outcomes, including treatment response, side effects, patient compliance, and safety signals; and
- Supports patient and physician decision making about treatment choices across all stages of the disease.

QOPI provides a uniquely strong foundation—but ASCO recognizes our members and the oncology community will benefit from an initiative with even greater sophistication. In 2011, the ASCO board directed that immediate work begin on construction of a cutting-edge rapid learning system for oncology. The rapid learning health care concept is promoted as the ultimate goal in the Federal Health IT Strategic Plan, and is described as an "*environment where a vast array of health care data can be appropriately aggregated and analyzed, turning data into knowledge that can be put to immediate use. A learning health system can shorten the gap between the creation of new knowledge and its widespread adoption in health care from the often-quoted 17 years to 17 months, or even 17 weeks.*"

Based on recommendations from an expert workshop convened by the Institute of Medicine, ASCO is leading the development of a system in which data routinely generated through care of cancer patients and cancer research feeds into a central databank or coordinated databases, triggering continuous innovation. This rapid learning system will be useful in preventing many quality issues from occurring with real time decision support, and will automate increasingly sophisticated quality reporting. Equally important, the same infrastructure will facilitate real-world studies of treatment effectiveness in patient populations that are common but rarely represented in clinical trials (*e.g.,* the elderly and patients with multiple comorbidities); it will allow for early adverse event identification, support many types of scientific research, and support studies of quality and health care disparities.

The potential power of an oncology RLS can be illustrated with the example of erythropoietin stimulating agents (ESAs). Based on studies demonstrating reduced need for blood transfusion in chemotherapy patients, the first of these agents was approved for oncology use in 1993. ESAs subsequently became a commonly used component of cancer supportive care during active treatment. Beginning in 2004, emerging safety concerns led to product label warnings. In 2007, additional studies suggesting negative effects on survival and disease progression caused the FDA and CMS to issue further product label warnings and to restrict coverage.

However, if we had access to data from an RLS at the time, with real-time capture of millions of clinical data points and patient outcomes, it is reasonable to conclude that we could have identified these safety signals by 2004, perhaps even earlier. If the use of ESAs from 2004 -2007 had been at levels seen between 2008 and 2011, the quality of health care provided to our patients would have been improved, and CMS could have saved more than $3 billion (assuming a conservative estimate of 6,000 practicing oncologists prescribing ESAs during these years).

Oncology is a logical and ripe area for the initial development and testing of an RLS because of the prevalence, seriousness, and costliness of cancer; the long tradition and integration of clinical oncology research; and the proliferation of investigational therapies. Consistent patient engagement in cancer, the acknowledged need for patient-centered care, and existing well-studied patient reported outcomes also position oncology to adopt such a care model. Importantly, transformation of oncology practices to fully integrate health information technology capabilities through a learning network can inform novel payment models that could provide incentives to enhance patient outcomes and reduce costs. Achieving a rapid learning system will be at the top of ASCO's priorities for the foreseeable future.

So, what are the next steps that we recommend?

ASCO has joined the rest of the medical community in calling for repeal and reform of Medicare's Sustainable Growth Rate (SGR) payment formula, which has not been able to properly consider treatment advances, promote quality or control costs. This payment system is at odds with the triple aim and the concept of value-based purchasing. ASCO recommends repealing and replacing the SGR with a value-based payment system, recognizing there must be a multi-year transition guided by a series of pilots that point to successful, scalable models.

Leverage the tremendous investment already made by leading specialty societies in registries, quality monitoring and measure development. In particular, in the area of cancer, build upon the emerging rapid learning system infrastructure and initiatives that ASCO is pursuing. We urge Congress and CMS to take steps that foster the development of a rapid learning system for cancer in a manner that is consistent with the Federal Health IT Strategy and the creation of care delivery systems that are ready-made for innovations. Taking advantage of lessons learned from proven and emerging programs, CMS should work with leading specialty societies to launch and test value-focused demonstration projects. In the area of oncology, ASCO is prepared to build on the work we have done in this area to improve the patient experience, not just for Medicare, but for all our patients.

Provide for fair and adequate payment levels for delivering oncology services that correlate with enhanced care and patient outcomes, including the provision of comprehensive outpatient services and treatment planning, which improve patient outcomes, reduce complications and promote the selection of efficient therapies.

Construct models that reward high performing physician practices with more favorable payment updates and relief from certain administrative requirements and burdens. The demands of today's practice environment call for significant investment to achieve required efficiencies, aggressive disease management and care coordination—all vital to both high quality care and continued economic survival. Practices making that investment should share in the savings they generate. Oncology care routinely involves services from as many as eight different types of providers and occurs across multiple practice settings. This complexity has evolved over time and presents a challenge to the traditional health system structure, both in the office based and hospital setting. Oncologists should be encouraged to make investments that can control the downstream costs of that complexity (e.g., emergency department visits, unplanned hospitalization, duplicate/unnecessary testing, etc.). Re-engineering care management, work flow, staffing and information technology to provide cost effective, high value care requires professional and financial investment—but an investment that offers significant return to the health care system, but most importantly to patients.

Chairman Herger, The American Society of Clinical Oncology stands ready to work with you and your colleagues to test new ideas, to share what we have learned through QOPI, and to continue progress towards a system that supports delivery of high quality care for every patient with cancer.

**Center for Fiscal Equity**

**Comments for the Record**

**U.S. House of Representatives**

**Committee on Ways and Means**

**The President's Fiscal Year 2013 Budget Proposals**

**Department of Health and Human Services**

Tuesday, February 28, 2012, 1:00 PM

By Michael G. Bindner

Center for Fiscal Equity

Chairman Camp Ranking Member Levin, thank you for the opportunity to submit these comments for the record to the House Ways and Means Committee. The beginning of the budget debate for a new year brings with it the opportunity to rethink proposals. The Center for Fiscal Equity is using this opportunity to change our proposed fix for Social Security and Health Care. As always, our proposals are in the context of our basic proposals for tax and budget reform, which are as follows:

- A Value Added Tax (VAT) to fund domestic military spending and domestic discretionary spending with a rate between 10% and 13%, which makes sure very American pays something.
- Personal income surtaxes on joint and widowed filers with net annual incomes of $100,000 and single filers earning $50,000 per year.
- Employee contributions to Old Age and Survivors Insurance (OASI) with a lower income cap, which allows for lower payment levels to wealthier retirees without making bend points more progressive.
- A VAT-like Net Business Receipts Tax (NBRT), which is essentially a subtraction VAT with additional tax expenditures for family support, health care and the private delivery of governmental services, to fund entitlement spending and replace income tax filing for most people (including people who file without paying), the corporate income tax, business tax filing through individual income taxes and the employer contribution to OASI, all payroll taxes for hospital insurance, disability insurance, unemployment insurance and survivors under age 60.

Discretionary activities of the Department of Health and Human Services would be funded by the VAT. While some of our VAT proposals call for regional breakdowns of taxing and spending, they do not for this department. While some activities, such as the Centers for Disease Control, exist outside the Washington, DC metro area, even these are site specific rather than spread out on a nation-wide basis to serve the public at large. While some government activities benefit from national and regional distribution, health research will not.

The one reform that might eventually be considered in this area is to more explicitly link government funded research with ownership of the results, so that the Department might fund some of their operations with license agreements for some of the resulting research, enabling an expanded research agenda without demanding a higher budget allocation.

Of course, regionalization is possible if the Uniformed Public Health Service is put into the role of seeing more patients, particularly elderly patients and lower income patients who are less than well served by cost containment strategies limiting doctor fees. Medicaid is notoriously bad because so few doctors accept these patients due to the lower compensation levels, although we are encouraged the health care reform is attempting to reduce that trend. Medicare will head down that road shortly if something is not done about the Doc Fix. It may become inevitable that we expand the UPHS in order to treat patients who may no longer be able to find any other medical care. If that were to happen, such care could be organized regionally and funded with regionally based taxes, such as a VAT.

The other possible area of cost savings has to do with care, now provided for free, on the NIH campus. While patients without insurance should be able to continue to receive free care, patients with insurance likely could be required to make some type of payment for care and hospitalization, thus allowing an expansion of care, greater assistance to patients who still face financial hardship in association with their illnesses and a restoration of some care that has been discontinued due to budget cuts to NIH.

The bulk of our comments have to do with health and retirement security.

One of the most oft-cited reforms for dealing with the long term deficit in Social Security is increasing the income cap to cover more income while increasing bend points in the calculation of benefits, the taxability of Social Security benefits or even means testing all benefits, in order to actually increase revenue rather than simply making the program more generous to higher income earners. Lowering the income cap on employee contributions, while eliminating it from employer contributions and crediting the employer contribution equally removes the need for any kind of bend points at all, while the increased floor for filing the income surtax effectively removes this income from taxation. Means testing all payments is not advisable given the movement of retirement income to defined contribution programs, which may collapse with the stock market – making some basic benefit essential to everyone.

Moving the majority of Old Age and Survivors Tax collection to a consumption tax, such as the NBRT, effectively expands the tax base to collect both wage and non-wage income while removing the cap from that income. This allows for a lower tax rate than would otherwise be possible while also increasing the basic benefit so that Medicare Part B and Part D premiums may also be increased without decreasing the income to beneficiaries**. Increasing these premiums essentially solves their long term financial problems while allowing repeal of the Doc Fix.**

If personal accounts are added to the system, a higher rate could be collected, however recent economic history shows that such investments are better made in insured employer voting stock rather than in unaccountable index funds, which give the Wall Street Quants too much power over the economy while further insulating ownership from management. Too much separation gives CEOs a free hand to divert income from shareholders to their own compensation through cronyism in compensation committees, as well as giving them an incentive to cut labor costs more than the economy can sustain for consumption in order to realize even greater bonuses.

Employee-ownership ends the incentive to enact job-killing tax cuts on dividends and capital gains, which leads to an unsustainable demand for credit and money supply growth and eventually to economic collapse similar to the one most recently experienced.

The NBRT base is similar to a Value Added Tax (VAT), but not identical. Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

A key provision of our proposal is consolidation of existing child and household benefits, including the Mortgage Interest and Property Tax Deductions, into a single refundable Child Tax Credit of at least $500 per month, per child, payable with wages and credited against the NBRT rather than individual taxes. Assistance at this level, especially if matched by state governments may very well trigger another baby boom, especially since adding children will add the additional income now added by buying a bigger house. Such a baby boom is the only real long term solution to the demographic problems facing Social Security, Medicare and Medicaid, which are more demographic than fiscal. Fixing that problem in the right way definitely adds value to tax reform.

The NBRT should fund services to families, including education at all levels, mental health care, disability benefits, Temporary Aid to Needy Families, Supplemental Nutrition Assistance, Medicare and Medicaid. Such a shift would radically reduce the budget needs of HHS, while improving services to vulnerable populations.

The NBRT could also be used to shift governmental spending from public agencies to private providers without any involvement by the government – especially if the several states adopted an identical tax structure. Either employers as donors or workers as recipients could designate that revenues that would otherwise be collected for public schools would instead fund the public or private school of their choice. Private mental health providers could be preferred on the same basis over public mental health institutions. This is a feature that is impossible with the FairTax or a VAT alone.

To extract cost savings under the NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit, provided that services are at least as generous as the current programs. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but not so much that the free market is destroyed. Increasing Part B and Part D premiums also makes it more likely that an employer-based system will be supported by retirees.

Enacting the NBRT is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Conceivably, NBRT offsets could exceed revenue. In this case, employers would receive a VAT credit.

The Center calculates an NBRT rate of 27% before offsets for the Child Tax Credit and Health Insurance Exclusion, or 33% after the exclusions are included. This is a "balanced budget" rate. It could be set lower if the spending categories funded receive a supplement from income taxes. These calculations are, of course, subject to change based on better models.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

**Contact Sheet**

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**Committee on Ways and Means**
**The President's Fiscal Year 2013 Budget Proposals**
**Department of Health and Human Services**
**Tuesday, February 28, 2012, 1:00 PM**

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.

**Gundersen Lutheran Health System**

February 7, 2012

The Honorable Wally Herger, Chair
House of Representatives
Ways and Means Committee, Subcommittee on Health
1102 Longworth House Office Building
Washington D.C. 20515

**Re: Hearing on innovative quality and efficiency healthcare programs**

Dear Chairman Herger and members of the Ways and Means Subcommittee on Health:

I write to you on behalf of Gundersen Lutheran to share with you one of our many innovative approaches to providing healthcare to our patients that incentive quality and efficiency of healthcare. I want to thank you for calling this important hearing on approaches to improving the health of our nation's population and incentivizing providers to deliver high quality healthcare.

Gundersen Lutheran is an integrated tertiary teaching health system headquartered in La Crosse, Wisconsin. Our locations cover Wisconsin, Minnesota, and Iowa along the rural stretches of the Mississippi River. We serve over one million patient visits per year and operate a tertiary care hospital, critical access hospitals, dozens of clinics, air and ground ambulance, a health plan and medical education program. Gundersen Lutheran is a Thomson Reuters Top 100 hospital and top scorer in many HealthGrades clinical areas.

Gundersen Lutheran is a strong supporter of reforming the current Medicare fee-for-service payment model to incent efficiency and quality of care. In promoting healthcare delivery to reward *value,* the current reimbursement system needs to move away from rewarding volumes of care. In essence, health providers should be incentivized to keep patients healthy, driving down the cost of healthcare while improving outcomes.

Approximately 5% of the United States population accounts for half of healthcare costs. It is important to improving the health of our nation that our efforts to reform the delivery system focus on chronically ill populations. At Gundersen Lutheran, we developed a Care Coordination program that guides patients through the healthcare process with complex medical, social and financial needs. Our program has demonstrated to improve the quality of care and lowers healthcare costs by helping patients manage their disease and stay as healthy as possible. A major study of Care Coordination programs published in the February 2009 issue of *JAMA* found a model that blended an emphasis on patient education along with a close working relationship with both physicians and hospitals achieved healthcare savings. That is exactly the model we have implemented here at Gundersen Lutheran—a model that the current fee-for-service reimbursement system does not incentivize.

At Gundersen Lutheran, we chose to enroll the sickest 1% to 2% of our patients who met the Care Coordination program criteria. These patients are some of our highest utilization patients. After using the Care Coordination program, patients have been shown to:

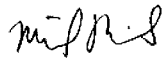
- Reduce their healthcare costs by approximately $18,000 per patient over 24 months.

**External Affairs Department 1900 South Avenue, Mailstop: C01-011, La Crosse, WI 54601**
**Email: ExternalAffairs@gundluth.org Phone: 608-775-1400 Fax: 608-775-6225**

- Use the healthcare system more appropriately, with fewer and shorter hospital stays and more preventive care.
- Receive the assistance they need to better manage their disease as their care coordinator helps them understand their illness, physician instructions, medications, etc.

In sum, on behalf of Gundersen Lutheran, we continue to support efforts to reform the current Medicare reimbursement system to move to value. Our care coordination program is an innovative approach to reducing healthcare costs while ensuring the optimal level of service utilization. We thank you for calling this hearing and look forward to continue working with the House Ways and Means Committee on developing innovative approaches to delivering healthcare.

Please feel free to contact me with any questions.



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**Integrated Healthcare Association**

February 10, 2012

Chairman Wally Herger, Subcommittee on Health
United States House Committee on Ways and Means
1102 Longworth House Office Building
Washington D.C. 20515

Dear Chairman Herger and Members of the Committee,

My name is Tom Williams, and I am the President and CEO of the Integrated Healthcare Association (IHA) in Oakland, California (the required contact information is included at the end of this letter). IHA is a non-profit California-wide multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care. Our activities include convening all healthcare parties for cross-sector collaboration on health care topics, administering regional and statewide programs, and serving as an incubator for pilot programs and projects.

Thank you for this opportunity to provide input on rewarding quality and efficiency in care delivery for Medicare providers. These comments are informed by IHA's ten-year administration of the California Pay for Performance (P4P) Program, the largest non-government P4P program in the United States. This program spans the state of California, covering 200 physician organizations representing about 30,000 physicians providing care to 10 million commercially insured patients in eight participating health plans.

Measuring and rewarding provider performance is a pivotal component of the solution to the dual problems of high cost and low quality that plague healthcare in America today. IHA's experience shows that quality and cost measurement can be done in a way that engenders physician buy-in to the process and investment in improvement; a 2009 evaluation of the program by researchers from RAND and the University of California, Berkeley found that participating organizations increased their organizational focus on, and support for, quality improvement, and increased both physician-level feedback and accountability for quality and the speed of adoption of health information technology.

Our experience over the past ten years offers key lessons concerning standardized quality metrics; the importance of a balanced, comprehensive measure set; creating incentives large enough to drive physician behavior; and rewarding both high performance and performance improvement. These are outlined below in an effort to help Committee members consider how to best design reimbursement strategies that will reward quality and efficiency by Medicare providers.

***Standardized Quality Metrics***
Many healthcare providers across the country are already subject to performance measurement and incentives by one or more of their payers. Measurement is a costly undertaking for providers, who must invest in data collection and reporting mechanisms in order to do well. Although measuring the performance of the healthcare system is important in understanding the quality of care delivered, too much measurement distracts from the ultimate goal of measurement – performance improvement.

Using pre-existing, national standardized quality metrics that align with current measurement and reporting programs (or planned programs that will be implemented in Medicare under the *Affordable Care Act*) can help to alleviate the burden of measurement and reporting on providers, and allow them to focus on improving the quality of care delivered.

Aligning quality metrics with existing Medicare programs, such as the Medicare Shared Savings and Pioneer ACO Programs, would have the added advantage of allowing for comparability between Medicare providers in different programs, thus helping to inform future decisions on payment and delivery system reform.

***A Robust, Comprehensive Measure Set***
Healthcare quality and efficiency are multi-faceted concepts that encompass following evidence-based processes of care, monitoring under-use and over-use of resources, structural measures of provider capacity (e.g. Meaningful Use measures), how patients perceive the quality of care delivered, and ameliorating patient outcomes. Any measurement initiative should include measures in all of these domains in order to give providers, purchasers (in this case Medicare), and consumers a meaningful picture of the overall quality of care delivered.

The California P4P Program's own measure set includes 85 measures in all of these categories, as seen in the accompanying table. These measures were introduced gradually over the life of the program – when measurement began in 2003, the measure set was comprised of only 25 measures. Introducing measures over time gives providers a chance to become comfortable with measurement and the process of improvement.

**Table: California P4P Measure Set Expansion, 2003-2011**

| Measurement Domain | 2003 | 2005 | 2007 | 2009 | 2011 |
|---|---|---|---|---|---|
| **Clinical – Preventive** | 8 | 10 | 12 | 14 | 18 |
| **Clinical – Chronic** | 3 | 9 | 10 | 12 | 17 |
| **Clinical – Acute** | 0 | 1 | 1 | 4 | 4 |
| **Patient Experience** | 6 | 7 | 7 | 9 | 9 |
| **Meaningful Use of HIT** | 8 | 10 | 19 | 21 | 20 |
| **Efficiency/Resource Use** | 0 | 0 | 0 | 16 | 17 |
| **Total** | **25** | **37** | **49** | **76** | **85** |

The California P4P Program began measuring efficiency and resource use in 2009 with a set of sixteen appropriate resource use measures that focus on overuse and underuse of key healthcare resources (e.g. hospitalization, readmissions, and generic drug use). In 2011, a new measure of Total Cost of Care was introduced that captures the total cost of care – including all covered

professional, pharmacy, and ancillary care – delivered to all patients enrolled in a physician organization on a per-member basis. Program stakeholders, including the physician groups subject to measurement, have embraced these measures as vital to understanding the overall quality of care delivered.

Although measuring efficiency and costs is key to first understanding, and then lowering, the costs of healthcare in this country, cost and resource use measurement is a relatively new frontier in American healthcare, as witnessed by the fact that the National Quality Forum has only recently endorsed resource use and cost measures. Looking at these measures is a good place for Medicare to begin when deciding upon what resource use measures to employ in any payment reform initiative.

***Creating Incentives Large Enough to Drive Physician Behavior Changes***
In order for incentive programs to drive changes in physician behavior, they must comprise a meaningful percentage of total compensation, generally thought to be around 10%. When the California P4P Program began in 2001, one of its overarching goals was "breakthrough" improvements in California's quality performance. To date, this goal has not been reached in part because performance incentives have made up a relatively small portion – less than 2% - of total physician compensation.

Saving money and improving quality in the Medicare program will require CMS to implement incentives that are large enough to drive changes in provider behavior. Any reform must also be monitored to ensure that the potential negative impacts of performance-based pay (e.g. patient exclusion and "teaching to the test," or focusing on what is measured to the exclusion of other, equally important aspects of care) are minimized.

***Rewarding Both High Performance and Performance Improvement***
Along with the size of incentives available, how those incentives are structured is also important in driving behavior. Certain payment methodologies are better-suited to driving improved quality across providers, regardless of initial performance, than others. Payments that reward high performance and performance improvement, rather than rewarding based on relative rank, are the most effective at encouraging improvement across the board.

The California P4P Steering Committee has adopted a recommendation that all participating health plans adhere to a standard payment methodology based on CMS' Value Based Purchasing methodology, which scores the performance of each physician organization in two ways: first, based on level of attainment, and second, based on the amount of improvement. The higher score is then used to determine payment amount.

***Bringing it All Together: Key Lessons***
Our experience over the past ten years offers four key lessons that Committee members must keep in mind when considering how to reward quality and efficiency by Medicare providers:

1. Use pre-existing, standardized quality metrics that align with already-existing performance measurement and reporting programs;

2. The measure set should be comprehensive, and address clinical quality (both process and outcome), appropriate resource use and costs, structural elements of the care setting, and patient experience of care;
3. Quality-based incentives must be substantial enough to drive physicians to deliver higher-quality, lower-cost care; and
4. Payment mechanisms must be designed to reward both high performance and performance improvement.

We applaud the Subcommittee on Health for taking on such an important topic; Medicare spending currently comprises approximately 13% of federal outlays, and bringing this number down is key to the ability to lower federal debt without crowding out equally important federal programs, as well as maintaining the US's competitiveness well into the future.

Sincerely,

Tom Williams
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## Pacific Business Group on Health

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**Statement for the Record**

**U.S. House of Representatives Ways and Means Committee**
**Subcommittee on Health**

**Hearing on Programs that Reward Physicians for High Quality and Efficient Care**

**February 21, 2012**

Dear Chairman Herger, Congressman Stark, and Distinguished Members of the Subcommittee on Health:

The Pacific Business Group on Health (PBGH) is one of the nation's leading non-profit business coalitions focused on health care. PBGH works on many fronts to improve the quality and affordability of health care, often in close partnership with health insurance plans, physician groups, hospital systems, and consumer organizations. We leverage the power of our 50 large purchaser members representing a wide range of industries who spend 12 billion dollars annually to provide health care coverage to more than 3 million employees, retirees and dependents.

Private sector and state purchasers have been at the forefront of innovative efforts to reward quality and efficiency in care delivery while reducing complications and wasteful spending. Performance transparency and performance-based payment are critical to addressing affordability and improving health outcomes. The collective experience of private purchasers not only offers important lessons to inform Medicare strategies, it provides hope for what can seem an insurmountable task.

Employers wish to recognize and pay providers favorably for achieving high quality care and efficient use of resources. The critical challenge to implementing such pay-for-value programs is our continuing difficulty in measuring performance along these dimensions of great social and policy importance. Employers wish to pay more to providers who help patients achieve good health outcomes, maintain positive health status and functioning, and make clinical decisions consistent with the best medical evidence. They wish to reward providers who collaborate with other health professionals and facilities, and with caregivers in the community, to manage an entire episode of illness more efficiently. Yet today there is a dearth of measures in these critical domains. As a result, our lessons learned continue to focus on the poor availability of key data and resulting measures. The following are lessons we have learned:

- **Use a parsimonious set of measures that 1) matters to patients, 2) reinforces other programs, and 3) evolves as better measures become available.** Employing a set of high-value measures drives attention to areas of high impact, gives consistent "signals" to physicians on where to focus, and reduces confusion from the cacophony of measures.

- **Identify the ideal dashboard of measures and chart a course for reaching the destination. Existing measures do not cover all the areas that are important to patients and purchasers.** A roadmap on

how to fill in the gaps in measures is important to evolving the field of performance measurement and so we can collectively make judicious use of resources.

- **Payment reform will not reach its full potential if it continues to be based on a system that is inherently flawed.** We know it will take time to move away from the current RBRVS system. Thus, making improvements to fee-for-service payment to physicians while also implementing new payment systems is imperative to the affordability and sustainability of health care.

- **Align select program activities (e.g., goals, measurement, and payment) across programs, both public and private sector.** Alignment creates synergies across programs, reduces the amount of effort physicians expend on data collection, and ensures that we are all "rowing in the same direction."

- **Focus on individual physicians, where variation in performance is most evident, and not just higher levels of aggregation, whenever feasible.** Programs generate the greatest improvements if it promotes individual accountability, in concert with shared accountability. Individual accountability reinforces professional motivation for quality improvement, provides information for patients to use in choosing physicians, and identifies improvement areas that are masked by higher levels of aggregation. As we see with the Sustainable Growth Rate and other initiatives, incentives applied at the group level can be less effective.

Below, we provide information on programs implemented by PBGH and its members from which these lessons are drawn.

Ambulatory Intensive Care Unit

The Ambulatory Intensive Care Unit (AICU) is a primary care-led, high intensity care management model for the high risk population. The design was funded by a grant from the California HealthCare Foundation (CHCF) to develop an innovative model of delivering care as a strategy for reducing costs while maintaining or improving quality. The designs and financial projections underwent a peer review panel of subject matter experts and leaders of traditional and more innovative practices.

The Boeing Company implemented a pilot of this model, which they called the Intensive Outpatient Care Program (IOCP), in Seattle. Key features of the model included:

- The program focused on high risk patients, i.e., the 5-20% who incur the highest costs.
- Each site created a new ambulatory intensivist practice.
- Practices were staffed by a physician, a nurse "health coach", and other support.
- The sites implemented shared care plans, increased access, and proactively managed care.
- Copays for the initial intake visit were waived; there were no other benefit changes.
- Sites were paid a case rate per member per month (pmpm) to cover non-traditional services; otherwise, the sites continued to be paid based on traditional fee-for-service contracts.
- The sites received a portion of the savings in total medical expenses.

Over a two-year pilot, Boeing achieved improved outcomes, lower costs, and increased patient access to care. The table on the next page summarizes the results. (Milstein & Kothari, 2009)[1,2]

## Boeing IOCP pilot, ran from January 2007 through July 2009.

IOCP Boeing Pilot results as published on Health Affairs blog 2009.10.20:

| Measure compared to baseline | Result |
|---|---|
| Health care costs of pilot participants versus control group | - 20.0% |
| Hospital admissions | - 28% |
| Improvement in mental functioning of pilot participants | + 16.1% |
| Participants feeling that care was "received as soon as needed" | + 17.6% |
| Average number of patient-reported workdays missed, 6 months | - 56.5% |

Following the success of the Boeing pilot, PBGH worked with CalPERS and Pacific Gas and Electric Company (PG&E) to replicate the model in rural Northern California with the Humboldt del Norte Foundation Medical Group. This program targets the top 20 percent of patients in terms of relative health risk. Leveraging the infrastructure of the medical group to serve a self-funded PPO population, care managers work closely with beneficiaries to coordinate care, design a self-care plan and connect the members to needed resources. In addition to the regular fee-for-service payments, the purchasers pay a monthly case management fee, and agreed to a distribution of shared savings among the purchaser, medical group, and Anthem Blue Cross. This pilot is being expanded in St. Louis, MO and Southern California.

Other PBGH members are experimenting with models for accountable care organizations (ACO). For example, CalPERS implemented an ACO-like pilot with Hill Physicians Medical Group, Dignity Health (formerly Catholic Healthcare West) and Blue Shield of California that introduced a shared savings model for improving care coordination and quality for 42,000 HMO beneficiaries in the greater Sacramento

[1] Milstein, A and Kothari P, Health Affairs, October 20th, 2009. Accessed at http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/.

[2] This model was also highlighted in Atul Gawande's recent "Hot Spotters" article in the New Yorker, and documented on the Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange. http://www.innovations.ahrq.gov/content.aspx?id=2941. Additionally, Steve Jacobson, MD and Jennifer Wilson-Norton of The Everett Clinic presented on "Connecting Providers and Managing High Risk Beneficiaries" at the CMS ACO Accelerated Development Learning Session on September 16, 2011, https://acoregister.rti.org/docx/dsp_lnks.cfm?doc=Module 3B. Connecting Providers Managing High Risk.pdf

area. Early results showed a $15.5 million cost reduction annually due to a 17% reduction in patient re-admissions and shorter lengths of stay.[3] Five months later, those results were updated to reflect $20 million cost reduction over the two years of the program, largely due to a 22% reduction in hospital readmissions[4,5].

Reference and Value Pricing

Reference pricing establishes a standard price for a drug, procedure, service or bundle of services, and generally requires that health plan members pay any allowed charges beyond the cap. In a Value Pricing arrangement, quality is considered in addition to the standard price. The goals of these programs are to:

- Encourage providers to offer lower prices.
- Encourage member engagement while preserving choice.
- Decrease the substantial price variation per unit.
- Increase value in health care.

Safeway Inc. and CalPERS have introduced reference pricing benefit designs that establish a fixed benefit coverage level for select services to incent selection of high-value providers and identify those providers who are price outliers relative to community averages. Examples of reference-priced services include colonoscopy, cataract surgery, hip and knee joint replacement, arthroscopy surgery, advanced imaging, and routine diagnostic laboratory procedures. For example, Anthem Blue Cross and CalPERS have established a threshold—reference price—of $30,000 for a standard inpatient hip/knee replacement procedure. (Note: prices vary from $15,000 to $110,000 in their commercial PPO population). The program to date has resulted in a 6.8% increase in volume at designated facilities, average facility paid amount per procedure was lowered by 26.5%, and some facilities are negotiating reduced costs to accommodate the program.

California Physician Performance Initiative

The California Physician Performance Initiative (CPPI), launched in 2006, is a multi-stakeholder initiative to measure and report on the performance of individual physicians throughout California using

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[3] CalPERS Press Release. (2011, April 12). *Press Release: April 12, 2011.* Retrieved February 21, 2012, from www.calpers.ca.gov: http://www.calpers.ca.gov/index.jsp?bc=/about/press/pr-2011/april/integrated-health.xml

[4] CalPERS Agenda Item 4. (2011, October 18). *Agenda Item 4 Memo to the Members of the Health Benefits Committee.* Retrieved February 21, 2012, from www.calpers.ca.gov: http://www.calpers.ca.gov/eip-docs/about/board-cal-agenda/agendas/hbc/201110/item-4.pdf

[5] Blue Shield of California Press Release. (2011, September 16). *HHS Secretary Kathleen Sebelius Reviews Key Pilot Program Tied to Health Care Reform Goals.* Retrieved February 21, 2012, from www.blueshieldca.com: https://www.blueshieldca.com/bsca/about-blue-shield/newsroom/sebelius-reviews-aco-pilot-programs.sp

information from a multi-payer claims database. This work is being conducted by the California Cooperative Healthcare Reporting Initiative (CCHRI), a statewide collaborative of physician organizations, health plans, purchasers and consumers that work collectively to help consumers and purchasers make informed health care decisions. CPPI's goal is to improve patient care and its affordability by:

- Reporting results to physicians to help them gauge how well care for their patients meets national standards of care.
- Applying the performance results in ways that help consumers and purchasers get better value when choosing and using health care; and
- Adopting performance measures and reporting methods using the best available science.

CPPI clinical quality results were mailed to more than 13,000 California physicians in July 2009. CPPI's physician-specific results are derived from the medical claims data aggregated across California's three largest commercial PPO health plans (Anthem Blue Cross, Blue Shield of California and United Healthcare) and the Anthem Blue Cross and Blue Shield of California commercial HMO health plans. Upon mailing the CPPI Performance Reports to physicians, each physician was asked to review and, as needed, correct their demographic record or quality scores. Any corrections provided by the deadline were applied to correct the quality results before the information was provided to health plans. CPPI assessed physician performance using clinical quality measures that are evidence-based, nationally standardized and endorsed by major standard-setting bodies (i.e., the National Quality Forum, or "NQF"). The measures address preventive care and chronic condition management and were approved by the CPPI Physician Advisory Group.

Blue Shield of California has launched its physician quality recognition program based on CPPI results. A set of physicians, who have sufficient patient samples to be reliably scored, was designated as higher quality performing physicians for select preventive screening and chronic care measures. Blue Shield members can view this new information in the plan's online physician directory.

California Joint Replacement Registry

Working with the California Orthopedic Association and the California HealthCare Foundation, PBGH launched the California Joint Replacement Registry (CJRR), a Level 3 clinical registry. The goals of the registry are to: (a) collect and report scientifically valid data on the results of hip and knee replacements performed in California, including device safety and effectiveness, post-operative complication and revision rates, and patient-reported assessments; and (b) promote the use of performance information regarding hip and knee replacements to guide physician and patient decisions and support programs for provider recognition and reward, and thereby encourage quality and cost improvements through marketplace mechanisms. The registry is specifically designed to:

- Compile reports assessing the outcomes associated with different devices and surgical techniques.
- Create confidential benchmarking reports for physicians and hospitals on their performance and comparisons to statewide averages.
- Establish a registry-facilitated process for reporting Physician Quality Reporting System (PQRS) measures to CMS for receipt of bonus payments.
- Transmit safety alerts on devices with short-term results that provoke concern.
- Shape a measurement and reporting system for orthopedic procedures.

- Provide patients with useful information about outcomes after surgery to help them make decisions about their care.

In August 2011, the CJRR concluded a three month pilot phase. Three sites, representing 12 surgeons, who perform 5 percent of the hip and knee replacements in California annually, participated in the pilot phase and continue to contribute data to the registry. During 2012, the CJRR will refine its operations and expand to include six additional hospital sites, accounting for 10-15 percent of the hip and knee replacements in California annually. Future strategies also include engagement of health plans to reward providers that participate in sharing their information and engage in quality improvement efforts.

Catalyst for Payment Reform

Catalyst for Payment Reform (CPR) is an independent, non-profit corporation working on behalf of large employers to catalyze improvements to how we pay for health care in the U.S. to signal powerful expectations for better and higher-value care. CPR was conceived in January 2009 and several of PBGH members are actively participating. CPR is guided by a multi-stakeholder Leadership Committee of influential experts and decision makers in health care. Key strategies and activities being implemented by CPR include:

- Demanding payments be designed to cut waste or reflect performance
  - Track progress with a National Scorecard on payment reform
  - Improve current payment methods (e.g. FFS) while pushing for new forms of payment
  - Achieve 20% value-oriented payment by 2020
- Leveraging purchasers and creating alignment
  - Encourage use of standard health plan RFI questions and a model contract to open a dialogue with plans about payment reform priorities
  - Alignment with CMS
- Implementing Innovations
  - Encourage price transparency
  - Implement reference or value pricing
  - Change maternity care payment to align with clinical evidence

To conclude, we concur that the Medicare fee-for-service system is financially unsustainable and that the "pay-it-forward" suspension of the Sustainable Growth Rate (SGR) places mounting pressure on the federal budget. Efforts have been made to use value-based payment but it has not been nearly sufficient. Although there are innovative initiatives in physician payments, it is still much more prevalent for physicians to be paid the same irrespective of their quality and efficiency. The federal government must act as a prudent purchaser and support information every American needs to get better care as a public good.

As you consider options to revise Medicare's physician payment system, it is important to recognize that any changes will impact costs and quality in the private sector. Private purchasers are looking to Medicare to be their partner – to work in parallel and take major steps forward together. Thank you for the opportunity to provide comments. If you have any questions or need additional information, please

contact William Kramer, MBA, Executive Director for National Health Policy or David Lansky, PhD, President & CEO for Pacific Business Group on Health.

**The Alliance of Specialty Medicine**

*Sound Policy. Quality Care.*

# Statement for the Record

**of the**

# Alliance of Specialty Medicine

**before the**

## Ways and Means Subcommittee on Health
## U.S. House of Representatives

**on the topic**

## "Programs That Reward Physicians Who Deliver High Quality and Efficient Care"

The Alliance of Specialty Medicine (Alliance), a coalition of 12 national medical specialty societies representing approximately 100,000 physicians and surgeons, would like to thank the Committee on Ways and Means, Subcommittee on Health for the opportunity to submit testimony for its February 7, 2012, hearing on "Programs That Reward Physicians Who Deliver High Quality and Efficient Care." The Alliance is dedicated to advocacy for the development of sound federal health care policy that fosters patient access to the highest quality specialty care. To that end, the Alliance appreciates the Subcommittee's consideration of innovative approaches to recognizing and rewarding physician quality and efficiency in its search for a long-term solution to the Medicare physician payment system. Many of these medical specialty societies have a physician-driven national quality improvement initiative based on national registries with clinically-relevant performance measures developed from evidence-based guidelines. While more work remains, these physician-driven initiatives provide a unified approach to benchmark specialty practices and provide relevant feedback to physicians on how their performance compares with the national standard. Nevertheless, the Alliance remains deeply concerned that many payer-led quality improvement efforts are misaligned with physician-driven quality initiatives, lack sufficient flexibility to accommodate different specialties and care settings, rely on measures that are inadequately risk adjusted and not necessarily linked to better patient outcomes, and divert significant resources away from direct patient care.

As you already know, unless Congress acts, the flawed SGR formula will continue to slash physician payments by more than 40 percent over the next decade, despite the fact that Medicare reimbursement rates are already well below market rates. Deep cuts jeopardize the viability of many physicians' businesses and imperil Medicare beneficiaries' access to specialty care. The Alliance supports replacing Medicare's SGR formula with a stable mechanism for updating Medicare fees that adheres to the following principles:

- **Ensures that all physicians receive adequate reimbursement.** Physician shortages are looming in many specialties, not just primary care, and any payment differentials will further exacerbate significant shortages of specialty physicians.
- **Recognizes reasonable inflationary medical costs** such as the Medicare Economic Index (MEI).
- **Allows Medicare beneficiaries access to the physician of their choice.** Patients and physicians should be able to freely contract for Medicare covered services without having to lose their Medicare benefits.
- **Maintains a fee-for-service option.** As other payment systems are explored for both Medicare and the private sector, it is important that both public and private payers maintain a fee-for-service option, as this may work best for some physicians and their patients, especially those with serious illness or in underserved areas where provider choice is already limited. The key is not eliminating fee-for-service, but rather identifying where this option makes the most sense.
- **Provides an appropriate timetable and required investment for reforms.** New payment systems, including those targeting quality and efficiency, need appropriate time for proper implementation, as well as investment in key infrastructure.
- **Aims to improve quality and efficiency** through flexible strategies that are evidence-based, meaningful and appropriate for a range of patient populations and care settings, feasible, and non-punitive.

Given the emphasis of this hearing, the sections below will focus on those elements critical to ensuring successful implementation of efforts to improve physician quality and efficiency.

**Measurement Development and Selection**

Many measures widely used in public and private payer recognition programs are of questionable value and are not necessarily valid indicators of quality or value. For example, a study recently

published in the Archives of Internal Medicine[1] linked higher patient satisfaction scores with greater healthcare costs and increased risk of mortality, suggesting a tenuous link between patient satisfaction and healthcare quality and outcomes. Using data from more than 50,000 patients, the study found that those who reported the most satisfaction with their care had a 26 percent higher mortality risk, after adjusting for health status, sociodemographics, insurance status, and other factors. Those patients also had higher overall healthcare expenditures, higher drug expenditures and higher inpatient admissions. Despite the growing reliance on satisfaction scores as a tool for evaluating physician performance, efforts to satisfy patients may have downsides that lead to unnecessary care and risks without the benefits.

To ensure that measures are meaningful to consumers and reflect a variety of clinical encounters, quality improvement programs should employ a combination of measures, including 1) process-of-care measures for which evidence shows that better performance leads to better outcomes, 2) measures that evaluate outcomes directly, and 3) structural measures that encourage the use of technology and other infrastructure to improve quality and efficiency. This multi-pronged approach helps minimize the pitfalls of relying solely on process-of-care measures, which are not always relevant to all specialties and can encourage gaming, or solely on outcomes measures, which may be difficult to achieve and beyond the control of physicians. The Alliance recommends that a physician-driven, unified approach to quality improvement is the best approach to determine the combination of measures that will reduce variation in care and provide clinically-relevant feedback to physicians.

The Alliance asks that both the public and private sector give careful consideration to the development of cost of care measures-- an undeveloped area of measure development that is in its infancy. Payers continue to struggle with how to accurately define and measure appropriate resource utilization in health care and very few trustworthy mechanisms currently exist. In fact, the RAND Corporation recently issued a series of studies that questioned the reliability of cost profiling.[2] [3] One study found that physician ratings based on cost of care can be incorrect up to two-thirds of the time for some physician specialties while misclassifying one-fourth of all physicians under the *best-case* scenario used by most health insurers. The authors ultimately concluded that "current methods of physician cost profiling are not ready for prime time" and that "current cost profiling approaches need to be improved, or new approaches need to be developed." The Alliance recommends that physician performance not be linked to cost of care measures until further study and refinement occur.

Measures that evaluate spending must be evidence-based and must be primarily aimed at improving the quality of patient care, rather than achieving monetary savings. The practice of medicine cannot be judged on cost alone, especially since improvements in care often require the expenditure of resources and may lead to increased spending. A 2009 study, for example, underscored how difficult it can be to predict when additional treatments – and, thus, spending – will benefit a particular patient and suggested that there are instances in health care when more spending can actually save lives.[4]

The Alliance also recommends that payers carefully consider the limitations of using procedure volume as an indicator of quality or efficiency, especially for complex, heterogeneous aspects of specialty care.[5] [6] [7] Since high volume is not always associated with superior outcomes, this

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[1] Fenton, J., et al. **The Cost of Satisfaction.** Arch Intern Med. Published online February 13, 2012, at http://archinte.ama-assn.org/cgi/content/abstract/archinternmed.2011.1662v1

[2] Adams, J., et al. Physician Cost Profiling — Reliability and Risk of Misclassification. N Engl J Med 2010; 362:1014-21.

[3] Mehrotra, A., et al. The Effect of Different Attribution Rules on Individual Physician Cost Profiles. *Ann Intern Med.* 2010; 152:649-654.

[4] Ong, M., et al. Looking Forward, Looking Back: Assessing Variations in Hospital Resource Use and Outcomes for Elderly Patients with Heart Failure. Circulation: Cardiovascular Quality and Outcomes. Published online October 13, 2009 at http://circoutcomes.ahajournals.org/content/early/2009/10/13/CIRCOUTCOMES.108.825612.short

[5] Daley J. Quality of care and the volume-outcome relationship— what's next for surgery? Surgery 2002;131:16-8.

[6] Sheikh K. Reliability of provider volume and outcome associations for healthcare policy. Med Care 2003;41:1111-7.

[7] Heros RC: Editorial: Case volume and outcome. J Neurosurg 99: 945-946, 2003.

information should only be used in confidential feedback reports to physicians and not in reports released to the public.

While measures should be developed through a consensus process that includes all relevant stakeholders, physician involvement in the development and testing of measures is critical and the only way to ensure measures are valid *and* clinically appropriate. Process and outcomes measures should be based on the highest levels of evidence available, but should also take into account importance and feasibility to collect and report data. Overall, the Alliance recommends that measures should be clinically-relevant to improve patient care, and not simply adhered to for the sake of reporting or to comply with a poorly developed quality initiative.

Measures should be carefully developed to take into account differences in patient health and patient compliance with treatment. The importance of risk adjustment cannot be overstated, especially when payment is tied directly to physician performance. If the measurement specification is not accurately adjusted, physicians who provide compassionate treatment to more complicated or riskier patients-- such as those with multiple chronic conditions-- will suffer the unintended consequence of performing below the national standard and may try to avoid such patients in need, creating serious access to care issues. Risk adjustment is equally important for measures of cost as it is for measures of quality. The Center for Studying Health System Change recently studied regional spending variation using autoworkers' health claims and found that the biggest contributor to higher regional spending was patient case mix.[8] Poorer health status of patients contributed the most to spending, not unnecessary utilization of services or higher prices charged by physicians. Given the continued paucity of trustworthy tools, the Alliance recommends that public and private payers devote additional resources to the development of improved risk adjustment and attribution methodologies.

Participation in all quality improvement programs must be voluntary, and physicians should have the opportunity to select measures relevant to their patients and practice. Even physician-driven quality programs recognize that the local capacity to implement quality into the practice will be incremental in order to assure unintended disruption in patient care. Furthermore, sponsors of quality improvement programs should work collaboratively to align and harmonize measures, which will promote consistency and limit the overall cost and burden of collecting data from physicians.

**Flexibility In Quality Improvement Approaches**

There is currently little empirical evidence supporting the superiority of one quality improvement strategy over the other. In most cases, the optimal model will depend on the clinical context. We also have learned from Medicare's Physician Quality Reporting System (PQRS) and other public and private initiatives that one size does not fit all when measuring quality. For example, what may be a useful indicator of quality of care for a primary care physician may reveal little about the quality of care provided by a specialist. The long-term potential of public and private payer initiatives to close quality gaps and achieve better value lies in the ability to accommodate multiple aligned quality improvement strategies rather than any singular approach.

Much of Medicare's current physician quality improvement efforts focus on strategies that are primarily targeted toward primary care and chronic disease management. Many of these efforts rely on a long list of evidence-based process-of-care measures to evaluate physician quality. While these process measures can be readily acted upon and may be important in some clinical settings, they are not necessarily consistent with clinical outcomes and say very little about the quality of specialty care. In fact, various studies have shown that incentivizing the reporting of process measures often only

[8] White, C. Health Status and Hospital Prices Key to Regional Variation in Private Health Care Spending. Center for Studying Health System Change. 2012.

produces improvements in documentation rather than a change in the quality of health care delivered to patients.[9 10 11]

To ensure that quality improvement initiatives are actionable and meaningful for a range of patients and physicians, the Alliance recommends that public and private payers must offer flexibility in terms of measures and reporting options.

**Recognizing the Value of Clinical Data Registries**

Claims data is an inaccurate surrogate for determining the quality of care. Medicare's current physician quality improvement efforts also rely heavily on claims data. While claims data are easy to collect, the claims system was developed for billing purposes only and not for quality measurement. There is no nationally accredited certification that assures that layman professionals are qualified and adequately trained to collect accurate claims data for purposes of reporting quality data. As a result, claims data are limited in clinical scope and rife with inaccuracies and attribution errors. These errors can result from limitations of the claims system itself, from inappropriate/incomplete coding, and even from health plan reimbursement policies. For example, capitated payments make it difficult to identify when visits actually occurred and what services were delivered, bundled services do not allow for the identification of separate services, and "carved-out" services often hide data necessary for quality measurement.

The Alliance believes that observational data submitted to a registry is more clinically relevant and more accurate than the current claims reporting system. Although clinical trial data offers the strongest evidence-base, it is extremely expensive, lengthy to conduct, and vulnerable to other challenges such as maintaining clinical equipoise. Therefore, the Alliance strongly encourages public and private payers to recognize the value of observational data by aligning their quality programs to incentivize physician use of registries (i.e., to off-set the on-going costs to implement and maintain a registry). Registries are a well-recognized quality improvement tool to collect and provide feedback to physicians on their performance relative to a national standard. They are designed to identify, monitor, and compare differences in processes and outcomes within and among communities. When a difference is established, a registry can undertake subsequent analyses to identify factors that may or may not be associated with that difference. Since registries are ongoing, physicians have the tools to monitor changing practice patterns and the impact of those patterns on patient outcomes. Registries also allow for more accurate attribution and the capturing of more detailed data than claims-based systems, including patient-reported outcomes. The information provided by registries helps to guide physician treatment decisions and has been known to change practice in a beneficial manner.

Several of member organizations of the Alliance have developed or are participating in specialty specific clinical registries. Examples of these registries include:

- NCDR® CARE Registry® (The Society for Cardiovascular Angiography and Interventions, the American Association of Neurological Surgeons, and the Congress of Neurological Surgeons with the American College of Cardiology): For carotid artery revascularization and endarterectomy procedures. This registry provides: (1) A "best practices showcase" for all disciplines involved in treating carotid artery disease — cardiology, neurology, radiology, vascular surgery, neurosurgery, and interventional neuroradiology; (2) benchmarked decision-

[9] Roski J, Jeddeloh R, An L, Lando H, Hannan P, Hall C, et al. The impact of financial incentives and a patient registry on preventive care quality: increasing provider adherence to evidence-based smoking cessation practice guidelines. Prev Med. 2003;36:291-9. [PMID: 12634020].
[10] Fairbrother G, Hanson KL, Friedman S, Butts GC. The impact of physician bonuses, enhanced fees, and feedback on childhood immunization coverage rates. Am J Public Health. 1999;89:171-5. [PMID: 9949744].
[11] Fairbrother G, Siegel MJ, Friedman S, Kory PD, Butts GC. Impact of financial incentives on documented immunization rates in the inner city: results of a randomized controlled trial. Ambul Pediatr. 2001;1:206-12. [PMID: 11888402].

making data to answer critical questions on quality assurance related to high-risk new technologies; and (3) independent neurological assessment, including NIH Stroke Scale scores before, immediately after, and at 30 days post-procedure, to support treatment choices.

- NCDR® CathPCI Registry® (The Society for Cardiovascular Angiography and Interventions with the American College of Cardiology): For diagnostic cardiac catherizations and percutaneous coronary interventions. The CathPCI Registry offers: (1) risk-adjusted benchmark reports containing practice patterns, demographics, and outcomes of diagnostic procedures and therapies showing the facility, comparable facilities, and the national comparison group data; and (2) an unique view of guidelines in practice, PCI records tracking pharmaceutical and device safety, plus research findings from peer-reviewed journal articles and abstracts.
- NCDR® ICD Registry™(Heart Rhythm Society with the American College of Cardiology): For implantable cardioverter defibrillators and leads. The ICD Registry is able to: capture atrial, ventricular, defibrillator, and left-heart lead data at time of implant, revision, replacement, or surgical abandonment; monitor and report pediatric ICD implantation data to expand the knowledge base for an important patient population with unique needs at implantation; ICD/CRT-D generators for primary and secondary prevention and update key quality indicators and align its data set more closely with current guidelines.
- NCDR® IMPACT Registry™ (The Society for Cardiovascular Angiography and Interventions with the American College of Cardiology): Assesses the prevalence, demographics, management and outcomes of pediatric and adult patients with congenital heart disease who are undergoing diagnostic catheterizations and catheter-based interventions.
- Ophthalmic Patient Outcomes Database (The American Society of Cataract and Refractive Surgery with the American Academy of Ophthalmology): A CMS-certified registry that allows providers to submit data to CMS' Physician Quality Reporting System (PQRS). This registry also includes benchmark reporting capabilities allowing physicians to compare their practices with their peers.
- Digestive Health Outcomes Registry ™ (American Gastroenterological Association): Aims to improve patient health outcomes and cost effectiveness of digestive care using scientifically valid methods to collect, analyze and report clinically relevant data, empowering the health-care community to optimize quality of care. The AGA Registry is a CMS-certified registry, enabling practices to submit data for PQRS. It also captures and provides feedback to gastroenterology practices regarding the quality of their colorectal cancer prevention care, as well as the care of patients with inflammatory bowel disease and hepatitis C. Quality can be assessed at the clinician level, across all practice settings. The overall goal is to optimize the care and outcomes of digestive health conditions by: implementing evidence-based guideline recommendations in clinical practice; assuring that the right things are done for the right patient at the right time in a safe manner; and support efforts to improve digestive healthcare, quality, and safety through novel quality improvement strategies. In the summer of 2012, the AGA will launch the Digestive Health Recognition Program (DHRP), which will enable clinicians to be recognized by the AGA and/or rewarded by health plans for meeting quality thresholds.
- NeuroPoint Alliance (NPA) (The American Association of Neurological Surgeons/Congress of Neurological Surgeons): An effort to coordinate a variety of national projects involving the acquisition, analysis and reporting of clinical data from neurosurgical practice, using a web-based data submission and management platform. The NPA aims to satisfy practice data collection requirements for board certification and Maintenance of Certification (MOC), establish risk-adjusted national benchmarks for both the cost and quality of common neurosurgical procedures, allow practice groups and hospitals to analyze their individual morbidity and clinical outcomes in real-time, generate both quality and efficiency data to support claims made to public and private payers, and demonstrate the comparative effectiveness of neurosurgical procedures. The National Neurosurgery Quality and Outcomes Database (N2QOD), which launched last year, is a targeted effort to collect site-specific, risk-

adjusted quality data related to spine surgery, including patient-reported outcomes. The N2QOD will analyze practice variations and utilization in an effort to demonstrate the value of neurosurgical care.

To ensure these registries can reach their fullest potential, the Alliance encourages both the public and private sector to support programs that incentivize continuous and prospective participation in a clinical data registry and the use of collected data to improve care processes. While national specialty societies or other stakeholders would be responsible for the development, validation, and management of registries, CMS and other private payers could set minimum requirements for registries to qualify for incentive payments. A registry may need to demonstrate it employs a valid risk adjustment methodology; may need to collect data on specific outcomes such as complications and recovery time; may be subject to sample size requirements; or may be required to use standardized clinical definitions to ensure uniformity with other registries. Furthermore, payers could require physicians to demonstrate what actions were taken to target gaps in care identified by the registry.

The Alliance is confident that up-front investment through incentives to offset the cost of registry participation will have a positive impact on reducing morbidity, mortality, and the costs associated with complications, as well as the potential for decreased volume and efficiency over time as physicians reflect on collected data, refine care processes that lead to better outcomes, and more clearly define indications for various procedures.

Various private payers have approached specialty societies with interest in incentivizing the use of registries. Some, such as the Blue Cross Blue Shield Blue Distinction Program, already recognize registry reporting as one of various factors that defines a center of excellence. This illustrates private payer confidence in the value of continuous clinical data collection as a driver of rapid learning about both quality and efficiency. It also stands as a testament to their understanding that alternative, more targeted strategies are necessary to better effect improvements in specialty quality.

**Public Reporting of Physician Data**

While public reporting may stimulate more rapid improvement among those being measured and may make patients more informed decision-makers, it also carries risks. If data are released prematurely or in a format that is not accurate, it can increase a physician's exposure to medical liability, lead to perverse incentives such as gaming or other actions to avoid high-risk patients, and deter physicians from partaking in quality improvement activities in general. Furthermore, if data are not adjusted properly and not presented in a format that is meaningful and comprehendible to a range of audiences, it may create confusion among patients and unfairly harm the reputation of a physician.

Medicare's first public effort to identify hospitals with patient safety problems recently pinpointed many prestigious teaching institutions around the nation, raising concerns that the measures are skewed in a way that exaggerates problems at hospitals that treat lots of complicated cases or very sick patients.[12] Hospital performance on these patient safety measures is already being reported to the public and Medicare payments to hospitals will be tied to the measures starting in 2013, despite the fact that the National Quality Forum (NQF) recommended against using the measures for payment due to concerns about the reliability of the data sources. Critics claim the measures are not properly risk-adjusted and based on Medicare claims data, which do not properly distinguish between various levels of illness and health problems among patients. Others say the measures were never intended to compare hospitals, but were developed to help hospitals internally flag events that needed attention. Either way, the public reporting of inaccurate information may confuse the public and divert patients from experienced centers of care.

[12] Rau, J. Experts Question Medicare's Effort To Rate Hospitals' Patient Safety Records. Kaiser Health News. February 13, 2012.

It is imperative that public and private payers adhere to the following principles if reporting physician quality and cost data to the public:

- Physicians should be provided with confidential, user-friendly interim feedback reports so that they can understand their progress, better target areas of improvement, and flag any discrepancies between their records and that of the measurer;
- The Alliance cannot overstate the importance of appropriately risk-adjusting data and ensuring that it is accurately attributed to those directly involved in the care of the patient prior to it being released to the public;
- Data must be presented in a way that is both meaningful and understandable to physicians and the public. Public reports should include clear discussions of context, the measures and methodologies used (e.g., how were episodes defined, how were patients identified, why were certain units of analysis used), data limitations, and guidance on how to use the data when seeking medical care (e.g., talk with your physician). Medicare's Nursing Home Compare website currently includes valuable information for consumers on how to use the comparative reports, including telling consumers that information on the web it not a substitute for visiting a nursing home in person;
- Physicians should be offered a formal and timely process to review, question, or appeal performance and other data (e.g., demographic, volume, resource use) that they believe to be inaccurate before it is publicly reported or linked to reimbursement. Results determined to be inaccurate after the reconsideration process should be corrected. As an example, data posted on Medicare's Hospital Compare website are externally validated and hospitals are given an opportunity to review their own data prior to reporting; and
- Physicians should have an opportunity to explain to the public, alongside the reported data, why they may have chosen not to participate in or failed to meet the requirements of a program. Public reports should positively recognize, not punish or shame, physicians who attempted to participate, but were unable to do so for a variety of reasonable obstacles. Physicians also should be recognized for a range of quality initiatives, including those sponsored by CMS, private health plans, employers, individual specialty societies and their local institutions or practices. A "one-size-fits-all" approach to quality improvement is simply not sustainable.

**Incentives**

Incentive payments for achieving the goals of improved quality and efficiency should be provided in addition to annual positive increases in the Medicare physician payment update that accurately reflect increases in medical practice costs. Only fair, meaningful, and *positive* incentive structures will encourage positive change. Incentives must be large enough to change behavior and aligned to processes of care that are actionable by a physician.

As discussed earlier, public and private payers should continue to broaden the scope of quality improvement activities that qualify a physician for an incentive payment. Incentives should be offered for a range of efforts, such as reporting to a clinical data registry, maintaining medical board certification, using e-prescribing technology, and reporting on a designated set of process/outcome measures. Rather than making each of these activities mandatory, physicians should be able to choose to participate in those programs that are most relevant to their practice. A graduated incentive structure could be used to recognize the additional time and resources required to participate in more complex quality improvement activities.

Physicians must also receive incentive payments on a timely basis. Payments should be made as close as possible to the time that the service is rendered, without a substantial time lag in determining the amount of payment due to a physician. A physician practice, like any other enterprise, must operate on a business plan based on predictable and reliable financial fundamentals. This is nearly

impossible if a substantial amount of a practice's revenue stream is unknown and delayed for months or even years.

Payers should also explore a mix of incentive structures, such as rewarding physicians who achieve significant improvements in their absolute performance (i.e., overall improvement), as well as those who achieve high performance (i.e., achievement of a minimum threshold). Studies have shown that those with the lowest baseline performance may improve the most, yet garner the smallest amount of performance pay if only threshold performance targets are used,[13] [14] highlighting the need to consider a mix of incentives. Payments should not be based on relative performance or arbitrary assignment of physicians to a percentile. These structures would only be fair in a perfect world where all physicians and patients were exactly alike. Since it is impossible to adjust for all patient case-mix and other confounding factors and difficult for individual physicians to gauge their performance relative to others throughout the year, these structures should be avoided.

**Redundancies in Quality Programs**

Each medical specialty society is dedicated to improving the quality and overall efficiency of the care of their patients. However, we are highly concerned about inconsistencies in requirements for various quality-related reporting programs-- including Medicare's Electronic Prescribing (eRx) Program, Electronic Health Records (EHR) Program, and Physician Quality Reporting System (PQRS). The inconsistent and duplicative reporting requirements of these and other public and private payer programs create confusion among physicians and their patients and are incongruous with the goals of improving the quality, efficiency, and coordination of care. In 2011, the Government Accountability Office (GAO) issued a report[15] calling on CMS to address these inconsistencies. Considering the hard economic times and the fact that physicians already face the threat of substantial cuts through the SGR, it is simply unreasonable and unfair to expect physicians to be able to provide high quality, patient-focused care while also having to contend with these cumbersome reporting requirements. As noted throughout our comments, requirements imposed in the name of advancing quality should be reasonable, should not distract from care delivery, and should be relevant to all affected professionals. We urge Congress to work to better align the various, overlapping quality incentive programs in order to minimize confusion and prevent the imposition of unjustified financial and administrative burdens on physician practices.

While each of our societies is taking steps to improve quality measurement tools and encourage participation in such programs, physicians will need time to acclimate to these new programs and to modify clinical and administrative processes to accommodate these new care models. Public and private payers should not rush physicians into new delivery system models until they have been fully tested among a range of specialties and patient populations and until an appropriate infrastructure exists to support consistent and long-term application of these new models. Careful implementation includes ensuring patients can maintain access to current care options as new payment and delivery models are being tested.

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[13] Rosenthal MB, Frank RG, Li Z, Epstein AM. Early experience with pay-for-performance: from concept to practice. JAMA. 2005;294:1788-93.

[14] Pourat N, Rice T, Tai-Seale M, Bolan G, Nihalani J. Association between physician compensation methods and delivery of guideline-concordant STD care: is there a link? Am J Manag Care. 2005;11:426-32.

[15] U.S. Government Accountability Office. Electronic Prescribing: CMS Should Address Inconsistencies in Its Two Incentive Programs That Encourage the Use of Health Information Technology. Published online February 2011 at http://www.gao.gov/new.items/d11159.pdf

**Conclusion**

Although the Alliance understands the desire to measure and improve both the quality and efficiency of health care, programs that rely on inaccurate ratings to steer patients to select physicians and to alter physician reimbursement will only restrict patient access to the high value care they deserve. More time and resources are needed to test valid measures of cost and quality and mechanisms that adjust for more complex clinical scenarios before the public and private sector can move forward with programs that further tie physician payments to performance. More flexibility is also needed so that physicians are recognized for engaging in quality improvement processes that are most relevant to their patient population and care setting.

The Alliance appreciates the opportunity to share its concerns with members of the Ways and Means Committee, Subcommittee on Health, and to point out the unique needs and contributions of specialty medicine. Should you or your colleagues have any questions or want to discuss in further detail the issues raised in this letter, please feel free to contact Rachel Groman at 202-729-9979 or info@specialtydocs.org.