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ROUNDTABLE DISCUSSION ON MEDICARE PHYSICIAN PAYMENT POLICY: LESSONS FROM THE PRIVATE SECTOR

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

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CONTENTS

OPENING STATEMENTS

	Page
Baucus, Hon. Max, a U.S. Senator from Montana, chairman, Committee on Finance	1
Hatch, Hon. Orrin G., a U.S. Senator from Utah	2

WITNESSES

Safran, Dr. Dana, senior vice president, Blue Cross Blue Shield of Massachusetts, Boston, MA	3
Edwards, Peter, president of provider development, Humana, Louisville, KY	4
Reisman, Dr. Lonny, senior vice president and chief medical officer, Aetna, Hartford, CT	5
Burrell, Chet, president and chief executive officer, CareFirst BlueCross BlueShield, Washington, DC	6
Cardoza, Darryl, president and chief executive officer, Hill Physicians Medical Group, San Francisco, CA	8

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Baucus, Hon. Max:	
Opening statement	1
Prepared statement	35
Burrell, Chet:	
Testimony	6
Prepared statement	36
Cardoza, Darryl:	
Testimony	8
Prepared statement	42
Edwards, Peter:	
Testimony	4
Prepared statement	48
Hatch, Hon. Orrin G.:	
Opening statement	2
Prepared statement	57
Reisman, Dr. Lonny:	
Testimony	5
Prepared statement	58
Safran, Dr. Dana:	
Testimony	3
Prepared statement	63

COMMUNICATION

Center for Fiscal Equity	71

ROUNDTABLE DISCUSSION ON MEDICARE PHYSICIAN PAYMENT POLICY: LESSONS FROM THE PRIVATE SECTOR

THURSDAY, JUNE 14, 2012

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:08 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Wyden, Cardin, Hatch, Grassley, Kyl, and Thune.

Also present: Democratic Staff: Russ Sullivan, Staff Director; David Schwartz, Chief Health Counsel; Karen Fisher, Professional Staff Member; and David Sklar, Fellow. Republican Staff: Chris Campbell, Staff Director; and Dan Todd, Health Policy Advisor.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Thomas Edison once said, "To have a great idea, have a lot of them."

Today, we hold our second roundtable on Medicare physician payments. The payment system Medicare currently uses is broken. There are a lot of ideas about how to fix it, and today we want to hear them.

We know the sustainable growth rate, or SGR, must be repealed. It causes uncertainty. It causes seniors to fear losing access to their doctors. It threatens physicians with increasing payment cuts year after year.

We need to take a look at the underlying fee-for-service system that Medicare uses to pay physicians. Fee-for-service rewards physicians who do more tests and more procedures, even if those services are unnecessary. It does not encourage physicians to coordinate patient care to save money and improve results.

We need an efficient system that rewards physicians for providing high-quality, high-value care. Today, we will hear from five organizations that have developed innovative physician payment systems in the private insurance market. These organizations are changing how they pay physicians to create incentives that will improve patient care. They are rewarding the physicians who keep patients healthy and cut down on emergency room visits and hospital readmissions.

These results not only save money, they mean better care for patients. We want to learn how these ideas also can be applied to the Medicare program. Medicare needs solutions that will work in a range of settings—in cities, rural areas, large doctor groups, solo practitioners, specialists, and primary care providers. What works in California may not always work in Montana.

Fortunately, our panelists can describe ideas that have worked in many different regions of the country, and we look forward to candid, direct suggestions from them as to how to solve this problem.

Thank you.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch?

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Thank you, Mr. Chairman. I want to thank you for convening today's roundtable as we continue discussing options to improve the way we pay physicians and improve quality in Medicare. It is critical that we speak to folks in the private sector who are successfully lowering costs while providing better care and outcome for patients.

The chairman and I agree that we must find a better way to pay physicians in Medicare. We must repeal the flawed SGR system—in my opinion, an albatross around the Congress's neck that must be addressed at the end of every year. This is not an easy task, but our physicians and patients deserve better. We must establish a more stable foundation to pay our physicians who treat Medicare patients.

As we all know, our current fee-for-service system provides little financial incentive to manage care properly. Instead, the current incentive is to increase the volume of services. Over the years, we have learned that more care does not necessarily mean better care or better outcomes.

Today, we have the opportunity to hear from some of the top performers in the private sector. These industry leaders are making real advancements in care delivery and physician payment. They are showing that you can improve quality and lower costs in a collaborative way that does not alienate the physician community.

Chairman Baucus, I just want to thank you again for scheduling this series of roundtables. I hope today's provides us with another opportunity to learn about the best practices that are occurring in the private sector.

And I do look forward to hearing from our witnesses, hearing about their efforts, and thinking about how to relate their experiences to Medicare.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. I am now pleased to welcome our panelists. Today, we will hear from Dr. Dana Safran, senior vice president, Blue Cross Blue Shield of Massachusetts. Next is Mr. Peter Ed-

wards, president of provider development, Humana. Dr. Lonny Reisman is senior vice president and chief medical officer at Aetna. Mr. Chet Burrell is president and chief executive officer of CareFirst BlueCross BlueShield of Maryland. And our last witness is Mr. Darryl Cardoza, chief executive officer, Hill Physician Medical Group in northern California.

Dr. Safran, why don't you begin? You know our usual custom here. Statements are automatically included in the record, and I ask each of you to summarize your statements and tell it like it is.

STATEMENT OF DR. DANA SAFRAN, SENIOR VICE PRESIDENT, BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, BOSTON, MA

Dr. SAFRAN. Thank you, Chairman Baucus, Ranking Member Hatch, and members of the committee. I am Dana Gelb Safran, senior vice president for performance measurement and improvement at Blue Cross Blue Shield of Massachusetts.

As this committee considers the important issue of physician payment and, specifically, the SGR, I appreciate the opportunity to discuss the payment reform model that Blue Cross Blue Shield of Massachusetts has been implementing since 2009.

The model known as the Alternative Quality Contact, or AQC, employs a population-based global budget, together with substantial financial incentives on a broad set of quality and outcome measures.

Rates of inflation on budgets are negotiated up front for the 5-year contract period, thereby creating much-needed predictability in medical spending growth. Budget and quality targets are designed to accomplish our twin goals of significantly improving health care quality while, at the same time, significantly slowing spending growth.

The AQC is now our predominant payment model, in place with nearly 80 percent of providers State-wide. These organizations vary enormously in size, scope, composition, and geography, most of them comprised of many small and solo practices united through a common leadership.

With 2 complete years of data, the AQC is on track to cut spending trends in half over a 5-year period. A formal evaluation led by Harvard Medical School economist Dr. Michael Chernew found that, even in year 1, AQC providers slowed spending growth by 2 percent, while simultaneously improving quality. These savings and quality improvements deepened in year 2.

Providers are achieving savings both through the use of lower-cost care settings and, importantly, through significant changes in utilization. In 2010 alone, AQC providers saved more than $10 million by reducing avoidable hospital admissions, readmissions, emergency room use, and high-tech imaging.

With respect to quality, each and every AQC organization has made significant improvements across a broad set of quality and health outcome measures. To accomplish these results, AQC organizations are innovating in ways that are truly sowing the seeds of sustainability. They are investing in new infrastructure and information systems, deploying new staffing models, and implementing new approaches to patient engagement.

These early findings offer evidence that a payment model that creates provider accountability for medical spending, quality, and outcomes is a powerful vehicle for realizing the goal of a high-performance health care system with a sustainable rate of spending growth.

On behalf of Andrew Dreyfus, president and CEO of Blue Cross Blue Shield of Massachusetts, and our leadership team, we look forward to working with you as you address these important issues.

And I thank you for the opportunity to be here today.

The CHAIRMAN. Thank you, Dr. Safran, very much.

[The prepared statement of Dr. Safran appears in the appendix.]

The CHAIRMAN. Mr. Edwards?

STATEMENT OF PETER EDWARDS, PRESIDENT OF PROVIDER DEVELOPMENT, HUMANA, LOUISVILLE, KY

Mr. EDWARDS. Mr. Chairman, thank you. Thank you for the opportunity to share learnings from our 25-year experience in partnering with physicians on a variety of innovative, value-based models that reward efficiency and effectiveness across a continuum of product lines.

I am Peter Edwards, president of provider development, responsible for Humana's partnerships with physicians and related performance-based model plans.

Relevant to today's discussion, Humana is one of the Nation's largest Medicare private plan contractors, with 2.2 million members. Additionally, we own 300 medical centers, run over 250 worksite medical facilities, and contract with nearly 320,000 physicians.

By year's end, about 1.8 million of our Medicare Advantage members will get care from physicians in Humana's network arrangements that include one of our various payment models, and we expect 80 percent of our network primary care physicians will be in rewards programs.

While my detailed written statement is on record, here are a few highlights. We believe delivery system transformation is predicated on creating physician payment models that recognize the variability in physician practices and engage physicians based on factors like practice resources, geography, and patient panels.

Beginning in Florida in the mid-1980s, we introduced basic capitation payment models. Then we moved to global risk arrangements across all of our Medicare benefits, then added combined risk arrangements—shared risk for Part A and full risk for Part B and D—and, ultimately, we introduced fee-for-service rewards programs in 2010 in areas where the primary payment model was fee-for-service.

Our rewards program has four variations tailored for differing practice structures. There are opportunities to increase payment on a graduated basis as program complexity increases. Payment beginning with fee-for-service with an annual bonus rises to quarterly based bonuses, then peer coordination fees plus a bonus, and, finally, shared savings and capitation.

We provide real-time data and detailed reporting of patient-centered costs and quality information to physicians. In some cases, such as in rural areas where primary care access is limited, we have added nurse practitioners to assist practices.

As we developed our rewards program, we engaged directly with the leading primary care physician societies, and today we continue to solicit their suggestions and recommendations.

During the first 9 months of 2011, our rewards program resulted in improved health outcomes, including an over 50-percent increase in the number of participating physician practices meeting and/or exceeding patient care measures.

One of the lessons we have learned is that, without incentives, costs run 5 to 20 percent higher. Any proposal to modify Medicare payment policy should be sufficiently flexible to allow for practice variations. A single, uniform, well-established performance measurement strategy is critical across all public and private programs. And, lastly, real-time data is a critical component of any payment policy initiative.

As we continue to develop innovative payment models, our focus will be on models that reduce fragmentation, improve communication, reduce unnecessary costs, and ensure that patients receive the right care at the right time, in the right setting, from the right level care practitioner.

Thank you, again.

The CHAIRMAN. Thank you, Mr. Edwards, very much.

[The prepared statement of Mr. Edwards appears in the appendix.]

The CHAIRMAN. Dr. Reisman?

STATEMENT OF DR. LONNY REISMAN, SENIOR VICE PRESIDENT AND CHIEF MEDICAL OFFICER, AETNA, HARTFORD, CT

Dr. REISMAN. Good morning. Thank you for inviting me to testify today. My name is Lonny Reisman. I am the chief medical officer for Aetna.

Aetna views provider collaboration as key to transforming patient care and building a more effective health care system. Since 2005, Aetna has invested more than $2 billion to acquire or build a variety of capabilities to support and enable provider collaboration models.

We recognize that there is no single model or solution to meet the needs of every health system and patient across the country. We need our provider partners at the current state of readiness, with a shared goal of moving toward a more effective and patient-focused health care delivery model.

Our partnerships are designed to support all patient populations, qualified providers, and insurance payers, and are not limited to Medicare or Aetna members.

We believe successful provider collaborations incentivize quality improvement, give actionable patient information, and use low-cost technology solutions that create interoperability between providers, patients, and health systems.

Our provider collaborations provide a model for health care delivery and payment that ties provider reimbursements to improved population health and reductions in the total cost of care.

Our Medicare Advantage care management models provide health information technology and nurse case managers embedded within participating provider groups. For example, by collaborating with Aetna, InterMed's independent physician association, Nova

Health in Portland, ME averaged 45 percent fewer acute admits, 50 percent fewer acute days, and 56 percent fewer admissions in 2011 compared to State-wide unmanaged risk-adjusted Medicare populations.

New research on medical advances is published frequently. ActiveHealth Management has a large team of board-certified physicians, pharmacists, and registered nurses that applies research from the most reputable sources to develop and maintain our clinical decision support tool. We alert physicians to errors or omissions in care and opportunities to improve health, resulting in better quality and reduced medical costs.

In a randomized clinical trial, ActiveHealth Management's technology was found to lower average charges by 6 percent compared to a control group in 1 year.

Regarding fragmentation of care delivery, people with chronic conditions, such as diabetes and/or high blood pressure, often receive care from many different providers. For these high-risk patients, it is especially important that physicians are able to effectively coordinate care and information.

Aetna's Medicity technology lays the foundation to securely exchange patient health information. Medicity accomplishes this regardless of which electronic medical record is being used.

Michigan Health Connect, MHC, engaged Medicity to help them tackle the referral process, which was a significant pain point for physicians, involving filling out and faxing forms, as well as numerous phone calls between providers.

Within 120 days, MHC rolled out the iNexx e-referrals application to 100 practices, including 21 specialties, and is adding practices to the e-referral network at a rate of nine practices per week. These practices are now able to replace the multiple phone calls and fax exchanges with secure electronic team networks that enable e-referrals.

We share the committee's goal to transform the health care delivery system and believe Medicare can benefit from our innovative care solutions.

Aetna has achieved positive results through our provider collaborations. We are making it easier to pull meaningful health care information out of silos and act upon it more quickly to improve patient care. We believe that these models can be applied more broadly to improve population health and create a sustainable care delivery system.

Thank you.

The CHAIRMAN. Thank you, Doctor, very much.

[The prepared statement of Dr. Reisman appears in the appendix.]

The CHAIRMAN. Mr. Burrell?

STATEMENT OF CHET BURRELL, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CAREFIRST BLUECROSS BLUESHIELD, WASHINGTON, DC

Mr. BURRELL. Thank you, Mr. Chairman, Ranking Member Hatch, and other members of the committee. I am Chet Burrell. I am the CEO of CareFirst BlueCross BlueShield. We cover the area of northern Virginia, DC, and all of Maryland. We also are the

major carrier for the Federal Employee Program, covering some 620,000 FEP members here in the Capitol area.

Several years ago, we started our own patient-centered medical home program, and the way we approached it was, we asked primary care physicians in this area who are in active practice, of which there are about 4,000, to form small, what we call medical care panels, teams typically of eight to ten primaries as a team. This includes solo practitioners who are in rural areas, who themselves form teams with others in those rural areas. These are self-chosen teams.

There are 300 such panels in this region now. There are 1 million CareFirst members being served by these panels. What we do is a blended capitation fee-for-service system. And I would say that the most important thing we have learned is how important payment reform is.

But this model, I think, is distinct in the sense that it offers the benefits of global capitation. We establish global expected cost of care for each panel's population of patients. Each panel serves about 3,000 members of ours.

Three thousand members could be expected to run up $12 million a year in health care costs for something like 50,000 service encounters. What we do is, we project what that cost would be, and then we ask them to better that; and, if they can, we share the savings. We pay them during the course of the year on a fee-for-service basis, because we can get the data better that way, and we can track the services better that way. And if, at the end of the year, they have bettered the expected cost of care on a global basis, we share the savings with them. This can often provide major incentives, bonuses, if you will, to these physicians.

We also have extensive quality measures during the course of the year to see to it that there is not a gain by under-serving the population of patients in the panel. We have 1 year of full operating experience under this, through which nearly $3 billion worth of claims flowed, and here is what we found in the first year: that about 60 percent of the panels, of the 300 panels, actually beat the targets, and they beat them, on average, by 4 percent, and that is a big number.

And, of the panels that did not, the 40 percent that did not, they exceeded it by 4 percent. And so there was an 8-percent spread. And what has happened as a consequence of that is that the ones that won have become more interested in what they can do better, and the ones that did not now want to find out what they can do. And so it has established a great deal of interest in the physician community. Over 80 percent of all of the primaries in this area are in the program.

So in essence, that is the way we have approached it. We are looking to get Medicare into the program through a waiver from CMS to bring Medicare fee-for-service patients into the same design, same incentives, same structure.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Burrell. That was very interesting.

[The prepared statement of Mr. Burrell appears in the appendix.]

The CHAIRMAN. Mr. Cardoza?

STATEMENT OF DARRYL CARDOZA, PRESIDENT AND CHIEF EXECUTIVE OFFICER, HILL PHYSICIANS MEDICAL GROUP, SAN FRANCISCO, CA

Mr. CARDOZA. Chairman Baucus, Ranking Member Hatch, members of the Finance Committee, I appreciate your invitation to join you today and share the experience of Hill Physicians Medicare Group in managing our physician payment system. And thank you for holding this roundtable on what is a very important topic.

Hill Physicians Medical Group has operated for more than 25 years in northern California, serving people insured by commercial plans, the Medicare Advantage prescription drug program, and Medicaid. We now serve 300,000 people through our network of 3,500 physicians, most of whom are independent and self-employed in small practices ranging from one to several physicians. We are paid prospectively through capitation and compensate our physicians for their services to these patients through our own compensation plan.

I have submitted to the committee written comments about our experience for your reference and consideration, and I appreciate your including my comments in the record for this roundtable. I will offer these brief opening thoughts.

For 30 years, I have been boots-on-the-ground embedded with practicing physicians helping to organize them and develop tools and systems to build a value-oriented delivery system. There is remarkable consensus in what you have heard today and in your first roundtable.

We get what we pay for. And with fee-for-service, we pay for volume. As a practical matter, it would be difficult to entirely abandon fee-for-service, but Hill Physicians would encourage payment strategies that move away from fee-for-service to those that are population-based, enabling proactive approaches to care management and more intelligent resource allocation across the continuum of care.

Hill Physicians has had success in compensating physicians to reflect performance-based incentives, capitated payments, and case rate payments. Hill Physicians has succeeded by prospectively defining desired outcomes, measuring and reporting on individual physician performance, achieving those outcomes, and supporting our physicians in their efforts to continuously improve their practice performance.

Medicine is delivered today in increasingly sophisticated environments. An affordability crisis has long been anticipated, we thought, due to an aging population. While true, we did not anticipate the larger cause, which is the explosion of medical technology and know-how.

Marcus Welby could not make it in medicine today. There were precious few tools in his medical bag. Today, he could not carry his tools in a wheelbarrow, and he would not be capable of using them all on his own. Yet, the reimbursement model used today was built when Dr. Welby was in his prime.

We at Hill Physicians have worked for over 25 years to build a large, accountable organization of physicians, supported with information systems and care management programs designed to support our physicians to optimize value for our patients.

How we pay our physicians is important, but no payment strategy alone will be enough to achieve the objectives we all share to optimize affordability and quality. Hill Physicians has been successful because of our consistent organizational engagement and support for our physician network for over 25 years. The organizational framework for these collective efforts has been essential to our success, and I will encourage you to consider strategies that foster organization and system development for the physician sector.

I hope that sharing our experiences will be helpful to your efforts, and I thank you for inviting me to join you today.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Cardoza appears in the appendix.]

The CHAIRMAN. This is a bit different, how we are going to conduct this hearing today. It is not really a hearing. I like to call it kind of a roundtable; that is, everybody just participates informally. It is like around the kitchen table. If somebody wants to say something, say it. If someone says something that kind of makes sense, reward that person. If it does not make sense, speak up and say why, and so forth. That applies to both sides of the table, that is, with Senators, as well as for all of you.

So feel free just to jump in, if you want to, and I say that to my colleagues too. Just jump in if you want to.

I will just ask the first question, and then we will let it rip.

I am very intrigued with what you are doing, Mr. Burrell, and I am wondering about your system. I guess you start out fee-for-service, and savings are then rebated back to the participants, and you set a target at the outset, as I understand it.

Mr. BURRELL. Yes.

The CHAIRMAN. So one question I have is, how do you set that target? And then, what lessons does that have for the target that is in SGR, because, in each case, there is a target? One is statutory, and one is set by yourselves. And you said you asked for a waiver to apply your approach under the Medicare payment system.

It would be helpful, to me anyway, if you could tell us the degree to which you think SGR can be modified to maybe follow some of your practices or what have you learned that could help us decide what we are going to do about SGR.

Mr. BURRELL. Well, let me start with a description of the way we do it, which is very similar to the way premiums are established. So, they will think of it this way. You have a particular panel, as I described, let us say, 10 doctors, 10 primaries.

The question is, how many patients do those primaries have? Who are the patients who are attributed to them, who actually go to them? And then the first question we ask is, once we know that, what are the claims experiences of those particular patients?

It reflects their age, their sex, their illness or health, it reflects everything about the local aspects of health care, when health care is intrinsically local. And when I said it would be typically the case that 3,000 members would be in a panel of ours, they would be expected, just on historical experience, to have about $12 million a year today in health care expenditures.

So we take that base, whatever it was, and——

The CHAIRMAN. And that is the target?

Mr. BURRELL. No, that is the base. In this case, we use 2010, an unmanaged base before the program started.

We look at the illness burden of the population that is in that panel, and we take that into account and changes in that illness program, and then we apply what we call an overall medical trend factor, which reflects what we believe are the overall trends in health care in this region. We apply it to the base. And we then come out with the expected cost of care.

What we are expecting is that, as panels perform and attempt to beat that number—when I said that 60 percent of the panels actually were 4 percent under that number, in this region, that number is between 7 and 7.5 percent. So to be 4 percent under it, you are at 3.5 percent.

And what we do is, we track that trend over time. We do 1 full year of prospective trend going forward. Then, as the next year comes, it is 50/50 prospective of what actually happened. By the third year, it is two-thirds/one-third, one-third prospective, two-thirds retrospective.

So, as the cost curve bends by action of the panels, we think it moderates the cost curve, and what happens is the panels have harder and harder targets to beat. But, by the time that occurs, they are more and more experienced in what it takes to beat them. And so much of the cost is driven by chronic disease that we believe that the essential thing that they must focus on is how to manage the chronic disease patient.

That means they have the ability to identify them, set up a care plan for them, follow them through the community, watch for the breakdowns. So we assign a nurse to help them do that with each case, and we do not expect the primary to do it all by themselves.

The CHAIRMAN. To what degree, though, could this approach be applied to Medicare?

Mr. BURRELL. The same exact approach could apply to Medicare. So you could say—this was for our under-65 population—but you could, say, take Medicare members, beneficiaries in this region who are in those very same practices, and establish Medicare expected cost of care in a similar manner, Medicare fee levels.

In other words, we establish a credit system. Expected cost of care is a credit to the panel. Debits are the fees themselves. And what we would say to the panel is, "You manage the Medicare patients in the similar manner to the way you manage the CareFirst patients, and you look particularly for chronic disease, and Medicare is the chronic disease capital."

Senator CARDIN. Mr. Chairman, what Mr. Burrell is doing at CareFirst is popularly received locally. So it has credibility to it. And I think one of the main features is that there is help given to the primary care provider through nurses to manage the more complicated and more costly patients, which I think gives confidence that this is not an effort to deny care to people in order to reach the target, but to manage the cost of high interventions in a more cost-effective way.

This is the question I would have for you, Mr. Burrell, or anyone else on the panel. You mentioned that you do oversight to make

sure that quality is maintained. But there is always a fear that the bonuses are based upon dollar amounts; so, therefore, are we just denying people needed care rather than providing the quality?

How do you assure that the necessary care, in fact, is given?

Mr. BURRELL. We have five different ways, five different categories of quality measures that each physician in the panel is measured on, and the panel as a whole, relating to access, gaps in care, appropriateness of care, and we have one category we call engagement. And this is the degree to which the physician is actually engaged in the care of a chronic disease patient.

Are they too busy? Do they take the call-backs? Will they deal with the nurse? Are they engaged? You cannot get an outcome incentive award in our design unless you have overall quality scores that indicate that you are providing quality services and you are engaged with the patients who need you the most.

In an under-65 population, less than 10 percent of all of the patients consume 65 percent of the medical spending, and these are typically people with chronic disease or the exacerbation of chronic diseases. They need differential attention.

So we ask the primary care physician to do that. If there is evidence that they are not doing that, they are disqualified from then forward.

One further statement on this. It is meant to be a multi-year award. So we look for consistency of performance over time, not a quick hit. And the reward goes up as the consistency occurs.

So if Mary Smith, the patient, has multiple chronic diseases, take care of her over time. The only way you can win is to actually stabilize her, improve her outcomes—less breakdown, less readmission, ER visits, that kind of thing—and track that.

Dr. REISMAN. And I would suggest there are two elements to quality. One is a kind of retrospective analysis based on measures articulated in HEDIS or the National Quality Forum.

But I think an important issue to raise is the fact that many of these practices do not have an intrinsic capacity to manage patients as well as they would like to. They do not have complete information. So, as patients see multiple doctors in a community, particularly those with chronic diseases or multiple chronic diseases, the information is not coordinated.

We have played a role in actually not being removed relative to these practices and simply paying claims, but becoming an integral part of the actual delivery of care.

So, to the extent that we can use our health information exchange capabilities to create an aggregate organized record for presentation to the physician or practitioners, that has been a huge help.

The second issue relates to decision support. The good news about having complete data on a patient is you have complete data on the patient. The bad news is there is quite a bit of it. And, given the constraints of time, it would be hard to analyze all of that data on the patient and relate it to what has been, in fact, published in the literature or what represents the safest levels of care.

So the ability to distill massive amounts of information using clinical decision support into actionable activities that can be pur-

sued by the physician in concert with a team ends up being an important issue.

And the third point I would mention—we could talk about it more as we go forward—is the role of the patient. For all the best intentions of doctors, patients are frequently not adherent with therapy.

We have done a lot to, in fact, motivate and provide incentives for patients, but I would urge the committee to consider the role of the patient in all of this as we tackle the issues of total costs.

Dr. SAFRAN. I would like to add in, because your question is such an important one, that, as we move to models that create accountability for total medical spending, how do we ensure that quality does not get sacrificed along the way? And the approach that we have taken to that, which is proving to be very successful, is to pair those incentives for total medical spending with a very broad set of quality and outcome measures with known targets that represent a continuum from good to great care.

So for every measure—and there are 64 quality and outcome measures in our portfolio of measures that these organizations are accountable for. For every measure, there is a range of performance targets from good to great, with great being a number that tells us the best that can be achieved for a population of patients by an organization.

And what we see these organizations doing is embracing those measures with the data that we provide to them and the substantial incentives that are on the table to do well with these measures and, systematically, over their 5-year contract period, moving quite aggressively to improve care for patients.

And because the measures include not just clinical process, that is, following evidence-based care—that is important—but also measures of health outcomes and measures of patient care experiences, these practices have to engage their patients in a new way, because you cannot accept accountability for patient health outcomes without thinking about what happens to that patient when they are outside of your four walls living their life, working on issues of adhering to chronic disease and managing their health.

So these practices are innovating new ways to actually understand individual patients, what their lifestyle is, what their constraints are around managing their condition. And what we have seen, even in the first 2 years of their performance, is, on the outcome measures, them moving to the highest level of performance that our data tell us is possible to achieve for a population. They are achieving very important advances in health outcomes, at the same time that they are managing overall medical spending.

Mr. EDWARDS. And I would like to add to that. Our rewards program, it moves along a continuum. Starting with the fact that they are all based on HEDIS measures. So in order to receive——

The CHAIRMAN. On what measures?

Mr. EDWARDS. Health employer data information. Set measures. And you have to achieve six out of nine of the various ones, and they include cancer screening, glaucoma screening, body mass index. There are various ones. And when they hit six out of those nine, they receive a reward for that.

And each of the programs will then layer on other factors on top of that, such as generic dispensing rates or readmission rates, improving readmission rates. And the payments for all of those move up as you move along the continuum of the reward program.

And the reward program is important because it works in all areas, including rural areas. We have found that this reward program—just for instance, we have two practices in South Dakota this last year that are going to receive $102,000. These are PCP practices. We had four in Montana, with over $144,000 coming to them; eight in Utah for over $492,000. And these are practices receiving rewards for quality outcomes for their patients.

The CHAIRMAN. Senator Grassley wants to pipe in here.

Senator GRASSLEY. Yes. I want to bring up an issue that might be a little bit different.

Mr. Edwards, you mentioned Humana uses different approaches to account for variation in practices, and I want to ask about delivery of health care in rural America, because that is, obviously, where Iowa fits.

Could you expand on what Humana does differently in rural areas, what challenges you encountered, and what you have found to be successful?

Mr. EDWARDS. Sure. A couple of things. Recently, we have partnered with a company called GenCare. These guys opened, so far, 13 clinic-based primary care centers that provide coverage to seniors and primarily low-income and under-serviced neighborhoods and rural areas. And this group will grow to add 40 centers over the next few years.

The second thing is, we have created in this reward program a program we call PODS, for Physician Organization Delivery System. And what we have done is, in rural areas, where you have a small patient panel and the administrative burden may be a little bit hard for them to want to adopt the reward programs, we put a team together, which includes a nurse practitioner, to go into the office and to help them understand the disease management programs and the things that can be done to help serve the rural population.

Senator GRASSLEY. You just brought up nurse practitioners—and I know it was in your written testimony—and just now touched on it for the first time.

Would there be supervision requirements in the case of nurse practitioners? And more importantly, I am interested in what type of response you have received from the physician community regarding the idea of using nurse practitioners.

Mr. EDWARDS. We have had no issue, because they are coming in with—the key thing for the rural providers is they are absent actionable data, data that they can use to help them manage their patients.

So the nurse practitioner comes in, in a soft way, with data and can show them what they can do to improve the health of the patients that they are seeing, and they have a team of other folks who go with them.

They have the ability to contact a doctor and take a doctor with them, if they need to. But we have had no issue with the nurse practitioner walking in and sitting side-by-side with a physician.

Dr. REISMAN. May I comment on a couple of issues with regard to rural care? One is, as we think about reforming the payment mechanism, it actually behooves the physician to have the sort of support that a nurse practitioner can provide.

So, in the non-fee-for-service environment, it actually ends up being more cost-efficient and perhaps more lucrative for the primary care physician. That is the experience we have had.

The other challenge—we have not spoken much about electronic medical records—that I have heard of a couple of times is the availability of data. One of the challenges in a lot of these smaller practices in rural communities is the expense associated with implementing an electronic medical record.

And in Michigan, as I mentioned in my testimony, for example, we have actually introduced the capability to build effectively a light sort of electronic medical record for free that meets meaningful use criteria and can participate in the exchange of data around certain patients.

So in many ways, we are seeing the same level of sophistication with regard to availability of data, analysis of data, and the creation of activities that can be pursued by doctors or nurse practitioners, nutritionists, other members of the care team, effectively creating an environment that simulates what we have started to see in some of the major medical centers around the country.

So we think there are very real possibilities leveraging technology and payment reform in order to bring some of these models to these other communities.

The CHAIRMAN. But do we not have a long ways to go in health IT?

Dr. REISMAN. We have a long ways——

The CHAIRMAN. I have asked an earlier panel to rank, on a scale of 1 to 10, how well we are doing, and they all said about a 2.

Dr. REISMAN. Well, let me be specific about—rather than ranking, let me tell you a couple of concerns I have. One is the notion that an electronic medical record is certainly appealing, but the reality is, for most doctors—think about your own experience—they know about you. They have a paper record, and the electronic medical record maybe advances their ability to access information about you, but does not probably help that much.

The real issue is your doctors do not communicate with one another. I am presuming that you theoretically see multiple doctors. And what would frustrate me as a practitioner was not so much what I was doing for the patient, but what others were doing in terms of adding drugs or doing tests that I did not have access to.

So one of the things I do not think we have focused on sufficiently with regard to health technology is the need for health information exchange so, in fact, I can be provided with information about you generated by others.

The other notion which I think has gotten short shrift is this notion of clinical decision support. How do you convert massive amounts of information about you into specific activities that will correct problems relative to our level of compliance as a team, relative to the medical literature, that are safe and effective for you?

The CHAIRMAN. I know Senator Hatch wants to speak. But is there some way to develop some incentives? There are some bright people figuring that out.

Dr. REISMAN. Well, there are a couple of things. One is—there are two things. One is incentives for using electronic medical records, with a meaningful use of $44,000. But I would argue that a greater incentive would be the ability to assume risk and manage a community. So that, if I write a prescription for you, I have the capacity through this exchange to know whether or not you have actually filled that prescription or to the extent that you have gone to another doctor who did a drug test or a lab test that, in fact, represents a contraindication to the drug I prescribed to you.

The CHAIRMAN. So how do we solve that one? I go to a doc, he gives me a prescription, and——

Dr. REISMAN. So there are two ways. One is by downloading the capabilities that I just described; they can e-prescribe so that information is available. And secondly, when you fill that prescription at the pharmacy through your pharmacy benefit manager, we can access the data to know that, in fact, you have filled that prescription.

So there are two components. One is, I order the drug. The second is the degree to which you have complied.

It is a huge issue. Patients frequently do not comply, and one of the things we have actually introduced and published recently in the *New England Journal of Medicine* is an experiment where, for patients after a heart attack, we gave away drugs associated with the management of heart attack for free.

The good news was that it helped a bit. The bad news is that still fewer than 50 percent of the patients took their drugs. But we can access those data.

The CHAIRMAN. I am sorry. I will stop. But I was talking to the head of Denver Health, and she was telling me that they had exactly that problem, and their heart mortality or morbidity, whatever it is, was not good.

Dr. REISMAN. Right.

The CHAIRMAN. "Are you taking the meds?" they asked. "Oh, yeah, yeah, we're taking our meds." No, they were not. But they acquired or had a tie-in to a pharmacy. So they would check with the pharmacy—it was a local, in-house pharmacy, I think—and found out that they were not taking the meds. So they went back to the patient, "No, you're not taking your meds, and make sure you take your meds."

But the point there is some kind of coordination where the——

Dr. REISMAN. That is exactly what I am suggesting, and I am suggesting that our scalable technologies can be introduced, in many cases, for free to address the issues that we are discussing.

The CHAIRMAN. Sorry. Go ahead.

Senator HATCH. How do you handle privacy?

Dr. REISMAN. It is a huge issue. So one issue is that, under HIPAA, some of this information applies regarding the operations of health plans.

The most direct way to address privacy issues relates to getting permission directly from the member. And, in addition to the pri-

vacy issues and the agreement of the member, there are issues of security, which are just as daunting.

Senator HATCH. I take it it is the same thing in relation to overprescribing by other doctors?

Dr. REISMAN. Yes. And one of the things we can do is ascertain that patients are, in fact, shopping—for example, I presume you are thinking about opioids like oxycontin. So we, in fact, can accumulate from a variety of electronic records or pharmacies that a particular patient is, in fact, accessing excessive amounts of drugs, which, obviously, can work to the detriment of that patient.

That is the sort of information we could then communicate back to the treating physician as it relates to the specific patient to warn them about this patient's propensity to ask for narcotics.

Senator HATCH. We have all said we want to work towards repeal of the SGR formula. However, a main problem we face is, what do we do then?

It seems to me that your organizations, as you testified, have moved well beyond where Medicare fee-for-service is today.

Now, what should we focus on as we are listing goals in the near term to improve payment within the fee-for-service system, and should we focus on quality measures or data reporting, bundled payments, or incentives? What can we do within our existing framework——

The CHAIRMAN. We need an answer here.

Senator HATCH [continuing]. That still moves us forward in the right direction?

Dr. SAFRAN. I will take the first shot at it.

Senator HATCH. I have only given you about seven questions.

Dr. SAFRAN. So, one of the fundamental problems of the SGR—this may be obvious, but has not been stated here—is that it deals with individual actors, individual clinicians as actors, but the targets are set based on a whole population of physicians across the country whose behaviors it has no influence over. So the individual actor has no real incentive around efficiency, no real incentive around quality, no real ability to control anything.

So what you have heard in common across all five of these testimonies is that organizations are dealing with payment in a way that relates not to individuals, but to organizations, to organizations that have been willing to accept accountability for both total medical spending and for the quality and outcomes of patient care.

And so one of the most important things, I think, that you can do, as you look to fix or replace SGR, is to move toward a model that does not deal with individual clinicians and does not set targets based on a population of other clinicians that they do not know and never will, but rather to have physicians identify who are the organizations they work with and to have those organizations accept accountability for total spending and for quality and outcome.

And, of course, not every physician or every physician group or organization around the country is ready for that kind of accountability today. We only saw 32 pioneers sign up. Those organizations are ready for that. They are far along.

What do we do with the others? I think we send a signal that that is where we are going and we take the initial step of having

clinicians identify who is the other set of clinicians that they are going to share accountability with.

And by starting with—what we have done in our case, outside of our AQC model, is, for our physician fee schedule, we have had for 4 years running zero-percent payment increases, zero percent, and the only way to earn additional revenue is through your performance on a defined set of quality and outcome measures.

So, beginning a path and having every physician in the country understand that this is where you are going ultimately, but that the initial steps are defining who it is that you are going to share accountability with, and starting accountability with quality and moving toward accountability for quality on total medical expense——

Mr. CARDOZA. It is a terribly important point that I would emphasize as well. As long as we are dealing with the physician community at the granular level, the unorganized level, paying fee-for-service, we cannot get to where we need to get to.

So what we would encourage you to do is develop policies to foster the organization of physicians coming together into groups, large and small, with all the metrics that we have talked about on performance so that they have a reason to go there.

The other point that I would make is, the consistent theme in what you are hearing is the emphasis on primary care, because that is the gateway to the system. If we had a health care delivery system, we would have a robust primary care system. In fact, what we have instead is more of a medical rescue system, which is why it is dominated by hospitals and high-tech specialists.

So the unfortunate underlying truth that we have not spoken to here is, if you want to manage a chronic care population, you need a robust primary care community, and it is going away.

In California, the primary care community is withering and dying on the vine, while hospital edifices are being built with billions of dollars. We have to fundamentally address that issue or we will not be able to get to where we need to get to.

Mr. BURRELL. I would like to reinforce that, if I could.

The CHAIRMAN. I would too.

Mr. BURRELL. We organized, as I said, small performance teams of primaries, over half of which were in solo practice or practices of less than three—not sophisticated practices. By giving them a total expected cost of care to beat and some structure, they actually pay attention to the quality and, most importantly, they pay attention to who are the chronic patients that run up costs—the 10 percent of the patients who run up two-thirds of the cost. Who are these patients and what do they need?

And we have assigned nurses to them to follow them into the community. Where do you break down? At home. Where do you get depressed? At home. Where do you fail to comply with your meds? At home. And a lot of times, the primary does not have direct evidence of that.

So we support them by providing home assessments of what is happening to these patients at home. Medications are critical. A lot of these patients are on 10 or more medications. Nobody ever reviews the full picture. Not only do they not comply, they have too many, and they have drugs that interact or make them unstable.

So we try to get the primaries in small performance teams to understand who among their panel of patients is at highest risk, who among them has chronic disease, and are you paying attention to them out of the sight of your office. And we try to give them help in that regard with nursing support in the community and in the home. And, if Mary Smith is the chronic patient and breaks down, the doctor is informed immediately. If she is admitted, the doctor is informed immediately, and it all builds on primary care and provides strong financial rewards to them. We do not increase their fees. We have not increased their fees. We have increased the rewards to them if they get a better outcome for their population.

Senator HATCH. Are doctors being educated at all on the people using dietary supplements as well? For instance, it is my understanding that if you are on, say, Crestor, then it would be very wise to take CoQ_{10}, a dietary supplement, to make up for some of the deficits that do occur from Crestor. And this is an area that really is not very well-defined right now.

Mr. BURRELL. It is not, and it should be.

Senator HATCH. But you agree with me on that.

Mr. BURRELL. I totally agree with that. Here is what we——

Senator HATCH. A lot of people do not know that. I mean, they will take Crestor and not realize that they may be putting themselves in—I don't mean to pick on Crestor, but I just use it as one example—they may be putting themselves in some sort of jeopardy if they do not balance it with, say, CoQ_{10}, which is a dietary supplement.

Mr. BURRELL. Twenty-one percent of our medical spending is for prescription drugs; 24 percent of our medical spending is for inpatient hospitalization. So the drug part of the equation is dramatically increasing. A lot of primaries do not know what drugs their patients are on, and, if you ask the patient, they cannot reliably tell you.

So what we do is create a drug profile of the patient, all the medications they are on. Sometimes you are on two generics and one branded at the same time, and you do not realize it because the names are different or a drug was prescribed by a specialist and another specialist, and, when you went into the hospital, by the hospital, and the primary did not even know you were on all these drugs.

So one of the things we provide the primaries is a view of the total drug profile of the patient and say, "Do you realize that this is what your patient is on?" A lot of times, they do not, and then they start to act and say, "I didn't realize that. I will try to revise that, and then we will educate the patient better." That stabilizes them more, and then you prevent the cycle of breakdown, admission, and readmission, and the ER visit. And that is where so much of the cost in the system is. I know that it is true in this region.

Dr. REISMAN. And, Senator, at the risk of being disagreeable, but this, after all, is our kitchen table, right?

Senator HATCH. Sure. You can be disagreeable.

Dr. REISMAN. I think we need to spend a lot more time on appreciating——

The CHAIRMAN. All families do not all agree on things.

Dr. REISMAN. There you go.

Senator HATCH. Just be careful, that is all. [Laughter.]

Dr. REISMAN. Thank you. I will heed the warning. I have already changed my remark, in my mind. I think people are accessing alternative therapies. We are supporting a lot of alternative therapies and ways of supporting patients.

But bear in mind that we do need to adhere to rigorous evidence-based clinical trials.

Senator HATCH. Sure.

Dr. REISMAN. Just as an example of something that I think everybody accepted, vitamin D and calcium to prevent osteoporosis, recent literature—it was published this week—suggests that a normal diet in the absence of supplements is probably more than adequate.

So we need to be careful about what we, in fact, suggest and prescribe, particularly as we become more sophisticated with these decision support tools. We need to ensure that we are quite rigorous.

On the SGR point, I just wanted to suggest that the real issue that we are grappling with is quality and total cost. And perhaps what we really need to do is understand that that is really the issue here, and we can back into issues like SGR. But considering SGR in isolation is not going to get us to the greater issue, which is actually transforming and reengineering and providing the right incentives for a new health care delivery system. We will just be doing the same thing over and over again if we do not address that.

Mr. EDWARDS. And I would like to add to that just a couple suggestions. Make sure that you vary your programs to allow for practice variations. They are not all the same. So, whatever you do with the fee-for-service, you have to make sure you have different programs.

And developing a hybrid program that maybe begins with fee-for-service, so you are not having to change too much right out of the gate, and transitions to payments based on outcomes, are going to be a couple of quick hits for you, I think.

Senator THUNE. Mr. Chairman, I want to come back to the point that was discussed earlier with regard to electronic medical records. In some ways, Mr. Reisman, you have said that that is not the most important issue to focus on. I agree with that.

But, Mr. Burrell, you were just talking about all the issues with regard to patients who have medications that perhaps are conflicting with what they need, and all that information is out there in the universe somewhere, which could be captured if everybody—if we had some sort of system—now, I agree with what Senator Hatch said about privacy. I think that is an important issue.

But it just strikes me that so many of these issues of duplication and medical errors could be eliminated if we had a system where people's information, medical information, was available sort of irrespective of where they access the health care system.

And it strikes me—because I was at the hearing the chairman referenced where we asked the panel about where we were on a scale of 1 to 10—and maybe that is not a good way to measure it—but everybody said in that 2 to 3 range. And the issue, I think, is these standards of interoperability, which we do not seem to have come up with a solution for yet.

But it just strikes me that everybody talks about this issue in anecdotal form, about what it does to add costs in the health system, and it just seems like so much of this could be fixed.

And I do not know, again, how we achieve that. I know that it was discussed a lot, has been discussed a lot in the past, but I am very unsatisfied, I guess, with any of the answers I have received from anybody whom we have talked to about the subject and the progress that we are making toward that. But that is one issue.

The question I had with regard to—I think it was Dr. Safran. You had talked about the program that you have, Alternative Quality Contracts. And last year, in July, the *New England Journal of Medicine* had published an article that reviewed year 1 of that program, and it found that health spending decreases were largely associated with changes in referral patterns rather than with reduced utilization.

And I guess I am wondering, one, if you agree with that assessment; and, if you do, what can we be doing to put downward pressure on utilization, because, to me, that is really the issue.

Dr. SAFRAN. Yes. It is a very important issue, and, yes, I do agree with those findings that in year 1 of these 5-year contracts, what most organizations reach for as the most easily achievable savings is savings that they can get through moving care to less expensive care settings. And they are doing that, I would say, in very smart ways that do not disrupt clinical relationships, partly because they have accountability for patient experience as well.

And so they are doing things like moving care related to lab tests or imaging or basic procedures, where there are not established clinical relationships and where the patient is really happy to go wherever their clinician tells them as long as it is convenient. So there were significant savings to be realized through that, and many groups reached for those savings in year 1.

The harder job is to change utilization, because to change utilization requires changing how physicians think and then changing how they behave. And what we have seen in year 2, and what we are seeing now in years 3 and 4, is that those utilization changes have really started to take hold.

So they are putting in place the infrastructure, for example, to prevent avoidable admissions, avoidable use of the emergency department, by doing innovative things like having a nurse practitioner in the emergency room to catch the patient as they come through and triage and figure out, is this a patient who really needs emergency care or does this patient need urgent care, because, if they need urgent care, let us take care of them over here where we will not incur the expense of an emergency room visit.

We will take care of the patient's needs. They will not wind up in a bed, because, when you have a hospital in isolation and an emergency room, sometimes you not only get that emergency room visit, but you then get an inpatient admission too.

So they are putting infrastructure in place to make some significant changes in utilization that we see in years 2 and forward yielding even deeper savings than they got in year 1 through those site-of-service moves.

But we all have to realize that changing utilization is the much tougher task, because it does involve changing how physicians think and how they act.

Mr. EDWARDS. I would like to go back to your data question, because I think I might make you feel a little bit better about it, because I think we are not a 2. I think we have come a long way, and, if I was to rank us, we would probably be a 6.

The CHAIRMAN. Nationwide? I am talking about nationwide.

Mr. EDWARDS. Yes.

The CHAIRMAN. Six nationwide.

Mr. EDWARDS. So here is what—we just purchased a company, Anvita, that has a rules engine, and we are able to run every one of our 2,200 Medicare members through that engine overnight, and it will deliver back to us actionable gaps in care, including issues with drugs not being filled or being filled and not refilled over a 30-day period.

So the first time we ran it, it identified 355,000 actionable gaps in care that we could then turn around and turn over to our teams. And, as a result of that, working with the physicians, 31 percent of the gaps were converted into actions to improve outcomes for the members.

So this is a brand-new company that we just purchased, and we can run, like I said, full data through it overnight.

Dr. REISMAN. If I can answer that—a couple of things. One is, the sort of data that you are referring to, which we take advantage of as well, has been available in the managed care world for a long time. We can get drug data, we have claims information, we have information from laboratories.

I think the point that you are raising relates to interoperability among electronic medical records, where the interest is in richer clinical data; what do the radiology tests show, what do the pathologies show, what do the physical exams show?

And the way we have addressed that is through the acquisition of a company called Medicity, which actually does it through brute force. So, while we are waiting for standards of interoperability, I would refer you to the 850 hospitals and 200,000 physicians who are linked to this system.

A couple of specific examples. One is Carilion in Virginia, which is using this capability, and another is the Banner Health Care System based in Arizona, which is actually using it to support a Medicare pioneer ACO grant.

So, despite the fact that they have multiple EMRs, the ability to couple the traditional data we have always had with interoperable data that we have now accessed through brute force could, in fact, provide a substrate of information that I think you were referring to.

I would argue that that is not sufficient and you need capabilities, whether it is Anvita or ActiveHealth, to, in fact, convert that massive amount of information—after all, it is quite a bit, chiefly on complex patients—into activities.

So, as you think about a patient who is on 10 drugs, by definition, they might have 10 different diseases, hundreds of different lab results, how can any physician—and this is where the insecurity came from that drove me as a practitioner to the creation of

ActiveHealth. I could not keep up with the literature. I did not know what other physicians were doing. And the ability to, in fact, create this composite of data introduced this interrogation capability with clinical decision support. And then, in fact, to define discrete activities to pursue is really what we are trying to introduce around the country.

Senator WYDEN. Thank you, Mr. Chairman. And my apologies for being late. Too many hearings simultaneously. And I know this has been a very good panel.

I want to start with a question that stems from what I have heard all of you say, not just today, but repeatedly: that you are payers. And when you come before the Congress and talk to us about issues, it almost always comes back to information, which really means data, and you need access to it; and particularly global data, because you can really only look at what is inside your system.

And the fact is that, under Federal law, you cannot really get access to the data. Now, Senator Grassley and I want to change that. We have a bipartisan bill to open up the Medicare database so that it would be possible to look at, I think, what you call global information, be able to compare what you have in your system to others.

Dr. Reisman and Mr. Cardoza, I think you, in particular—and I think it is generally true of all five of you—are really sort of the point persons on this question.

Dr. Reisman, would this be helpful to you, and how would you assess the need for this effort legislatively, to open up the Medicare database so that you really could get access to this kind of information and use it to drive improved quality and hold down costs?

Dr. REISMAN. I would suggest that there are two elements of this discussion of data. One is retrospective analysis of aggregate data to identify trends, to support comparative effectiveness research, to understand what really works best, and we think that is enormously important. In fact, we are working with the administration and Todd Park, the CTO office, in order to, in fact, take advantage of those data capabilities. And one of the capabilities that we bring to that is the ability to apply our analytics to ask some of these important questions.

The other element—which is related, but I just want to define it as being separate—is the notion of availability of real-time data at the point of care to support the physician in regard to taking care of the patient who is sitting in front of him.

So there should be, in fact, the record locator that would allow me to identify data about you, analyze those data, and make sure that what I am doing for you is, again, consistent with the best clinical evidence and is not contraindicated relative to other activities that other doctors are pursuing with you.

So I think there is the aggregate and there is the real-time, but in any case, the availability of information that resides within the Medicare database would be enormously important, for a number of reasons.

Mr. CARDOZA. I would second that. I think what there is to be encouraged about on this topic is that we are talking about it. There is consensus that data matters, and sharing it among clinicians matters.

It was not very long ago that you could not have that conversation. Physicians are fiercely protective of their medical records. And we have seen a sea change just in the last 3 years in working with our physicians on this topic.

They are coming to understand, as I said in my opening comments, medicine is really complicated now, and it takes a team. It is not an individual walking into his office in the morning and back out at night, and he is all by himself and he is taking care of the patient. Those days are past.

So they know they need to interact with other physicians. They understand the importance of sharing data. And by law, patients have access to their records, and why would other physicians involved in the team care of that patient not have access to them as well?

We are at the advent of this, but I think it is going to move fairly quickly.

Senator WYDEN. Why don't I bring the other three of our valuable witnesses into the second topic I wanted to ask, and, if any of you would like to elaborate on the question of the Medicare database, certainly we can do that either in writing or as you respond to this.

But the second question I wanted to ask all of you is—since you come from the private sector and you watch the Federal Government, and, obviously, the Federal Government, to all of you, sometimes looks like it is moving very slowly and is slow to change and slow to adapt and slow to evolve, and traditional Medicare, even as we talk today, is still in the sort of demonstration project kind of stage—what would be your recommendations for speeding all of this up? Particularly, you have the chairman and ranking minority member here. We are in a position to look at ways to speed up and accelerate these changes so they get out of the demonstration stage and can be sped up.

So why don't we take our other three witnesses who did not get a crack at the first question and have them relay thier counsel on how to speed up changes and reforms.

Dr. Safran, why don't you start?

Dr. SAFRAN. Sure. I would say that, over the last couple of years, what we have seen actually is quite impressive speed with respect to the uptake of the Accountable Care Organizations——

Senator WYDEN. Right.

Dr. SAFRAN [continuing]. And that I would leverage that, because, as we were talking about before, the key is going to be for Medicare to be able to move away from a model of payment that deals with individual actors yet holds them accountable for the behaviors of every other doctor across the country such that, if others are using too much, my rates are going to go down next year, to a model where I have a group of peers that I have accepted accountability with and we are working together to manage total medical expenses, quality, and outcomes.

So the fact that you have stood up 32 pioneer ACOs in such a short period of time and that the Medicare Shared Savings program is getting underway, I think sort of sets out the beginning of a continuum that, to me, actually reminds me very much of the way that we waded into the AQC model that I talked about today.

When we launched the AQC in 2009, we hoped that, by the end of that year or possibly the following year, we might have 10 or 15 percent of our network accepting that broad accountability for total medical expenses, quality, and outcomes.

By the end of year 1, we had a quarter of our network contracted that way, and, at this point in time, we have close to 80 percent of our network across the State contracted in that way.

Why did it happen? Why did we have that fast uptake? I think there are lessons to be learned for the Federal Government, and a big part of it was that it was voluntary to begin. We were not forcing anybody in. We said, "If you believe this is a better way, and you can see that you can earn well under this model by making care better and by contributing to affordability over the long term, then come on into this contract."

And then what I think led to the rapid acceleration was a couple of things. One, organizations started to see that the initial pioneers—no pun intended—in our AQC model were succeeding both at improving quality and at managing their budgets.

Second, they saw that the fee-for-service system was starting to look pretty unattractive. It was starting to look like low or no payment increases, no real opportunities to advance, and that created some acceleration.

They started to understand the kind of support they were getting from us as a payer—and I think the Federal Government will have to work out similar models—to help them as they transitioned from a volume-based system to a value-based system.

Senator WYDEN. Take that last point, because I think that's the ballgame.

Dr. SAFRAN. Yes.

Senator WYDEN. I think that is the ballgame. And that, of course, is what we started essentially almost 3 decades ago in our part of the world, whether it is Group Health up in Seattle or Providence or other kinds of plans in our area.

What could the Federal Government do to accelerate that transition beyond fee-for-service?

Dr. SAFRAN. Well, I think there it goes back to your earlier question about the datasets, because from Washington, DC or Baltimore, it will be hard to partner with the provider organizations that have the courage to sign up for these new models in the ways that we have seen have been critical to their success in our market.

But imagine that if those who sign up for it are able to partner with their private payers, who are also paying them in that model, and if those private payers and the providers who come into it have all the data to work with, if we could be doing the same rich analytics for the providers in our market that are AQC organizations and also Medicare pioneers, this would be enormous assistance to them.

If we could then take those analytics and help them with the performance improvement guidance that we give them on the commercial side, give them that same guidance on the Medicare side, I think you would start to see more rapid uptake across the country, because fear is one of the rate limiters right now.

I think folks think, I would not know the first thing about how to transition from a system that pays me for every unit I produce

to a system that is now going to ask me to have accountability for overall spending and quality. So you have to help them.

Senator WYDEN. Mr. Chairman, when a witness says that they support the efforts along the lines of what Senator Grassley and I are talking about to expand access to this Medicare data, and they want to promote a transition beyond fee-for-service, I usually think I ought to quit while I am ahead. [Laughter.]

The CHAIRMAN. You are doing just great.

Senator WYDEN. I thank you for the time.

The CHAIRMAN. To follow up on your first point, there has been—and you mentioned it, Mr. Cardoza—earlier physician resistance to access to Medicare data.

I assume some physicians are proud of their billing practices. I am wondering whether their billing practices will be questioned. Maybe there are some medical liability issues there.

And I am just wondering if you could help us figure out how to bridge that gap, because I do think it makes sense for that data to be available, but we should do it in a way that is sensitive to legitimate physician concerns.

Mr. CARDOZA. Well, it is a journey. In our setting, we have been doing this for 25 years, and our 3,000-plus physicians are in an accountable structure, and they know they are being watched.

So in areas of the country where there is no transparency at all and they just walk into their silo in the morning and out at night, yes, there is going to be some trepidation, just that somebody else is going to be looking. But you have to go there.

In response to the question of, how do we accelerate it, how do we get there: put the money where you want the systems to go, and they will go there.

So payment reform has to precede delivery system reform. It has to enable delivery system reform. So the more we can create population-based reimbursement methodologies along the lines being espoused in Massachusetts, the faster we will get there.

The CHAIRMAN. So do you suggest modified payment reform under Medicare?

Mr. CARDOZA. Yes.

The CHAIRMAN. And what would it be?

Mr. CARDOZA. Well, you just went above my pay grade. [Laughter.] I am much more eloquent describing the problem. I do think the underlying principles, as we have all been talking about, are to put in place policies that give physicians reason to group up, to get connected to organizations so that they have—because I'm telling you, the physicians on their own cannot do this. It is not what they were trained to do. It is not what they signed up for.

The expectations of them now are very different from what they thought they were signing up for. They are okay with it, they are willing to sign up for it because they understand it is the right way to go, but they just lack the skills and wherewithal to do it.

So organizations like ours, the kinds of organizations in Massachusetts that have been described, are enabling structures for them to do what they would like to do, if they could. At the granular level, they have no chance.

Dr. REISMAN. Could I just suggest that we link the data question to some of the incentive questions? So if, in fact, we had access to

these data and the purpose was to say, you are a bad guy and you are a good guy, obviously, physicians are concerned about it.

But suppose we shifted the incentives, and we were talking about managing real populations, and we said, "Gee, there's a population in an adjacent county where, in fact, the number of the coronary angiograms done is half as many as you do, and, by the way, the incidence of obstructive coronary disease is 3 times higher, suggesting that you are doing angiograms on people who, in fact, do not need them." In fact, we could ascertain that as well.

We could go to that community and say, "Gee, we're actually changing the payment structure from fee-for-service, notwithstanding the SGR issues, to one where you, in fact, will receive the case rate or a global rate for your community, and, by the way, by looking at the CMS data, we, in fact, can assure you that by reducing utilization and being a little bit more thoughtful about your use of angiography—and we can name 25 other tests, obviously, if we care to—you, in fact, could put yourself in a position where you could responsibly assume risk, financial risk, without compromising the care of your population."

So I think for a lot of these issues, we need to think about companion solutions and actually collect and combine some of the issues that we have been talking about.

Mr. CARDOZA. Do not underestimate the power of peer pressure. If we can profile these practices and create the data and make that data available to people—we had two large cardiology groups in adjacent counties, and the utilization practices in one of those counties was egregious.

We went to those cardiologists, and we showed them their data compared to the next county, and, if we had just sent that out to them and not engaged them, they would have thought, "Well, I guess that means we're doing a better job."

So instead, we were able to engage them, hold their feet to the fire, and now, 2 years later, their utilization practices are exactly what the other county is. It was driving toward the mean.

The CHAIRMAN. Is it working in McCollum, TX?

Mr. CARDOZA. I do not know.

Dr. REISMAN. But the incentives are not there.

The CHAIRMAN. I am talking about peer pressure at least between——

Dr. REISMAN. Not at all.

The CHAIRMAN [continuing]. Particularly El Paso and McCollum. I am referring to the Atul Gawande article that——

Dr. REISMAN. I know you are, yes.

The CHAIRMAN [continuing]. Was written several years ago.

Mr. CARDOZA. Actually, my understanding is that there is some movement there since they have been exposed.

Mr. BURRELL. We are finding peer pressure, to the point—among the 300 panels we formed, the small groupings of primaries, there is peer pressure within the panel, and then there is peer pressure across panels. How am I doing relative to others?

You could have two physicians in a panel of 10 who are high, wide, and handsome, and the other eight have their incentives based on how the total panel does, and they start to police themselves.

Mr. CARDOZA. Doctors hate being an outlier. They just hate it.

Mr. BURRELL. They do.

Dr. REISMAN. But they also like making money. I would just suggest—we have peer pressure, plus financial incentives, and it did, in fact, create a synergistic relationship.

Mr. EDWARDS. Any modification to the policy has to make sure it is flexible among practice variations, because variations exist today.

The CHAIRMAN. What is the role of medical schools here?

Dr. REISMAN. I think there is a considerable role. Based on my experience recently, these issues are not being addressed particularly well. There is a little bit more of a focus on primary care. I think there is a need to further acknowledge the contribution that other types of practitioners can make. There is a lot of anxiety, of course, about conversation around primary care, but we are not doing nearly enough to, in fact, introduce these issues to the curriculum in medical school.

Mr. CARDOZA. Senator Baucus, I want to go back to a point I made earlier. We are not training physicians today to enter into a health care delivery system. We are training them to be medical rescuers. We are training high-tech, giving them lots of tools, and that is where the money is, and that is where the glamour is.

It is a real problem. So medical schools are not doing what is needed today, but so is a lot of this system.

I am not going to demonize them, but I think if we start setting this out there and challenging them, I think they can move in this direction. But they are not there now. They are training medical rescuers.

The CHAIRMAN. You touched on this anyway, but it is a little tense between specialists and primary care docs. It is my understanding that a lot of the Medicare reimbursement weighting schedule is contracted out to AMA, and it is weighted toward specialists, with a disadvantage to the primary care physicians. I do not know if that description is accurate.

But just your thoughts on how we can deal with this difference in reimbursement between specialists and primary care physicians. I do not want to take anything away from the specialists, but your point triggered my thought. We always train to the high glamour stuff and technology, and that is where the money is and so on and so forth, and it is probably a bit siloed as well. I do not know.

But I am trying to figure out how we get a little more focus on primary care physicians here.

Dr. SAFRAN. I think the models that you have heard us discuss today, while we have not explicitly said it, each of them is primary care-centered. So I will speak for our model.

The only requirement we have of an AQC organization from the perspective of what that organization has to look like is, it must have primary care at the center. Beyond that, if they want to have specialists in their contract, if they want a hospital as a partner in their contract, they may, but they do not have to. They still have to be accountable for that whole care across the continuum.

Well that, coupled with the fact that the quality incentives are so largely primary care-based, has really changed the dynamic of power and resources within these organizations, because these or-

ganizations understand that they cannot succeed at managing total medical expense and improving quality and outcomes if they are not investing in primary care at the core.

And so we are seeing them looking to hire more primary care clinicians, physicians, as well as nurse practitioners and medical assistants, investing in the infrastructure in primary care practices, rewarding those practices for the success that the organization is having at managing their budget and improving quality.

And it has, interestingly, changed the dynamic with specialists in a very important way. Specialists are sitting forward saying a couple things. One is, gee, how can we be helpful in this new model? How can we be helpful at managing total medical expenses? And are there not any measures for us? Are there not any good quality measures for us? That is a welcome question, because the available measures that are nationally endorsed really are, at this point, very much primary care-focused.

And being able to have accountability for quality of care in the specialty environment is very important.

Mr. EDWARDS. I agree with Dr. Safran. I think the PCP is the quarterback and——

The CHAIRMAN. Say again, Mr. Edwards.

Mr. EDWARDS. The PCP is the quarterback of the team, and he needs to funnel the care to the efficient specialists that he has. The most efficient model we have is where the specialists are capitated and the PCP is driving the care to the most efficient specialist that he has in the network.

Dr. REISMAN. I think we need to, again, focus on this team-based patient-focused orientation. So suppose I am a specialist doing bariatric surgery and Aetna offers a case rate.

Now, you are the surgeon. Typically, you might ignore the role of the primary care physician with regard to the follow-up of that patient who had the bariatric surgery. But now, as the surgeon, I am at risk if that patient is readmitted with an infection, with metabolic problems, lack of adherence to the drugs, all of the things that we have been talking about.

Suddenly that primary care physician is my best friend, to the extent that I do not want to have to see this patient again.

So, again, as we realign incentives and create dependencies, if you will, for the specialists on the primary care physician, in much the same way as there is a dependency the other way when the primary care physician refers to the specialist, we, in fact, can, I think, restructure those relationships and restructure the reimbursements so the primary care physician is more generously reimbursed.

The CHAIRMAN. We are going to—I am not going to ask you to do this. I think it is a bit much. But an earlier panel consisted of former CMS directors, and the subject was SGR. And at the end, I decided, why not? So I tasked them to come back to us with recommendations on how to reform the SGR.

Those recommendations are due tomorrow. I am just trying to think. It is too bad we were not all together here to talk about this, but anyway——

So what should we be looking for when they give their recommendations? What are some of the key points that you would

think are most important in order to help us advance the ball here and to get a reform of SGR in a way that you think makes sense given your experience and how you compensate physicians looking forward toward a collaborative, patient-centered approach and delivery system reforms, not siloed, et cetera?

What would it be? What should we be focusing on or looking at when we get those recommendations?

Mr. CARDOZA. Where is the value-based component to the compensation that goes to the physicians? If we are going to continue to just pay for fees for the services that they provide, then they are just going to keep providing services. So I would look for that as one thing, along with the other things that we have talked about.

Mr. BURRELL. I would echo that; it has to be a global measure of the outcome for a defined population of patients and a structure of accountability, principally through the primary care physicians.

It is not the price movement that you are looking for. It is an overall cost of care, and the only way you can improve that is to have that accountability and the incentives to get better outcomes.

The CHAIRMAN. How do you measure quality?

Mr. BURRELL. Largely on outcome.

The CHAIRMAN. How do you measure outcome?

Mr. BURRELL. We look at it principally as reductions in the evidence of the fragmentation of the health care system, having fewer readmissions, fewer ER visits, fewer drug interactions. That is not the only way—gaps in care.

But we are looking at outcome measures that show the patient has been stabilized or their risks mitigated.

Dr. REISMAN. I think you back out of things that are most fearful with regard to particular disease states. So the bad thing about being a diabetic is not your sugar, it is that you are going to have a heart attack or a stroke or end up in dialysis.

So the outcome is not, did you test this or test that or get your sugar to this or that level? The outcome is, did people, in fact, end up having strokes, heart attacks, and end up in dialysis or blind or any of the other dreaded complications associated with diabetes?

The CHAIRMAN. That depends on some kind of follow-up records.

Dr. REISMAN. Yes, which is a lot of what we are talking about. So you need this longitudinal record to see how things have turned out, related to some of the questions that Senator Wyden was asking before.

With regard to the SGR question, I would hope that the answer would be more expansive than an immediate reaction to SGR in isolation. I would hope there would be companion solutions that are suggested, and that those companion solutions are, in their recommendations, a realistic assessment about whether or not many practices have the infrastructure, the technological capabilities, even the financial wherewithal to manage this new approach.

The CHAIRMAN. Thank you.

Mr. Edwards?

Mr. EDWARDS. I would echo that, but add a couple things. For the physicians, I think we have to transfer or get a transition from the piecework system that they are in today to one that more appropriately rewards their ability to coordinate care and perform-

ance. To me, that is one of the biggest things we need to do with the system.

The CHAIRMAN. Dr. Safran?

Dr. SAFRAN. I would look for five things. I would look for them to give you a model that moves from a focus on individual actors to a model that focuses on organizations.

I would look to them to give you a model that moves from the focus on individual services and the fees for those services to the global view of total medical expenses and quality and outcomes for a population cared for by those organizations.

I would look for them to have a model that involves data and ongoing support to those organizations as they venture into this new world of moving from volume to value.

I would look for them to have a model that places substantial financial incentives on quality and outcomes, to act as the backstop against any incentive to stint on care that a global budget constraint might impose.

And lastly, I would look for them to help with the further development of better and richer outcome measures. We have good outcome measures today, measures for making sure that the important chronic diseases are under good control and that we are avoiding complications for hospital care. Those are good outcome measures, but they are not good enough.

And so we need further development of good outcome measures to sustain a model that rewards outcomes.

The CHAIRMAN. Well, that is great. If they are watching, I bet they will ask for an extension to modify. [Laughter.]

Senator WYDEN. Thank you, Mr. Chairman. I thought the point you raised, Mr. Chairman, about primary care was particularly important.

And we have Mr. Burrell here, and he has gotten into this primary care area, I think, in a very interesting way, particularly, bringing providers and patients together around prevention, and, to me, that is really the ballgame.

We understand that most of the health care bill in this country goes for chronic disease, well over half of it, and we spend it picking up the damage caused by heart disease and stroke and cancer and diabetes. And you are trying to figure out a way to bring your providers and your patients together and reward the patients, and I think that is particularly good.

Since you and I talked, Senator Portman and I got together with the Cleveland Clinic and Oregon Health Sciences University and have actually proposed for the first time financial rewards for senior citizens under Medicare to lower their blood pressure or their cholesterol and stop smoking or use body mass and the like.

In the context of the chairman's question about primary care, tell us a little bit about what you are doing to bring together both your providers, your docs and others, and the patients to start having prevention and behavioral change—empowering the patients—be part of your new approach.

Mr. BURRELL. Well, on the patient side, it starts with awareness of risk, which starts with a health risk appraisal, which we offer for free. Just a discovery of the risks you have, the awareness of the risks you have, has a big effect on behavior.

We ask them to share it with their primary care doctor. And so we automatically transfer it with that consent to the primary. It has an effect on the primary's thinking sometimes.

We start with financial incentives to the member just to participate, and then it moves to financial incentives for outcome. You see that you are overweight, you see that you have hypertension, you see the risks that you have. It is one thing to see it. It is another thing to actually act on it.

We want to move to the day where stronger outcomes produce stronger financial rewards for the member. But if you are the only one who knows it, as a member, and your doctor does not, it does not do much good.

So we give it to our small panels of primaries. It is seen by the panel; then we identify the patients at high risk as evidenced by health risk appraisals, and we target interventions together with those primaries for the patients at higher risk.

So it is an incentive to the member to participate and be aware and to take action, and it is an incentive on the part of the primary because it is a global population-based incentive model. If they can get a better outcome, they have a financial reward—the member does and the physician does—and they are dovetailed together. And it is the working together that actually causes, we think, the best result.

Dr. REISMAN. Senator, just at the risk of being a wet blanket in this—and I completely agree with what you are discussing.

The CHAIRMAN. I like you. You are going to bring up contrary points of view. That is good.

Dr. REISMAN. Thanks. So we—and I am not sure you were here when I mentioned this—collaborated with Niteesh Choudhry at Harvard, and we published a piece in the *New England Journal of Medicine* a couple of months ago where we gave patients who had experienced heart attacks their drugs for free.

So they, in fact, did not have risk factors—they had already experienced the outcome. And, despite getting their drugs for free, zero co-pays, less than 50 percent of them were compliant.

So there is the ability for the doctor to do the right thing. They had written prescriptions for all the right drugs. There is the ability to convey information about risk. But the reality of human behavior is that we need to grapple with some of the complexities associated with this. It is very discouraging, but we have a long way to go, and we need to understand how to get into the psyche of patients.

Senator WYDEN. There is no question that there are a variety of factors involved here. I think what really swung me to this was the work of Dr. Roizen, who is a prevention officer at the Cleveland Clinic. And the program that they have put together—which essentially is what Senator Portman and I modeled our approach with Medicare on—really does seem to be working, and I think they do try to spend the time, certainly, talking with patients, talking with families, incorporating in some of the judgments that you are talking about.

But they are very clear—and Toby Cosgrove and others have had a long interest in prevention—they are very clear in their view that these financial rewards—and these are, of course, not enormous

sums of money—but the idea of a few hundred dollars in conjunction with some of these other kinds of approaches has been successful.

And since Chairman Baucus has given us a chance to kind of be around the kitchen table to kick these ideas around, hopefully we will be able to make more progress.

Dr. REISMAN. But it may be that our social networking and sense of community, which is something that we are pursuing——

The CHAIRMAN. I would like you to focus a little more on patient responsibility.

Dr. REISMAN. Yes.

Dr. SAFRAN. Well, one of the things that——

The CHAIRMAN. Patient responsibility. It is a big issue, huge. And your thoughts? How do we encourage it? You talk about probing the internal psyche of people. That is kind of scary.

Dr. REISMAN. And we have talked about——

The CHAIRMAN. How do we get it so we encourage more responsibility?

Dr. REISMAN. Part of it might be some sort of social pressure or social awareness or gamification, taking advantage of new approaches in behavioral health and behavioral psychology and behavioral economics to induce the sort of behavior that we are interested in.

But the simple-minded notion that I, as a doctor, tell you what you need to do and then go farther and say, you can do it for free, clearly is not enough, and that is really the point I wanted to make. And we need to invoke other considerations.

The CHAIRMAN. I would agree with that.

Mr. BURRELL. And just to add one thought here, because I think it starts with incentives, but it cannot end with incentives.

To go back to what I said earlier, we find that the breakdowns occur at home. You do not comply partly because you are depressed, partly because of the way you live your life, and so there is a psychosocial aspect to it.

So we found that when incentives and awareness are combined with actual follow-on—not by the doctor who prescribes whatever the medication is, but often by a nurse following it up—the connection with the nurse has an effect on compliance.

You cannot do this on every patient, but we are looking at the 5 to 10 percent of the patients who run up two-thirds of the cost, and you can do it for them. It is the combination of all of the above: the physician paying attention, the nurse following it up into the home where the breakdowns occur. It is so important to getting compliance. Compliance is very low.

Mr. CARDOZA. But you cannot do it in a straight fee-for-service-based system. There is no money for that, because what you are describing is absolutely essential. It is expensive to create the structure for it.

So unless you have that global money to deal with up front——

Mr. BURRELL. Correct.

Mr. CARDOZA [continuing]. It is very difficult to do in a fee-for-service.

Mr. BURRELL. Medicare does not cover it.

Dr. SAFRAN. Both that global money up front and an incentive that is based on the outcomes of care, because, up until this point of creating accountability for outcomes, adherence has been the great don't-ask-don't-tell phenomenon in health care.

When doctors give a patient a prescription or advice, they just assume and hope that that advice gets followed. And, as Mr. Burrell just said, the financial barriers are only one piece of it. And starting to systematically address the barriers to adherence is part of what health care means, starting to address, did the patient understand, are there cognitive issues that are going to get in the way of adherence, are there motivational issues, are there practical issues in terms of their neighborhood and what they can do or their work life and what they are able to manage?

The CHAIRMAN. Right.

Dr. SAFRAN. Addressing those has to become part of what health care means.

Mr. EDWARDS. And that group we brought up earlier that serves the low-income and the under-served neighborhoods on patient responsibility, they go and pick up the patient and bring them in so they do not miss their appointments, so that they are always there when they need to be there. So that has been a big help.

The CHAIRMAN. There are nine people who are working over here. It is called the Supreme Court. How is their decision going to affect all of this? What do you do?

Mr. CARDOZA. I have been asked that question a lot, and I do not profess to be an expert on it, but my comment has been, it will only affect pace, not direction, because we are all on a burning platform right now. We cannot stay where we are.

I think the Affordable Care Act—I am not an expert in it—I assume that it is flawed, but it is necessary. It gets us to the starting gate. And we are going to spend the rest of my career perfecting it, but we have to start down that road. We cannot stay on this platform. It is on fire.

The CHAIRMAN. Other thoughts?

Mr. BURRELL. I would essentially agree with that. I think the changes that are underway are unstoppable, regardless of what the court decides.

Dr. REISMAN. The economic imperatives will remain regardless. We have been working on this, as I mentioned in my testimony, since 2005 at least. We will continue.

The CHAIRMAN. Do you agree?

Mr. EDWARDS. Yes. We have been through a lot of changes over time, and we are just looking for a more sustainable program.

Dr. SAFRAN. Absolutely. We cannot stop.

The CHAIRMAN. Well, this has been a good session here. Thank you very, very, very much. You have given us a lot of very good ideas and, like most things, we just keep moving forward. Thanks a lot.

The hearing is adjourned.

[Whereupon, at 11:48 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Opening Statement of Senator Max Baucus (D-Mont.)
Regarding the Medicare Physician Payment System
As prepared for delivery

Thomas Edison once said, "To have a great idea, have a lot of them."

Today, we hold our second roundtable on Medicare physician payments. The payment system Medicare currently uses is broken. There are a lot of ideas about how to fix it. Today I want to hear them.

We know the sustainable growth rate, or SGR, must be repealed. It causes uncertainty. It causes seniors to fear losing access to their doctors. It threatens physicians with increasing payment cuts year after year.

We need to take a look at the underlying fee-for-service system that Medicare uses to pay physicians. Fee-for-service rewards physicians who do more tests and more procedures, even if those services are unnecessary. It does not encourage physicians to coordinate patient care to save money and improve results.

We need an efficient system that rewards physicians for providing high-quality, high-value care.

Today, we will hear from five organizations that have developed innovative physician payment systems in the private insurance market. These organizations are changing how they pay physicians to create incentives that will improve patient care.

They are rewarding the physicians who keep patients healthy and cut down on emergency room visits and hospital readmissions. These results not only save money, they mean better care for patients.

We want to learn how these ideas can be applied to the Medicare program.

Medicare needs solutions that will work in a range of settings – in cities and rural areas, for large doctor groups and solo practitioners, and for specialists and primary care providers.

What works in California may not always work in Montana. Fortunately, our panelists can describe ideas that have worked in many different regions of the country.

I look forward to candid and direct suggestions from our panelists.

Statement of
Chester "Chet" Burrell
President and Chief Executive Officer
CareFirst BlueCross BlueShield

Before the

U.S. Senate Committee on Finance
Physician Payment Roundtable

"Medicare Physician Payment Policy: Lessons from the Private Sector"

Thursday, June 14, 2012
10:00 a.m.

Chairman Baucus, Ranking Member Hatch, and other members of the Senate Finance Committee, thank you for providing me with this opportunity to discuss the steps CareFirst is taking to fundamentally change the way health care is delivered and reimbursed in the future. For the record, my name is Chet Burrell and I am President and CEO of CareFirst BlueCross BlueShield, a not-for-profit health care company which, through its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products and administrative services to nearly 3.4 million individuals and groups in Maryland, the District of Columbia and Northern Virginia – including, I am proud to say, a significant number of the Senators and members of their staffs here today.

CareFirst's Patient-Centered Medical Home (PCMH) is an innovative program designed to provide primary care providers with new incentives and tools to provide higher quality, lower cost care to our members. Our PCMH program is a model that is easily scalable as it is moving the region toward a new health care financing model that uses the incentives inherent in a global capitation model to counteract the volume-inducing aspects of fee for service, but without shifting risk to PCPs who are not in a position to assume those risks. Panels that produce a savings against their total global cost-of-care target share in the savings they generate based on savings, quality-of-care outcomes, the credibility/size of the Panel and the consistency of their performance over multiple Performance Years. A formula is used to calculate these factors and to derive an Outcome Incentive Award according to a matrix known to all Panels.

Understanding that 10 percent of CareFirst members account for 60 percent of the costs that we pay for health care services, and that nearly 80 percent of these patients suffer from multiple chronic conditions, the PCMH program is designed to enable physicians to closely coordinate care for the chronically ill, as well as help these patients better manage their diseases and improve their overall health.

The timing for today's Roundtable Discussion could not have been more appropriate. Just last week, CareFirst announced the results of its first full year of our PCMH initiative. With nearly 3,600 participating primary care providers, providing care for nearly a million of CareFirst's members, we believe CareFirst's PCMH program is the largest and one of the most ambitious of its kind anywhere in the nation. I am pleased to report that nearly 60 percent of eligible PCMH Panels (small teams of primary care physicians and nurse practitioners) earned increased reimbursements for their performance in 2011.

Increased reimbursements – or Outcome Incentive Awards (OIAs) – are based on a combination of savings achieved by a particular Panel against projected 2011 total care costs for CareFirst members as well as the attainment of quality points in the provision of care to a Panel's patients. OIAs will be paid to PCMH participants in the form of increased fee reimbursements for certain primary care services beginning July 1, 2012 and continuing through June 30, 2013.

The CareFirst PCMH is designed to improve health care quality while, over time, bending the cost curve. By providing incentives to primary care providers based on patient outcomes, promoting collaboration and integration between health care providers, and emphasizing coordinated care for the chronically ill, the PCMH is revolutionizing patient-centered care with unmatched support for the communities CareFirst serves.

The premise of our PCMH program is simple: let primary care providers (PCPs) serve as the "quarterback" of a team of health professionals to focus on providing coordinated care for those patients who need it most. Incentives to PCPs, including an immediate 12 percent increase in their fees as well as additional compensation for the development and monitoring of patient-specific care plans for their sickest patients, reinforce the central role of primary care in helping members manage their health risks as well as guide their care when they experience major

illness, especially involving chronic conditions such as coronary artery disease, congestive heart failure, diabetes, COPD, asthma and high blood pressure.

CareFirst's PCMH program enables collaboration between physicians, local nurses, and other health professionals to manage care. The team collaborates to initiate, more closely coordinate, and track care for the sickest of patients. In addition, the program facilitates implementation of Care Plans directed by primary care providers with the support of local community-based care teams (Care Coordination Teams) headed by RN Local Care Coordinators who arrange for and track the care of those members who are at highest risk or who would benefit most from a comprehensive Care Plan. As a result of collaboration and coordinated care, health care providers can take steps to keep patients healthier, and prevent chronic conditions from developing into even more serious health issues.

Providers are responding, with about 150 of the 250 eligible Panels earning Outcome Incentive Awards for the 2011 program year. The OIAs earned by Panels is based on both the level of quality and degree of savings achieved by the Panel's participating providers. While we are still in the early stages of an effort that requires new ways of delivering care, the first year of the program demonstrates to PCPs that we recognize the critical role they can play in improving care and meaningfully reducing costs over the long-term. We expect these incentives will motivate them even more to engage in the program and to focus on quality and reducing costs.

Let me share some highlights from the first year of the PCMH program:

1. Program participants (Panels) earning OIAs achieved an average 4.2 percent savings against expected 2011 care costs.
2. Program participants who did not earn OIAs registered costs that averaged 4 percent higher than expected for 2011.
3. On average, participants earning OIAs will see a 20 percent increase in their reimbursement levels, over and above the 12 percentage point increase paid to all participants that continue to remain in good standing in the PCMH program.

4. The cost of care for all CareFirst members attributed to PCMH participants was 1.5 percent lower than had been projected for 2011.
5. Quality scores for panels receiving an OIA and those not receiving an OIA were comparable.

In 2011, the PCMH program measured quality performance using nationally recognized measures for appropriate use of health care services and effectiveness of care. Panels also could earn quality points based on patient access (such as e-scheduling and extended office hours) and structural capabilities (including using e-prescribing and electronic medical records).

Since its launch in January 2011, the PCMH program has grown quickly and now includes about 80 percent of all eligible primary care physicians in CareFirst physician networks. In the first 18 months of the program, CareFirst has significantly enhanced the tools, resources, and supports available to PCMH participants. These enhancements include:

- A detailed online member health record and online care plan development tool available 24/7 via the internet.
- Comprehensive data on their CareFirst patient population to identify opportunities for care improvement and cost savings.
- Teams of registered nurses, community-based Local Care Coordinators and CareFirst Regional Care Coordinators, aligned with individual practices to help coordinate care for the sickest patients.
- A team of PCMH Program Consultants to help participants understand and utilize the tools and data available through the program.
- Free access to the American College of Physicians Medical Home Builder 2.0 tool to assist practices in transforming to a medical home model.
- Dedicated member service resources for CareFirst PCMH members.

The types of supports we have put in place have never been made available to primary care providers before and we are continuously refining and expanding these supports to meet the needs of PCPs and to achieve the long-term gains in quality and cost reduction that we believe are possible through PCMH.

Extending PCMH to the Health Safety Net and Medicare Populations

Recognizing the potential for significant improvements in overall health outcomes, through its *CareFirst Commitment* community giving program, CareFirst has committed to invest more than $8.5 million in grants and other resources over three years to support health safety net clinics in our service area to create and/or enhance patient centered care to the region's most vulnerable populations.

We also have an application pending to partner with the Centers for Medicare and Medicaid Services (CMS) to extend the PCMH program to Medicare beneficiaries in parts of our market service area. If accepted, this single-payer program would become a two-payer public-private cooperative program that we believe has the potential to move the region toward a new health care financing model that uses the incentives inherent in a global capitation model to counteract the volume-inducing aspects of fee for service, but without shifting risk to PCPs who are not in a position to assume those risks. It is also intended to move the region toward an all-payer model that starts with the two largest payers – Medicare and CareFirst.

We believe placing Medicare and CareFirst in a single, common model will help CMS achieve its goals of higher quality, improved outcomes and lower costs. Together, CareFirst and Medicare account for well over half of the region's health care spending. Should our grant proposal be accepted and it proves successful, it can be expanded to include other payers based on a PCP-focused common provider network and incentive model supported by high touch/locally based nurse-led care transition and coordination teams. These teams would take advantage of a newly created web-based patient tracking, reporting, care management and analytics system that has been developed specifically for this purpose and is the underpinning of CareFirst's existing PCMH program.

STATEMENT BY DARRYL CARDOZA

Roundtable on Medicare Physician Payment Policy: Lessons from the Private Sector

United States Senate Committee on Finance
June 14, 2012

Darryl Cardoza
Chief Executive Officer
Hill Physicians Medical Group
San Ramon, CA 94583-0980
925-327-6710

ABOUT HILL PHYSICIANS

Chairman Baucus, Ranking Member Hatch, and members of the Finance Committee. Thank you for the opportunity to participate in this roundtable to discuss Medicare physician payment reform – it is a privilege and an honor. I believe this issue is an important ingredient to the financial solvency of Medicare and I commend the Committee in its efforts to hear from all stakeholders in the public and private sectors.

My name is Darryl Cardoza and I am the Chief Executive Officer of Hill Physicians Medical Group ("Hill Physicians"). Hill Physicians was formed in 1983 and is now one of the nation's largest independent physician associations (IPAs). We have more than 3,500 participating primary care physicians and specialists across Northern California, serving 300,000 patients.

Hill Physicians' organization is based on the "delegated model" framework, which has had good success in California. Under the delegated model, a health plan contracts with physician organizations on a capitated basis and delegates responsibilities to these organizations to arrange for the medical care of the plan's enrollees. A delegated physician organization generally accepts responsibility for all physician services provided to enrollees that select the physician group for their physician services. Operating under this model, Hill Physicians' services go beyond simply providing medical care. We use our organizational infrastructure to enable and encourage care coordination, credential physicians, ensure appropriateness in the provision of clinical services, drive quality improvement, and manage risk associated with population-based payments. Hill Physicians is responsible for paying its affiliated physicians for the services provided to patients assigned to us by the health plans. I will discuss below some payment innovations we use to encourage physicians to optimize value for the people we serve by providing quality services, while striving to improve affordability .

Hill Physicians has been committed to developing and operating a coordinated care model as the key to achieving an efficient, high quality health care delivery system. Hill Physicians has been operating under this principle and implementing a model to support this vision since its inception. As such, we believe that we serve as a good, real-world example of how an accountable care organization can achieve the goals of the Affordable Care Act.

Hill Physicians can be described as a "virtual physician organization," in that we have organized a large number of independent, self- employed physicians into a single, accountable organization that is able to provide a specified scope of services for a specified price. Most of the physician practices that constitute our group are comprised of less than six physicians. In a country in which most physician practices are small and provide only a narrow scope of services, our organization creates an environment that enables integration and care management across a wide spectrum of services and providers so that the whole is greater than

the sum of its parts. Hill Physicians thus allows individual, small physician practices to be a part of a broad system of coordinated care.

Hill Physicians' organizational and management infrastructure has allowed it to be a nationally recognized leader in clinical quality, technological adoption, and the development of innovative healthcare delivery approaches such as Accountable Care Organizations (ACOs). Hill Physicians was among the initial organizers and proponents of the "Pay for Performance" program developed by the Integrated Healthcare Association in California and has consistently been rated as among the top performing medical groups in California by independent oversight organizations. In 2009, Hill Physicians became the physician organization component of an ACO to serve 40,000 members of CalPERS in the Sacramento area. This nationally watched program, a collaboration with Dignity Health hospitals and Blue Shield of California, reduced costs during the first year of operation by $20 million. Those cost reductions have been sustained and even increased in years two and three, as the program continues.

PHYSICIAN COMPENSATION MODELS

As noted above, Hill Physicians receives a capitated per-member, per-month payment from health plans and is responsible for paying each participating provider. This has allowed us to use innovative physician payment models to reduce practice variability, improve quality and moderate escalation of costs. Hill Physicians' compensation plan for our physician network is primarily fee-for-service based, but with some material innovations as outlined below:

Primary Care Compensation

Hill Physicians pays primary care physicians using a hybrid model of fee-for-service and performance based compensation. The fee-for-service component encourages physician access and availability for our patients. The fee-for-service rate is lower than the Medicare fee schedule and less than what is generally regarded to be required to sustain a viable practice. However, this rate is supplemented by a quarterly primary care management fee ("PMF") that results in our network physicians being paid at an average rate that is considerably higher than Medicare. The amount of this fee earned varies based on individual practice performance. Performance metrics are established for quality of care, using industry standard, evidence-based measures, such as HEDIS measures, and for utilization performance, using measures based on services provided in the practice, referrals to specialists, use of diagnostic services, E.R. usage, and inpatient utilization. Additionally, physicians are evaluated based on their participation in activities that support care coordination and the Hill Physicians organization and infrastructure as a whole, including regular meeting attendance to review data, use of our e-solutions to foster communication and coordination of care, and continuing education.

A minimum of 200 Hill Physicians patients must receive care from a primary care physician to qualify for performance measurement and compensation. This helps to address concerns related to random statistical variation in results and the statistical credibility of the measures. The patient population is risk adjusted using industry-standard external software. Appropriate stop loss protections are in place to protect practices from uncontrollable factors. The program has worked well to encourage high quality and efficient care in our primary care network, and reduce practice variability, and sustain the viability of primary care practice.

Specialty Capitation:

While our specialists are generally paid on a fee-for-service basis, in our Sacramento region we have implemented a system of specialty capitation for selected specialties. We have contracted with certain group practices to make them our exclusive provider for their specialty. These practices are paid on a capitated, per-member, per-month basis. We monitor their practice patterns and include performance measures in our agreement with them. This system has worked well in this market.

Specialty Case Rate:

Two years ago, we developed a case rate pilot program in which our largest medical oncology practice volunteered to participate. Whereas capitated payment arrangements establish payments based on a population (i.e., on a per-member, per-month basis), a case rate typically reflects a set amount paid for a defined episode of care or set of services. In our oncology case rate program, payments are based on nine distinct "cohorts," or cancer diagnosis groups. For example, the three most common cohorts are breast, lung, and colon cancers. A predetermined amount is paid to participating providers for each patient over a 36-month period. Case rate payments for each cohort mirror anticipated costs as they are incurred by participating providers for the total care provided to each cancer patient. Currently, approximately 50% of our oncology services are provided through this program.

The program has succeeded in maintaining quality, which is measured using certain American Society of Clinical Oncology metrics, while moderating the escalating cost trend for use of chemotherapy drugs. We are pleased with its results thus far, as are the oncology practices working with us in it. As we gain experience, we intend to expand our case rate program to other specialties in the future.

KEY STRENGTHS AND CHALLENGES

Our model has been successful for us, our physicians, our contracting health plans, our patients, and we believe the health care system overall. While we believe our model can provide benefits elsewhere, it is important to note that it may require some adaptation to work in a

different environment. I want to thus discuss some of the attributes of our model that have been the foundation of our success. As the Medicare program experiments with population and value-based payment models, it may be helpful to consider how these attributes are reflected or treated in a given model.

Infrastructure

A key component of Hill Physicians' ability to manage and foster high value care is our organizational framework and infrastructure, which is a distinguishing characteristic of the successful delegated model in California. The acceptance of population-based payments requires the use of sophisticated management, technology, intelligent use of data and interactive clinical-level communications, as well as a broad patient base, in order to effectively coordinate care, align incentives, and manage risk. Hill Physicians' infrastructure brings these resources and innovations to bear to create an enabling environment that encourages physician engagement and organization –an essential condition to creating an integrated and high value experience for patients.

Small Providers

While providing coordinated care requires a broad range of providers, small, independent practices can still contribute significantly to coordinated care efforts. The organizational structure of Hill Physicians allows small practices to participate in a larger, coordinated care system. As noted above, most of our practices have fewer than six physicians.

Network

Holding a network of providers accountable for the cost and quality of patient care becomes less viable to the extent that patients choose to seek care from outside of the network. Thus, there are significant challenges in developing a structure that enables providers to be accountable while also preserving the availability of unrestricted patient choice models such as broad network PPOs. Appropriate incentives need to be in place to encourage patients to stay within a given network while preserving their ability to have reasonable choices for where to get their care. We have been leaders in working with our health plan partners to determine the most effective methods for striking a balance.

Provider engagement

While our organization infrastructure provides significant support, Hill Physicians is driven by physicians, and physician engagement with our management support structure is key to our success. Physicians should be free to focus on doing what they do best – practicing medicine. To encourage physician engagement, we establish financial incentives for participation in care

management activities and maintain various outreach programs to educate physicians about their performance within the network. For instance, every primary care provider receives a quarterly report that details their performance relative to their peers. Our medical directors and staff hold numerous individualized and group meetings with physicians to review the data and discuss their performance and ways to improve.

CONCLUSION

Medicare is seeking to make greater use of population and value-based payment structures. There is something to be learned from the private sector and organizations like ours in understanding the conditions and investment in organization and infrastructure required for these models to succeed. Medicare Advantage is a well-established population-based payment model and we see value in efforts to explore the expansion of population-based payments to traditional fee-for-service Medicare.

However, across all these models, our experience is that certain variables need to be in place. Most importantly, organizing care on a population or value-based payment method requires significant infrastructure and technical expertise. Additionally, population and value-based care requires a strong network of providers who are engaged in the network. The goal of organizations like ours is to provide the necessary infrastructure and expertise upon which these models are built.

Again, I'm most appreciative for the opportunity to appear before you today, and I look forward to participating in the discussion today and in the future.

Thank you very much.

Medicare Physician Payment Policy:
Lessons from the Private Sector

Senate Finance Committee Roundtable
Thursday, June 14, 2012

Peter Edwards
President, Provider Development
Humana Inc.

www.humana.com

Humana

Medicare Physician Payment Policy: Lessons from the Private Sector
Senate Finance Committee Roundtable, Thursday, June 14, 2012

Written Testimony – Peter Edwards
Humana Inc.

Humana appreciates the opportunity to share information about the role we are playing in engaging and collaborating with physicians in innovative payment models to drive better health outcomes and quality of care. Like you, we believe payment innovations – if implemented in partnership and in full cooperation with physicians – can truly advance the health care delivery system and most importantly, enhance the quality of care provided to Americans.

Introduction

My name is Peter Edwards. As Humana's President, Provider Development, I am responsible for leading the expansion of Humana's population-health focus by pursuing engaged provider relationships and developing Medical Service Organizations (MSOs) and other joint ventures with providers. In this capacity I oversee the company's MSO services, and the Provider Contracting function.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of health and wellness services and health care coverage products that incorporate an integrated approach to lifelong well-being. Humana's 25-year experience in driving value-based health care delivery system transformation is predicated on creating physician payment models that reward efficient and effective care delivery, and doing so in a way that recognizes the variability in physician practices and tailors programs that engage physicians based on, among other factors, practice resources, geography, and patient panels.

Our perspective is built off of our broad knowledge of different markets and populations across the health care system. Humana is one of the nation's largest Medicare Advantage contractors with 2.2 million Medicare Advantage beneficiaries. In addition, Humana owns over 300 medical centers and has over 250 worksite medical facilities. Across the health care delivery system, Humana offers a wide array of health and supplemental benefit plans for employer groups, government programs, and individuals, serving 11.8 million medical members and 7.7 million specialty-benefit members across the country. Currently, we contract with close to 320,000 physicians, including both primary care physicians and specialists, practicing in urban, rural and suburban settings.

Humana is committed to strengthening our nation's health care system through partnerships with providers to implement new models of delivery and payment that seek to achieve the "Triple Aim" -- improving the individual experience of care; improving the health of

populations, and reducing the per capita costs of care for populations. Fully 1.4 million Medicare Advantage members get their care from physicians in Humana network arrangements that include one of our various payment models. Close to 70 percent of all primary care physicians in Humana's networks participate in our rewards programs.

Humana's Approach to Physician Collaboration and Payment Innovations

Humana brings a unique, comprehensive approach to physician collaboration. Our programs are built around the premise that there is no one-size-fits-all payment model – that health plan/physician collaboration and engagement is fundamental to an effective, successful program, that financial models must recognize and be tailored to varying practice arrangements, and that payment must focus on rewarding physicians for better health outcomes.

Our overall focus is built around the following principles:

- Value-based reimbursement direction (including such programs as physician rewards models, shared risk arrangements and ACOs);
- Shared responsibility for outcomes;
- "Bricks-and-Mortar" relationships (including direct relationships with primary care physicians and clinics);
- Strong physician industry relationships to vet new payment ideas and approaches (including specific engagement with the American Academy of Family Physicians, American Medical Association, American College of Physicians, American Medical Group Association and the Medical Group Management Association);
- Physician/provider/health plan collaboration, focused on providing continuous input on Humana policies and processes;
- Clinically focused activity; and
- Health Information Technology (including relationships to promote connectivity with the following leading electronic medical records vendors: Athena, eClinicalWorks, Allscripts, and NextGen).

Although the majority of our payment innovations center on engagement with primary care physicians (PCPs, we also have included specialists in certain initiatives. Much of specialty care revolves around procedure-based treatments and thus, development of programming based on procedures/bundles can be challenging. Additionally, our experience with primary care physicians is that they tend to be particularly interested in learning more about their practice patterns and how to improve efficiency.

We also recognize the differing practice patterns in rural and urban settings and are working to address variations in approach. For example, because we realize that outreach to rural practices in more remote areas can be challenging, coupled with limitations on access to primary care physicians, Humana is considering adding independent Nurse Practitioners to our

rewards program to help ease the burden of access in rural areas. In more remote areas where payment innovations may not be practical at this time, we have to default to more traditional payment models and/or adopt programs to facilitate a transition to different "engaged" payment models.

Evolution of Humana's Medicare Payment Model and Continuum

Because we understand the complexity of the various types of physician practice models, we offer innovative payments arrangements that are customized to fit varying practice characteristics, including: enhanced fee-for-service (in the form of an annual bonus payment); monthly care-coordination fees in our medical homes model; quarterly bonus/shared savings incentives, and several types of capitation arrangements. With each of these approaches, we support participating physicians by providing the necessary data and connectivity infrastructure supports to build and manage effective shared-responsibility partnerships.

Our approach to physician payment has evolved over our 25 plus years' experience with physician collaboration. Beginning in Florida in the mid-1980s, we introduced basic capitation arrangements; then moved to global risk arrangements (across all Medicare benefits); then added combined risk arrangements (shared risk for Part A and full risk for Parts B and D); and ultimately introduced Fee-for-Service (FFS) Rewards Programs (established in 2010 in areas where the primary payment model is FFS). This program has four variations designed for differing practice structures and experiences, and includes opportunities to increase payment on a graduated basis as program complexity increases:

1) STAR Quality Program: Increases FFS reimbursement for meeting specific HEDIS measures;
2) Model Practice Program: Quarterly payments for meeting specific HEDIS and utilization measures;
3) Medical Home Program: Prospective quarterly payment for all measures in STAR and Model Practice programs including additional utilization measures; and
4) Shared Responsibility (ACO) Program: Global quality/cost payment model.

Our Physician Engagement Continuum was developed to provide resources to assist primary care physicians in developing the competencies and practice infrastructure necessary to effectively and efficiently care for our members. We believe that many of our primary care physicians will move across the continuum toward risk-based models as they gain these competencies. Additionally, we are addressing value-based payment opportunities as well as bundled payment initiatives to advance coordination between primary care physicians and specialists. For example, we are addressing value-based opportunities in partnership with primary care providers and specialists focusing on bariatrics programming.

Collaborative Approach to Payment Models

Humana focuses on building innovative physician partnerships and models of care that offer better care and better value. By providing detailed reporting and modeling of patient-centered cost and quality information to physicians, our goal is to assist them in more effectively serving their patients, improving quality, removing inefficiencies and being financially rewarded for success. Our experience has shown (whether through discussions with our clinical professionals or by providing clinical resources to a particular practice) that peer-to-peer discussions about quality, efficiency, and chronic care management and enhanced communication between Humana and the practice work best in helping physicians begin the transition. One example that demonstrates our focus on improved physician communication is the development of "PODs." "PODs" is a grouping of our members and their affiliated primary care physicians with a dedicated Nurse. The role of the Nurse is to assist the physician in the management of their specific patient population through data reporting and analytic support, increased disease and chronic care management program awareness, and other clinical supports.

Humana's Physician Incentive Arrangements: Provider Rewards

Humana introduced a unique Provider Rewards program, focused primarily on primary care providers, to encourage improved health outcomes and reward physicians. Unlike other "pay-for-performance" models, Humana's program is designed to help meet physicians on their own terms based on level of practice complexity as well as to encourage quality improvements. We engage physicians with both hands-on assistance and reporting assistance. When we launched this program in 2010, it was focused on PCPs seeing Medicare Advantage members. We began by engaging directly with the Primary Care Physician (PCP) societies (AAFP, AMA, ACP, AMGA, MGMA) and solicited their suggestions and recommendations based on their constituencies. Since then, we have continued to build in opportunities to refine the program with feedback from the physicians involved.

During the first 9 months in 2011, the program resulted in improved health outcomes such as a 2% improvement in colorectal cancer screenings and a 4% increase in spirometry testing. Additionally, over the same time period, there was an over 50% increase in the number of participating physician practices meeting and/or exceeding patient care measures and 40% increase in assuring that patients got needed preventive and chronic care screenings.

Humana Payment Approach in Practice: *Patient-Centered Medical Homes & ACOs*

Humana has long supported the notion of patient-centered medical homes through various arrangements. Over the years, we have established Patient-Centered Medical Home arrangements in Florida, Ohio, Colorado, Illinois, Michigan, Kentucky, Texas, Tennessee, Missouri and South Dakota – serving over 70,000 Medicare Advantage and over 35,000 commercial health insurance members. Under some of these arrangements, Humana provides financial assistance to help selected physician practices acquire electronic health record (EHR)

systems, which can help facilitate enhanced care coordination and allow them to meet Meaningful Use criteria.

Humana joined in helping establish the Patient-Centered Primary Care Collaborative, founded by Dr. Paul Grundy – a coalition of more than 900 employers, consumer groups, quality organizations, hospitals and clinicians. The Collaborative is dedicated to advancing patient-centered medical homes that have the following attributes: (1) ongoing relationships with a personal physician; (2) physician-directed medical practice; (3) whole-person orientation; (4) coordinated and integrated care; (5) enhanced access to care; and (6) payment that appropriately recognizes the added value of services provided.

Humana also partnered with physicians affiliated with Norton Healthcare System, a Louisville, Kentucky-based, not-for-profit integrated delivery system, to pilot test an innovative, commercially-insured, ACO-type approach, sponsored by the Dartmouth Institute for Health Policy and Clinical Practice and the Engelberg Center for Health Care Reform at the Brookings Institution (Dartmouth-Brookings). Participation in this pilot has allowed the development of a global quality/cost payment model. Participating physicians are evaluated based on their performance on specified quality measures, such as diabetes measures, cancer screening, asthma care and cardiac care.

Central to this pilot is accountability of measured outcomes, cost, and patient delivery, focusing on industry-standard performance measures. The partnership is guided by three core principles: 1) integrated care delivery among provider teams; 2) defined patient population to measure; and 3) pay-for-results based on improved outcomes and cost. Recently, the Commonwealth Fund highlighted this partnership in a case study and symposium.[1] Already, the partnership has shown significant results. Our most recent data, based on Year-Two outcomes, showed marked improvement relative to baseline in quality, utilization and physician visits following hospitalization:

Measure	**Outcome**
Inpatient days/1000	↓29%
ER visits/1000	↓46%
Physician visit within 7 days discharge	↑14.6%
Diabetes- A1c testing	↑6.1%
Cholesterol Management-Diabetes	↑8.6%
Appropriate Imaging-Low Back pain	↑13.9%
Avoidance of Antibiotics w/Acute Bronchitis	↑32%

[1] *Norton Healthcare: A Strong Payer–Provider Partnership for the Journey to Accountable Care*, The Commonwealth Fund, Case Study Series, January 2012.

Our current partnership with Cincinnati, Ohio-based Queen City Physicians similarly is built on a model of integrated care delivery, strong data integration and focused care coordination. This too has shown demonstrable results:

Measure	12/1/08 – 3/31/11 Queen City Physicians	12/1/08 – 3/31/11 Control Group (Cincinnati)	Difference vs. Control Group
Total Medical Expense	↑ 8.8%	↑ 13.2%	Medical expense trend reduced 4.4%
Emergency Room Expense	↓ 9.8%	↑ 2.7%	Emergency room expense trend reduced 12.5%
Pharmacy Expense	↑ 3.8%	↑ 1.9%	1.9% increase in cost of prescription drugs
Diagnostic Imaging Expense	↓ 1.1%	↑ 49.3%	Diagnostic imaging expense trend reduced 50.4%
ER Visits/1,000	↓ 34%	↓ 14%	Emergency room utilization trend better by 20%

Additional examples of Humana's physician engagement initiatives include:

- Partnering with electronic health record (EHR) vendors to advance a Medical Home EHR Rewards Program centered on "Meaningful Use," aiming to support national adoption of electronic medical records in physician practices with subsidies, among other offerings.
- Addressing the shortfalls in primary care access by expanding primary care and urgent care centers and workplace wellness sites in 550 point-of-care locations through our new Concentra business division.
- Partnering with and opening clinic-based Primary Care Centers to provide coverage in specially- designed medical centers to seniors in primarily low income, underserved neighborhoods.
- Partnering with HHS's Center for Medicare and Medicaid Innovation to promote the Comprehensive Primary Care initiative across three geographies.
- Building information and clinical analytical models under our Anvita Health and CareHub systems to enhance care and health outcomes by integrating clinical guidance based on real-time data for physicians, identifying gaps in patient care and alerting both patients and providers to necessary care treatments. For example, our Anvita rules engine identified approximately 355,000 actionable gaps in care for our members that, in turn, generated a multitude of alerts to nurses, providers, members and our service

operations teams. As a result, 31% of these gaps in care were converted into actions to improve outcomes for those members.

- Teaming initially with Blue Cross/Blue Shield of Florida in 2001 (now expanded to include Health Care Services Corporation, Blue Cross Blue Shield of Minnesota and Wellpoint), Humana co-founded Availity, a cross-health plan, cross-provider, health information technology network that physicians and hospitals use free of charge to help with collecting payments, keeping track of referrals, detecting potential adverse drug-to-drug interaction and prescription drug fraud and abuse and ultimately, creating a comprehensive, multi-payor electronic patient health record. Availity now delivers health information solutions to a growing network that currently includes more than 200,000 physicians and providers of care, 1,000 hospitals, 1,300 health plans and 450 industry partners. Over 1 billion transactions are processed annually.

Lessons Learned: Maximizing the Opportunity for Improving Quality and Value System-wide

There are many takeaways from Humana's experience with physician collaborations and payment models over the past 25 years. Among the most impactful are:

- Without incentives, costs run 5%-20% higher.
- The principle reasons why physicians have not participated in our rewards' programs (based on surveys we have conducted) include the facts that: 1) the physicians' panels are not large enough; 2) their panel does not have enough attributable-members; and 3) largely due to previous reasons, the administrative work is too burdensome.
- Any proposals to modify Medicare payment policy should be sufficiently flexible to allow for practice variations. This will allow maximum success and account for all types of practices. One-size-fits-all approach will likely undermine ongoing active collaborations to customize models to meet needs.
- A national, uniform performance and quality measurement strategy is critical across all lines of business – employer/commercial insurance, Medicare, Medicaid and other public programs and payment models (e.g. ACOs; Comprehensive Primary Care Initiative Program). Alignment and harmonization is important – disparate quality metrics, for example, will spread finite resources too thin, diluting the effectiveness of a national strategy. Use of a well-established, tested set of performance measures is critical.
- Data is a critical component of any payment policy initiative. Physicians need regularly reported, credible and actionable data in order to understand practice patterns and ultimately, the cost of care. Better use of near- and real-time data and HIT capabilities to promote information exchange has proven to be essential to making progress toward quality and resource targets, while continuing to advance the national agenda of connectivity.
- Continued exploration of additional ways to recognize the role of the patient in achieving desired outcomes will be necessary to support the health plan and clinician roles.

Future plans

As we continue to develop innovative payment models, we expect to explore variation in models of care coordination and transition between primary care physicians and specialists. Our focus will be on models that reduce fragmentation, improve communication, reduce unnecessary cost and ensure that patients receive the right care at the right time in the right setting from the right level of care practitioner. The challenge across the entire system is that in many cases, providers don't fully understand the variations in cost of care and the impact on patients. We continue to work with physicians and other providers to educate them about the varying costs of care and implications for patients, striving to achieve an environment where fully informed shared decision-making can best take place.

Thank you again for holding this hearing to highlight the important role that the private sector is playing in developing innovative payment policies to drive health care system improvements. We look forward to continuing our work with the Committee in pursuit of these goals.

STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER U.S. SENATE COMMITTEE ON FINANCE HEARING OF JUNE 14, 2012 ROUNDTABLE DISCUSSION ON MEDICARE PHYSICIAN PAYMENT POLICY: LESSONS FROM THE PRIVATE SECTOR

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, today delivered the following remarks at a committee roundtable discussion on the sustainable growth rate (SGR) formula within the Medicare physician fee schedule:

I want to thank Chairman Baucus for convening today's roundtable. As we continue discussing options to improve the way we pay physicians and improve quality in Medicare, it is critical that we speak to folks in the private sector who are successfully lowering costs, while providing better care and outcomes for patients.

The Chairman and I agree that we must find a better way to pay physicians in Medicare. We must repeal the flawed SGR system — an albatross around Congress' neck that must be addressed at the end of every year.

This is not an easy task, but our physicians and patients deserve better. We must establish a more stable foundation to pay our physicians who treat Medicare patients.

As we all know, our current fee-for-service system provides little financial incentive to manage care properly. Instead, the current incentive is to increase the volume of services. Over the years, we have learned that more care does not necessarily mean better care, or better outcomes.

Today, we have the opportunity to hear from some of the top performers in the private sector. These industry leaders are making real advancements in care delivery and physician payment. They are showing you can improve quality and lower costs in a collaborative way that does not alienate the physician community.

Chairman Baucus, thank you again for scheduling this series of roundtables. I hope today's provides us with another opportunity to learn about the best practices that are occurring in the private sector. I look forward to hearing from our witnesses, hearing about their efforts, and thinking about how to relate their experiences to Medicare.

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Statement by Lonny Reisman,
Chief Medical Officer, Aetna Inc.

Roundtable on "Medicare Physician Payment Policy:

Lessons from the Private Sector"

Committee on Finance

United States Senate

June 14, 2012

I. Introduction

Chairman Baucus, Ranking Member Hatch and Members of the Committee, thank you for inviting me to testify before you today. My name is Lonny Reisman. I am the Chief Medical Officer for Aetna Inc.

Aetna views provider collaboration as key to transforming patient care and building a more effective health care system. We believe that aligning incentives and increasing transparency across the health system can improve quality, create efficiency and achieve a better total patient experience. However, we recognize that there is no single model or solution to meet the needs of every health system and patient across the country.

Since 2005, Aetna has invested more than $2 billion to acquire or build a variety of capabilities to support and enable provider collaboration models by aligning incentives around quality, efficiency, and outcomes.

We meet our provider partners at their current state of readiness with a shared goal of moving towards a more effective and patient-focused health care delivery model. Our partnerships are designed to support all patient populations, qualified providers and insurance payers (not limited to Medicare or Aetna members).

II. Keys to Successful Provider Collaborations

Provider payment models that incentivize improvements in quality and cost of care

Our provider collaborations provide a model for health care delivery and payment that ties provider reimbursements to improved population health and reductions in the total cost of care. Our model is unique because, alongside our collaborative payment model, we offer a comprehensive technology suite specifically designed to address the clinical care activities and cost saving activities identified in our contracts as appropriate objectives for population based care. Our Medicare Advantage care management model provides nurse case managers embedded within participating provider groups. Our care managers work in collaboration with physicians and their staff to:

- Develop care plans
- Monitor ongoing symptoms
- Coach patients to manage their conditions
- Help build continuity of care.

Using performance-based compensation, we align incentives and provide the tools and technologies to help providers achieve defined measures around the prevention and management of chronic conditions, improved quality of care, and reductions in avoidable hospital admissions and readmissions.

For example, by collaborating with Aetna, InterMed's Independent Physician Association, NovaHealth in Portland, Maine, averaged 45 percent fewer acute admits, 50 percent fewer acute days, and 56 percent fewer readmissions in 2011 compared to statewide unmanaged, risk-adjusted Medicare populations.

In addition to acute days avoided by quality care and care management we find 99% have office visits at least once a year, and 98% of those with Heart Failure, Diabetes or Chronic Lung Disease at least every six months. 95% of Hospitalized patients have office visits within 30 days of discharge and 99% of Diabetics have HbA1c tests at least annually. We have indeed seen real and measurable impact at the intersection of quality and cost.[1]

[1] Aetna Analysis and Hostetter. Case Study: Aetna's Embedded Case Managers Seek to Strengthen Primary Care. Quality Matters August 2010: 6-10.

Providing physicians with access to actionable patient information

New research on medical advances is published frequently. No physician can keep up with it all and relate new findings to patients in his or her practice who are likely to benefit. ActiveHealth Management has a large team of board certified physicians, pharmacists and registered nurses studying the findings of evidence-based research. We then take research from the most reputable sources to develop and maintain the evidence-based rule sets that populate CareEngine®, our clinical decision support tool. We alert attending physicians to errors or omissions in care and opportunities to improve health, resulting in better quality care and reduced medical costs.

In a double-blind, randomized study, CareEngine® alerts were proven to reduce costs by $8.07 per member per month, and reduce hospitalizations by 8.4 percent.[2] A follow up analysis published in the Journal of Health Economics found that ActiveHealth Management's technology lowered average charges by 6% compared to a control group. Results also suggested improved quality and that use over a longer period would increase savings to the extent the benefits of correcting missteps spill over into future years.[3]

Through Active CareTeam℠, an interactive dashboard workflow tool that enables physicians and other members of the care team to identify the patients that the practice is accountable for who are at risk for disease progression. Using predictive modeling and algorithms, the tool identifies opportunities to provide evidence based care. These interventions are proven to improve quality and reduce cost. By proactively reaching out to the identified patients, care team suite enabled physicians can provide better preventive care and avoid unnecessary health care events.

After just one year of providing disease management, case management, maternity management and lifestyle coaching services for members of the North Carolina State Health Plan for Teachers and State Employees, ActiveHealth Management engaged 81 percent of eligible members in care management programs. Member engagement in these programs can help lead to better health outcomes as members take steps to address health risks identified through the program.

In a study involving a large-scale commercial population of 200,000 members, ActiveHealth disease management achieved a 2.1 percent decrease in the cost trend in members meeting criteria for disease management interventions and an overall

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[2] Javitt JC, et al. Using a Claims Data-based, Sentinel System to Improve Compliance with Clinical Guidelines: Results of a Randomized Prospective Study. Am J Manag Care 2005;11:93-102.

[3] Javitt JC, et al. Information technology and medical missteps: Evidence from a randomized trial. Journal of Health Economics 2008;27 585-602.

reduction in covered charges of $3.10 per member per month across the entire population.[4]

Low-cost technology solutions that create interoperability between providers, patients and health systems

People with chronic conditions such as diabetes and / or high blood pressure often receive care from many different providers. For these high-risk patients, it is even more crucial that physicians are able to effectively coordinate care. For every 100 Medicare patients, the typical primary care physician must communicate with 99 physicians in 53 practices in order to coordinate care.[5] When these physicians are not able to easily share and act on patient information, patient experience suffers and avoidable health risks can arise.

Aetna's Medicity technology lays the foundation to securely exchange patient health information, which is essential to the success of provider collaborations in optimizing population health. Medicity accomplishes this regardless of which electronic medical record or health information technology they may be using. Applying the ActiveHealth decision support technology to these comprehensive data sets generates the patient-specific care actions needed to optimize clinical outcomes.

For example, Medicity currently connects providers using over 150 unique clinical technology solutions, giving providers timely access to current, accurate and actionable information. With this current information, providers can make better decisions. Medicity currently connects approximately 250,000 providers and 800 hospitals in its seamless communications networks.

Michigan Health Connect (MHC) is a nonprofit corporation founded by health systems to extend provider adoption of electronic health record systems. MHC engaged Medicity to help them tackle the referral process, which was a significant pain point for physicians, involving filling out and faxing forms, as well as numerous phone calls between providers. Medicity proposed using a referrals application running on iNexx™, a free data exchange and application platform that makes it possible for physicians to exchange information securely with other providers and coordinate care for their patients.

MHC was successful in promoting viral adoption of the iNexx™ technology solution throughout its physician population. Within 120 days, MHC rolled out the iNexx™ eReferrals application to 100 practices — including 21 specialties — and is adding

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[4] *ActiveHealth Management*, Study 2004.
[5] Annals of Internal Medicine

practices to the eReferral network at a rate of 9 practices per week. These practices are now able to replace the multiple phone calls and fax exchanges with secure, electronic care team networks that enable eReferrals, increase collaboration, and present a coherent picture of a patient's health to all members of the care team.

III. Conclusion

We share the Committee's goal to transform the care delivery system and believe Medicare can benefit from our innovative care solutions. Aetna has achieved positive results through our provider collaborations, using payment models that incentivize improvements in quality and cost of care and low-cost technology solutions to create interoperability between providers, patients, and health systems. We are making it easier to pull meaningful health care information out of silos and act upon it more quickly to improve patient care. We believe that these models can be applied more broadly to improve population health and create a sustainable care delivery system.



MASSACHUSETTS

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Testimony of Dana Gelb Safran, Sc.D
Senior Vice President
Blue Cross Blue Shield of Massachusetts
Senate Finance Committee
Medicare Physician Payment Policy: Lessons from the Private Sector

June 14, 2012

Thank you Chairman Baucus, Ranking Member Hatch and Members of the Committee for holding this roundtable. I am Dana Gelb Safran, Senior Vice President for Performance Measurement and Improvement at Blue Cross Blue Cross Blue Shield of Massachusetts ("BCBSMA"). I appreciate the opportunity to discuss the payment reform model that BCBSMA has been implementing in our provider network since 2009. The model I will discuss today, known as the Alternative Quality Contract (AQC), employs a population-based global budget together with significant financial incentives for performance on a broad set of quality and outcome measures. The model establishes provider accountability for clinical quality, patient health outcomes, and overall medical spending and cost growth. It is now our predominant payment model – in place with more than three-quarters of our provider network.

BCBSMA is one of 39 locally based, community operated Blue Cross and Blue Shield Plans that collectively provide health benefits to nearly 98 million Americans and contract with hospitals and physicians in every U.S. zip code.

At BCBSMA, our highest priority is to make quality health care affordable for individuals, families and employers who have made us the health plan of choice in Massachusetts. Our promise and vision guide our efforts to create greater value for our members and employers. Founded in 1937 by a group of community-minded business leaders, BCBSMA is the leading private health plan in the Commonwealth—a not-for-profit company with a proud history of community and health care leadership.

We applaud the Committee's bipartisan efforts to reform payment policy at the federal level. As the largest provider and payer of health care in the nation, the federal government is in a unique position to influence the delivery of safe, effective, affordable and patient-centered health care.

As the Committee considers the important issue of physician payment, and specifically, the Medicare Sustainable Growth Rate, I am pleased to have this opportunity to share a model that is flourishing in Massachusetts. The payment reform efforts of BCBSMA suggest that it may indeed be necessary to think beyond physician payment to overall

system payment in order to realize the goal of "sustainable growth." This holistic view of payment may also be necessary to reduce the fragmentation of care that we all recognize as a key failing of our current system. This fragmentation is a byproduct of payment models that contemplate physician payment and institutional payment separately. We are hopeful that the Pioneer Accountable Care Organizations and the deliberate move away from volume-based incentives will provide a source of insight and motivation for change for the federal government. We have been working closely with the five "Pioneers" in Massachusetts, who are also AQC providers, to capitalize on the synergies of the payment models to promote real delivery system reforms.

In Massachusetts, as in the rest of the nation, the rise of health care spending imposes an unsustainable burden on the economy and on individual consumers. In 2007, BCBSMA recognized that fundamental changes to provider payments and incentives would be required to address medical cost trends. With an annual medical spend of approximately $13 billion in claims, we sought to develop a model that would achieve the following twin goals: significantly improve the quality, safety and outcomes of care, while at the same time, significantly slow the rate of medical spending growth.

AQC: The Cornerstones

Developed in 2007 and launched in 2009, BCBSMA's AQC was our effort to address these twin goals. In general, the AQC model combines a global budget with significant quality incentives in a 5-year contract to establish provider accountability for overall medical spending and spending growth, quality and health outcomes for a defined patient population. As of June 2012, over three-quarters of our statewide network of contracted primary care providers (PCPs) and specialist physicians have opted into this contract model. The AQC is providing evidence that significant, rapid improvements in health care quality and spending are achievable through a payment model that establishes provider accountability for quality, outcomes and resource use across the full continuum of health care services.

The AQC includes several key components that distinguish it from our traditional contracts and that are designed to enable the provider organizations to succeed at significantly improving quality and outcomes while moderating costs and spending growth.

Integration Across Continuum of Care

A provider organization that enters an AQC contract agrees to accept accountability for the full continuum of care provided to their patients – from prenatal care to end-of-life care, and everything in between. This does not mean that the provider organization itself must be capable of providing every aspect of care, but they must agree to be accountable for both the cost and quality of care provided to their patients, regardless of where it is provided. The only stipulation related to organizational structure in the AQC is that the provider organization must include sufficient primary care physicians to account for at least 5,000 of our HMO or POS enrollees.

The very essence of the AQC is the important role of the primary care physician (PCP) as the center of a patient's care. The decision to forego a prescriptive approach to AQC organizational structure was made as we recognized that it was premature to know which structure or organizational features were truly required to be successful under a model requiring accountability for cost and quality. As it has unfolded, the range of organizational structures among AQC groups is extremely varied – including, at one end

of the continuum, an AQC organization with only primary care physicians and at the other end of the continuum, a large multispecialty physician group with a history and roots as a staff-model HMO (that is, as much like Kaiser Permanente as anything we have in Massachusetts). In between are several physician organizations of varying size and scope, some including a broad range of specialist physicians or a hospital as part of their contract, while others do not.. Almost all include a very large number of practices that are small or solo physicians tied together through an infrastructure and leadership that work to enable their success under the AQC model.

Regardless of the organizational structure and scope, each and every organization is accountable for the full continuum of care and for the total cost and quality of care received by their patient population. They do this through relationships that expand well beyond the confines of the providers that are party to their AQC contract. Importantly, as I will detail later, every one of these organizations is achieving substantial success – both on quality and on managing overall medical spending. This proves an important lesson of a payment reform model serving as the impetus for delivery system reform, and the importance of allowing those delivery system reforms to take shape in response to the new payment incentives. Further, the early results of the contract provide evidence that global budget models can work within different demographic areas, for different patient populations and with different provider organizational structures.

Sustained Partnership (Five-Year Agreement)
The AQC arrangement is a five-year agreement that encourages providers to invest in long-term, lasting improvement initiatives. It also establishes a new kind of partnership between the health plan and the organization that moves away from the sometimes adversarial relationship, which is focused on ongoing contract negotiations, and toward a more collegial partnership, which is focused on and committed to each other's success. These five-year contracts are significantly longer than BCBSMA traditional contracts, which are typically three years for a hospital and one to three years for physicians. We value the five-year arrangement because we recognized that success under this model would require provider organizations to make significant changes in care processes, staffing and infrastructure, and we did not want either the provider or Blue Cross to be concerned by a looming contract negotiation in six or twelve months.

Global Budget Financial Structure with Performance Incentives and Savings Opportunities
Each AQC contract establishes a population-based global budget for the provider organization, covering all services and costs for its defined patient population. Organizations that adopt the AQC accept responsibility for the full continuum of care received by their patients – including the cost and quality of that care – regardless of where the care is provided. The contract budgets encompass inpatient, outpatient, pharmacy, behavioral health and other costs and services associated with each of their BCBSMA patients. Budgets are adjusted annually over the 5-year contract period to account for health status changes in the organization's patient population. The initial global budget is based on historical health care cost expenditure levels specific to that provider organization's patient population. In this way, providers are assured that their starting budgets contain sufficient funds to care for their defined population – but importantly, the organization now has important incentives to consider how best to use those funds in service of the best quality and highest value care for each and every patient. If the AQC organization achieves savings on its budget, the organization shares

in those savings. If the organization outspends its budget, the organization is responsible for a share of that deficit. The model incorporates numerous protections to guard against excessive or inappropriate transfer of financial risk to providers, while creating a very real set of incentives for provider organizations to be careful stewards of health care dollars.

Beginning 2011, new AQC contracts have trend targets tied to the regional network average, generally requiring groups to outperform the regional trend by a designated amount. By tying the budget to the regional trend, environmental factors that are outside of the provider's control (such as an epidemic, mandated benefits or BCBSMA-negotiated rates with our network) are accounted for, thereby obviating the need for complex year-end adjustments. Since the budget and annual inflation targets are set at the outset of the agreement for a five year period, the model brings predictability and stability to annual health care cost increases, a significant benefit to the purchasers of health care, including consumers, employers and government.

Performance Measures

Central to the AQC model is a set of significant financial incentives tied to performance on a broad portfolio of quality, outcome and patient experience measures. As described elsewhere,[1] the model includes 64 nationally accepted, clinically important measures of hospital and ambulatory quality that collectively support the vision of safe, affordable, effective and patient-centered care. The accountability for performance on this broad set of quality and outcome measures, and the significant financial incentives associated with this, serve as an extremely important backstop against any impulse toward "underuse" or stinting that might otherwise be a concern under a global budget model.

BCBSMA evaluates AQC groups' performance on the quality measures in terms of performance targets ("gates") ranging from 1 to 5. For each measure, Gate 1 is set at a score that represents the beginning of performance considered to be good enough to merit some financial reward. Gate 5 is an empirically-derived score for each measure that represents the best that can be reliably achieved in a patient population. By presenting a range of targets that represent "good to great" performance, the AQC model incentivizes both performance excellence and continuous performance improvement. And through use of absolute performance targets that are fixed over the course of the contract and identical for every provider that enters the contract in that year, the model enables organizations to plan their resources in a way that will allow for continuous improvement toward Gate 5 performance over the course of the contract.

One of the most important aspects of the measure set is that it includes significant accountability for health outcomes – not just for health care processes. To our knowledge, the AQC is the first contract requiring providers to assume responsibility for the outcomes achieved through their care – not solely for the care delivered in the four walls of the care setting. The importance of this feature cannot be overstated.

Data Support

In order to succeed under the AQC model, BCBSMA understands that physicians need both clinical and financial data to help them identify opportunities for quality improvement and cost savings. Thus, with the launch of the AQC in 2009, BCBSMA established a

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[1] M. E. Chernew, R. E. Mechanic, B. E. Landon and D.G. Safran., "Private-Payer Innovation in Massachusetts: The 'Alternative Quality Contract," Health Affairs, Jan. 2011 30(1):51–61.

multidisciplinary team dedicated to supporting AQC groups' success in managing to the contract's incentives related to improved quality, health outcomes, and resource use. The AQC Support Program is extended to all AQC organizations and includes a series of regular data and performance reports, ongoing consultative support from a team of clinicians and quality improvement advisors, and regular organized sessions where the groups meet together to address performance improvement issues and share best practices. Some information is provided to AQC groups daily, including information on hospitalized patients, to allow the AQC group or provider to coordinate closely with the hospital and plan for the care that will be required when the patient is discharged. Performance information is provided monthly or quarterly through a series of reports that allow groups to monitor their performance on the quality bonus measures, monitor spending relative to their budget and to evaluate opportunities for savings.

One unique set of reports that BCBSMA provides to assist AQC organizations with managing their use of overall resources is information on clinically-specific, unexplained practice pattern variations. The approach is rooted in the seminal work and compelling observations of Jack Wennberg and the Dartmouth Atlas – but importantly, moves the observations of practice pattern variation off of maps and into a framework that is clinically actionable for practicing physicians. The set of practice pattern variation analyses (PPVA) reports that BCBSMA provides includes: (1) condition-specific variations in treatment provided in a given medical or surgical specialty; and (2) potentially avoidable use of hospital resources (e.g., 30-day readmissions, non-urgent emergency department use, admissions for ambulatory-sensitive conditions).

The condition-specific PPVA reports demonstrate how physicians within a given specialty (e.g., cardiology) differ from their peers in their use of particular treatments, tests or procedures for patients with the same underlying clinical status. The AQC groups receive analyses related to conditions such as: treatment of knee, back and hip pain; use of brand-name medications rather than generics; cardiac catheterization and coronary artery bypass graft (CABG) procedures; advanced imaging; non-urgent emergency room care; and treatment of gastroesophageal reflux disease (GERD). BCBSMA's PPVA approach draws from a methodology developed by Dr. Howard Beckman (Rochester, NY) and successfully implemented through his work with Focused Medical Analytics (FMA).[2] In beginning to use this approach in our network and the AQC groups in particular, BCBSMA's aim is to provoke important discussion among clinicians and leaders within each specialty, and ultimately to stimulate the development of best practices and standards of care from within the profession. Such a process is consistent with the incentives of a global budget and preferable to externally-imposed standards that might never be fully accepted by clinicians or patients.

AQC: The Results

In 2009, the first year of the AQC, participating groups made unprecedented improvements in the quality of patient care—greater than any previous one-year change measured in the Blue Cross Blue Shield of Massachusetts provider network. Every AQC organization showed significant improvements in clinical quality, including several dozen process and outcomes measures. In 2010, provider groups that joined the AQC in 2009 continued to improve quality and outcomes, while groups that joined in 2010 made

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[2] RA Greene, HB Beckman, T Mahoney, "Beyond The Efficiency Index: Finding A Better Way To Reduce Overuse And Increase Efficiency In Physician Care," *Health Affairs*, 27, no. 4 (2008): w250-w25.9

significant quality improvements in their first year. Participating groups exhibited exceptionally high performance for all clinical outcome measures with many approaching performance levels believed to be the best achievable for chronic conditions such as diabetes, heart disease and hypertension.

Early results also indicate that the AQC is on track to achieve its original goal of reducing annual health care cost growth trends by half over five years. In 2009, all of the AQC groups met their budgets, producing surpluses that enabled them to invest in infrastructure and other improvements that will help them deliver care more effectively and efficiently. Further, medical spending among AQC groups grew more slowly than the non-AQC BCBSMA network. In the second year of the contract, 2010, we saw savings deepen in key areas such as reduced inpatient admissions, improved use of high tech radiology and use of less costly settings of care.

It is important to note that despite the fact that the AQC groups vary widely with respect to geography, size, management structure and experience with taking on risk for patient care, each and every AQC organization was successful in managing the global budget and significantly improving quality and clinical outcomes. The range of organizational models in the AQC includes multi-specialty integrated groups, independent practice associations and several physician-hospital organizations, in which a physician group contracts with a particular hospital. Although all AQC physicians are part of some organizational structure that contracts on their behalf, about twelve percent of participating physicians are in one- or two-physician practices and one-third are in practices with fewer than five physicians. For these more distributed practices, qualitative feedback indicates that the role of the organizational leadership has been critical to their success. In fact, some of the most significant quality improvements come from the more loosely-affiliated, smaller provider organizations in the AQC.

Researchers at the Harvard School of Medicine are conducting a full evaluation of the AQC. Their year one findings, published in the New England Journal of Medicine, showed that the AQC was associated with significant quality improvement and two percent slower growth in medical spending in 2009. Among medical groups without prior risk-sharing agreements, the evaluation found even greater year one savings, with these groups reducing spending growth by 6.3 percent.[3] The research team's analysis of the second year of the contract is forthcoming in 2012.

To accomplish these results, AQC organizations are implementing significant delivery system changes and innovations for better, more integrated patient care. They are investing in new infrastructure and information systems, deploying new staffing models such as employment of case managers and expanded nursing staff, and implementing new approaches to patient engagement that leverage technology while simultaneously focusing on individual patient needs so as to improve outcomes through better adherence and self-care. Better communication within and across health care settings has become critical to avoiding poor outcomes, complications and unnecessary emergency room visits, admissions and readmissions. This compelling need has led to new care models and new approaches to ensure smooth hand-offs, robust information sharing and well-planned care transitions. In short, we see the seeds of sustainability being sown through the innovations that AQC groups are makings in order to succeed

[3] Z. Song, D. G. Safran, B. E. Landon et al., "Health Care Spending and Quality in Year 1 of the Alternative Quality Contract," New England Journal of Medicine, published online July 13, 2011.

under the incentives to manage total resource use while improving patient care and outcomes.

AQC: The Future

The AQC early results offer promise that provider organizations – given the right incentives, information, data and leadership – can quickly accomplish significant improvements in patient care and outcomes while at the same time reducing the growth in health care costs. With the growth of the AQC across our provider network, the delivery system innovations that providers have implemented under the model, and the significant successes they are experiencing as they assume accountability for total medical spending, quality and outcomes, we increasingly see providers who are eager to broaden the set of patients for whom they accept this type of accountability. Among the important future expansions many providers seek to make are the following:

1) PPO population: The AQC model is currently in place for our HMO membership only. We are actively exploring the possibility for expansion of the model to encompass our PPO membership, encouraged by a combination of provider interest, market interest and the demonstrated successes of the AQC model. Among the important operational considerations is how best to identify a primary physician within a PPO population. While a model that employs a claims-based algorithm ("attribution") to identify the primary physician for each member is one possibility, a "Physician of Choice" model, in which members proactively name the physician whom they consider to be their regular personal doctor, has a number of important advantages. These and other operational challenges will need to be addressed in order to successfully implement payment reforms that can apply to our PPO membership.

2) **Accountable Care Organization (ACO) demonstrations**: A majority of AQC organizations are now eager to have other payers adopt a global budget approach to payment. We have worked closely with officials from CMS and Massachusetts' Medicaid program as they have considered how to formulate these models. CMS cited the AQC as a model for its ACO programs in the regulations for the Shared Savings Program in 2011. We offered support and encouragement to AQC providers interested in applying for CMS's Pioneer or Shared Savings, and wrote strong letters of support for their applications to CMS. CMS's Center for Innovation named five AQC groups in Massachusetts Pioneer ACOs out of a total of 32 Pioneer ACOs across the country. Participation in the Pioneer pilot and the AQC means that these providers are now operating under a reformed payment model – with population-based global budgets and significant quality incentives – for the majority of their patients. This synergy will allow the provider groups to not only align operationally by having one global budget model, but also to apply strategies and best practices for care coordination learned in the AQC to the Medicare population.

Key Lessons Learned

For federal and state policymakers, the early findings of the AQC hold several important lessons. Among these is evidence that a payment model that creates provider accountability for both medical spending and health care quality and outcomes appears to be a powerful vehicle for realizing the goal of a high performance health care system with a sustainable rate of spending growth. Additionally, the demonstrated success of provider organizations that varied widely in size, scope, composition and geography – some with a hospital, others without; most comprised of many small and solo practices

united through a common leadership – is encouraging and should inform delivery system reform efforts nationally. Multi-year contracts based on a global budget, with annual inflation rates that are set at the outset of the agreement can bring important and welcome predictability to health care costs for employers, the public and others purchasing care. Finally, payment models that liberate providers from many of the constraints of fee-for-service payment, and importantly, from a mindset that one only does for patients those things for which h there is a billing code, are almost certainly necessary and fundamental to making real the vision of safe, affordable, effective, patient-centered care.

On behalf of Andrew Dreyfus, President & CEO of Blue Cross Blue Shield of Massachusetts and all of my colleagues, we look forward to working with you as you address the important issues of delivery system reform. Thank you again for the opportunity to testify. I look forward to any questions you may have.

COMMUNICATION

Comments for the Record
United States Senate
Committee on Finance
Roundtable Discussion on "Medicare Physician Payments:
Lessons from the Private Sector"
Thursday, June 14, 2012, 10:00 AM
215 Dirksen Senate Office Building

by Michael G. Bindner
The Center for Fiscal Equity
4 Canterbury Square, Suite 302
Alexandria, Virginia 22304

Chairman Baucus and Ranking Member Hatch, thank you for the opportunity to submit my comments on this topic. As you know, the Center submitted a response to the earlier hearing of this series of roundtables, which we will use as the basis for our analysis of this topic.

Hearing witnesses focused on Accountable Care Organizations and other possible solutions to bend the cost curve. This emphasis is all well and good of most beneficiaries of Medicare, Medicaid and other forms of directly and indirectly subsidized insurance in most years. Focusing on results is a worthy goal for both patient well being and cost control, provided the patient can be treated. Medicare, however, devotes significant resources to the expensive care found in the last year of life, which may involve multiple hospitalizations, full time nursing services through Medicaid or a period of intensive care which ultimately proves unsuccessful. In all of these circumstances, particularly the last, unless we are willing to either have doctors deny care or force survivors to pay bills that the government refuses to pay, some form of fee for service is necessary.

In April of 1998, our Principal's father, Jim Bindner, had a heart attack, due in part to either an undetected acute episode of diverticulitis (which was not detected until autopsy) and in part to a lack of oxygen resulting from successful radiation treatment for metastatic lung cancer. Had this attack occurred today, there is a chance that advances in emergency medicine, including cooling of the patient, might have resulted in a successful outcome. This strategy, however, did not exist in 1998 and is still not widely practiced. As a result, resuscitation was incomplete and Mr. Bindner was left in a coma in intensive care for almost a week before he passed.

The relevant question is, what would a results based medicine scenario pay for in situations such as this? Would the government have forced Mercy Medical Center to simply eat the costs? If so, would there have been pressure from the hospital to end care sooner? Would the alternative have been a copayment for these services for the family?

Worse yet, would someone have forced the choice on Mrs. Bindner to either agree to payment or discontinue life support earlier to save cost? These are the questions that such modalities as results based payment bring forward loud and clear and they will hit every family with children of a certain age. This is not the specter of the death panel. It is something much worse – a demand to agree to pay or make a tragic decision at the most difficult time in anyone's life.

While some families could, of course, afford to pay for greater end of life services, the prospect that money might by longer life, or a greater chance for miraculous recovery to occur, would turn such care from what is now a right to a commodity. The Center finds this unacceptable.

In fee for service medicine, this choice is simply not required. Certainly the richest society on the planet can afford to allow women facing imminent widowhood to avoid such heart breaking choices if possible. Recent reforms have essentially turned the Medicare Part A Payroll Tax into a virtual consumption tax already by taxing non-wage income above $250,000 a year. It would be as easy to shift from a payroll tax to a value added or VAT-like net business receipts tax (which allows for offsets for employer provided care or insurance) and would likely raise essentially the same amount of money, as most non-wage income actually goes to individuals now liable for increased taxes. If a VAT system is used, tax rates can be made lower because overseas labor will essentially be taxed, leaving more income for American workers while raising adequate revenue.

Premium support systems would not have any impact at all on end of life care decisions, except to the extent that they lead to cost cutting and the kind of choices mentioned above that we can all hopefully agree are abhorrent. Ultimately, this negates much of the cost savings that could come from premium support, so this idea should be dropped.

A single-payer catastrophic plan would guarantee payment by the widow of any difference between the catastrophic deductible and the accumulated health savings account. This, again, is the last thing any widow should have to face, even if the survivors have adequate insurance.

Replacing payroll taxes with VAT funding will have no impact on whether fee for service medicine at the end of life continues, except for the fact that more adequate funding makes the need to save costs less urgent.

As previously stated, a VAT-like Net Business Receipts Tax (NBRT) can provide an incentive for cost savings if we allow employers to offer services privately to both employees and retirees in exchange for a substantial tax benefit, either by providing insurance or hiring health care workers directly and building their own facilities. Employers who fund catastrophic care or operate nursing care facilities 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 no so much that the free market is destroyed.

This proposal is probably the most promising way to arrest 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.

Adoption of the NBRT does offer some interesting questions to the extent that offsets are allowed. This shifts the ethic locus from the government to employers, although the government would, of course, require superior coverage to use any offsets. Still, the decision-makers on the ground would not be someone at CMMS, but someone in the corporate benefits office. While the practice of buying life insurance for employees with the firm as beneficiary certainly mitigates the cost, it might also appear ethically problematic if the payout encourages the disconnection of support earlier than the family finds comfortable.

The form of the employer's company providing care in lieu of tax payment matters in this case. A firm with outside shareholders, even if it is a model of compassion, will always be looked upon as potentially untrustworthy in allocating end of life care, especially given their greater incentive to do so to minimize costs which would otherwise go to profit. Employee-owned firms, however, might be regarded as more trustworthy making these decisions, since employees would be responsible to each other rather than to outside owners for cost minimization. We believe such firms are less likely to force hard end of life choices on widows, at least for financial considerations.

As we have stated previously, shifting the Old Age, Survivors and Disability Insurance Employer Payroll Tax to a VAT-like Net Business Receipts Tax can facilitate the accumulation of employee-owned shares, especially if a faster transition which includes current retirees, who must be made whole (with some of these transition funds being provided by the U.S. Treasury from the OASI Trust Fund), will result in a lower NBRT levy immediately and in the future. Converting retained equity to employee-ownership may give some firms the opportunity to transition far quicker than any other plan envisions.

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.

