S. HRG. 112–876

IMPROVING QUALITY, LOWERING COSTS: THE ROLE OF HEALTH CARE DELIVERY SYSTEM REFORM

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

ON

EXAMINING THE ROLE OF HEALTH CARE DELIVERY SYSTEM REFORM, FOCUSING ON IMPROVING QUALITY AND LOWERING COSTS

NOVEMBER 10, 2011

Printed for the use of the Committee on Health, Education, Labor, and Pensions

Available via the World Wide Web: http://www.gpo.gov/fdsys/

U.S. GOVERNMENT PRINTING OFFICE

87–752 PDF WASHINGTON : 2014

For sale by the Superintendent of Documents, U.S. Government Printing Office
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C O N T E N T S

STATEMENTS

THURSDAY, NOVEMBER 10, 2011

IMPROVING QUALITY, LOWERING COSTS: THE ROLE OF HEALTH CARE DELIVERY SYSTEM REFORM

THURSDAY, NOVEMBER 10, 2011

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 1:30 p.m. in Room SD–430, Dirksen Senate Office Building, Hon. Sheldon Whitehouse, presiding.

Present: Senators Whitehouse, Kirk, Bingaman, and Franken.

OPENING STATEMENT OF SENATOR WHITEHOUSE

Senator WHITEHOUSE. I will apologize to everybody for what is going to be a somewhat uncoordinated hearing. It is perhaps ironic that in a hearing that is going to focus so much on improved coordination of care, we are going to have a hearing that is uncoordinated, but there are a whole array of votes that are beginning as early as 1:45, and so we will need to work through that. I think what we will probably try to do is to get through Mr. Blum's testimony first, and then depart for the votes, and then reconvene shortly after the series of votes. So let me thank everybody for being here.

Delivery system reform is sort of a passion of mine, and I think of some other of my colleagues as well. It may not get much public attention, but it is the way to lower costs and improve quality in our health care system. I have seen it in action dating back to the founding of the Rhode Island Quality Institute years ago to develop innovative health care processes in Rhode Island.

Chairman Harkin has been a champion of prevention and primary care. Senator Mikulski has been a forceful advocate for quality improvement. She took the lead on the quality title of the Affordable Care Act, and so the HELP committee has been engaged in this for a while, as has the Finance committee under the leadership of Chairman Baucus. His Ready to Launch program, well before the health care bill, helped position us into the payment reform mode that the health care bill so much reflects.

The hearing today is going to focus on the Affordable Care Act's delivery system reform provisions, and the opportunities and challenges that we face in restructuring the delivery of care. We will hear about real life examples from those who are already realizing the potential of delivery system reform to transform our health care system. It is now one of the world's least efficient, most com-

plicated, and most frustrating systems for patients and providers, but it does not have to be. It can be the envy of the world.

There is broad bipartisan agreement that the key driver of the national debt and deficit is health care. This year, Congressman Ryan said, "If you want to be honest with the fiscal problem and the debt, it really is a health care problem." I may not agree much with Congressman Ryan, but on that, we do agree.

And the facts bear it out, whether you are insured by Medicare or Medicaid, the VA or TRICARE, United or Blue Cross, in the last decade, you have seen costs across all insurers go through the roof.

Secretary Gates recently said in reference to the defense budget, "We're being eaten alive by health care." That ought to be a pretty strong signal that the problem is system-wide and that we need to act urgently to implement reforms to drive quality, value, and efficiency in our health care system. If we don't, the alternatives are bleak.

Gail Wilensky, who oversaw Medicare and Medicaid under President George H. W. Bush, said this April, "If we don't redesign what we are doing, we can't just cut unit reimbursement and think we are somehow going to get a better system." Indeed, we will be left with painful decisions about limiting benefits, or shifting costs on to families, or on to States, or on to the private sector.

The reforms we need fall into five key areas: prevention and primary care, improving and measuring quality, payment reform, administrative simplification, and health information technology.

I look forward to hearing from Mr. Blum, our first witness, about CMS's progress implementing the delivery system portions of the Affordable Care Act, and other initiatives that CMS is undertaking to improve our health care delivery system.

The President's Council of Economic Advisors estimated that over $700 billion a year can be saved out of our health care system without compromising health outcomes. Indeed, I would say probably improving health outcomes.

The Institute of Medicine put this number at $765 billion a year. The New England Health Care Institute reported that it was $850 billion a year, and the Lewin Group and former Bush secretary, Paul O'Neill, have estimated the savings at $1 trillion a year.

When you look at the drastic variations, and cost, and quality that we see today in our health care system, a chart on that is in the testimony of one of our witnesses, we have to drive the high-cost, low-performing States toward the States with high performance and lower costs.

Thankfully, we are not alone in this fight. There is a veritable movement out there of doctors, hospitals, insurers, employers, even some States who have taken it upon themselves to experiment in ways to improve the quality, safety, and effectiveness of care. To pioneer new delivery systems that encourage providers to coordinate care, and to test safety practices to determine how caregivers can reduce adverse events and errors.

The witnesses on the second panel fall into this category. I am proud of them and I look forward to hearing more about the work that they have accomplished.

The urgent nature of our debt and deficit, the pressure that our rising health care costs create should impel us toward the promise

that health care delivery system reform holds to deliver the savings we need and to do so in the most humane way by improving the quality of care.

I hope this hearing will further this purpose and I look forward to continuing this conversation with my colleagues.

Senator Kirk.

STATEMENT OF SENATOR KIRK

Senator KIRK. I thank the chairman for having this hearing, and it is very important, especially given what we are seeing now in the news.

Health care is driving the deficit and debt debate in the Congress, and we are seeing a collapse of European socialism before our eyes, as there is a run on the Greek bond, a run on the Italian bond, and now apparently the French bond is under siege.

Prime Minister Margaret Thatcher reportedly once said that, "Socialists eventually run out of other people's money." And people are demonstrating now in Athens to somehow get foreigners to lend them more money so they don't need to reform their State.

We have seen the Greek State go from 300,000 employees to 700,000 employees in just one generation. It is utterly unsustainable, and it is collapsing because no one will lend them more money.

In this space, we have seen now the United States' credit rating collapsing, so we have had one of three triple-A credit ratings collapse. It is likely the other two will be under siege, especially if the dire reports of the super committee prove true. I think if we don't pass the Budget Control Act legislation, then it is likely that Moody's and Fitch will also pull the triple-A credit rating of the United States. Much of that will not be because of patients or doctors, but because Congress, which has steadily expanded eligibility for various programs without an expanding economy or tax base to pay for it.

I am particularly worried because we want to provide health care, and we want to provide health care for the low-income Americans, but what we are seeing now in Europe is that health care for Europeans is going to collapse because the State cannot borrow any more money to pay for it. We should avoid having overly expensive programs that would especially promise seniors benefits, and then not be able to borrow money from China to pay for it.

Now I am very happy for our lead witness here. I will just note the real Ranking Member of this committee, Senator Enzi, 8 months ago asked Secretary Sebelius questions, for the record on this, and he has been told or the staff tells me now, it took you guys 8 months to get back to him, which I think probably you can do a better job than that.

The Center for Medicare and Medicaid Services spent $800 billion in 2010. The Medicaid expansion to the new health care law has increased spending by roughly $100 billion a year through 2019. Obviously, this is completely unsustainable and this is partially to fuel Medicare fraud which, according to the Administration, is running at $60 billion a year. That is the equivalent of a trip to Mars and back three times a year in wasted money by the CMS system.

I am particularly concerned about your philosophy of pay and chase, which cannot be explained in Peoria or anywhere else in America for how you handle reimbursement under the system.

I note here that the cost drivers are partially patients who have five or more chronic conditions a year and are seeing 14 different physicians on average. There does seem to be room for coordination, but the Government is totally incapable of doing that in any rational fashion. I would say that competition is able to do that. The Government is only capable of either spending money wildly, which is what Europe is underway and/or rationing care, which is—I used to live in Britain and I saw a rationed health care system—fairly shocking.

Most Americans visit that country as tourists and obviously you don't get on a plane for a European holiday unless you are healthy. But I was completely shocked at what I saw on the—especially the condition of Government health care and Government hospitals in that country. Especially taking a hospital like St. Bartholomew, I believe its name was, the oldest public hospital in Europe, 800 years old, but after the Government took it over, it took only 40 years to ruin that hospital and then bankrupt it under the NHS system.

I am particularly worried that Chairman Enzi highlighted HHS' claim on the Partnership for Patients, a new health care quality and safety initiative could, and this is your guy's quote, "Would potentially save $35 billion across the health care system including $10 billion in Medicare savings over the next 3 years." I have no way of backing that up. HHS has not conducted any actuarial estimate prior to releasing the savings estimate. No official estimate was prepared until Senator Hatch and Senator Enzi sent a letter in May to the Chief Actuary.

At the Centers for Medicare and Medicaid Services, Mr. Richard Foster was requested to do this, and he responded to Senator Enzi in September saying, "No cost estimate is currently feasible," and that's your own guy who said that.

Given these uncertainties, it does not appear that the Administration now can claim that this voluntary incentive program will achieve its goal of $10 billion in health care savings over the next 3 years, or $50 billion in savings over the next 10. And that's on top of the Ponzi scheme of the CLASS Act, which was intended to make the bill look like it was budget neutral, but everybody kind of got the joke of what was happening. And finally that effort collapsed, thankfully, when the Administration realized that they could no longer put up the charade that was going on there.

I am particularly interested also in the view of the witnesses here, but I will say that overall there appears to be a cloud over American health care and that cloud is: who is going to be the president next year? It is increasingly likely that we have no idea who is going to be the president, but I would say if it is Mitt Romney, then all of this collapses, and it probably collapses by next August when the Act is repealed. If it is President Obama, on the other hand, we will have to suffer under this legislation, and go the European route until our creditors pull the plug.

And so to me it seems that we have a very uncertain situation. I feel for you now because given that we have hundreds and hun-

dreds of pages which, as a House member I can report, no one read, now trying to be implemented. Now, the No. 1 subject of the Presidential contest, of which no one knows how it will turn out, as a health care provider and most importantly as a patient, no one knows where this is going. And all of this uncertainty is hurting one-seventh of the economy, and all created not by the patient, not by doctors, but by this committee and this Congress. And with that, I have said enough.

Back to you, Mr. Chairman.

Senator WHITEHOUSE. I think we still have some time for the witness anyway, and I would be delighted to get to Mr. Blum's testimony.

He is the deputy administrator and director for CMS, the Center for Medicare and Medicaid Services, and is responsible for overseeing the payment of Medicare fee for service providers, and privately administered Medicare health plans, and the Medicare prescription drug program.

He formerly served here in the Senate as an advisor to Senate Finance Committee members, and its current chairman, Senator Baucus. He has been a Medicare program analyst at the White House Office of Management and Budget, and was the vice president at Avalere Health overseeing its Medicaid and long-term care practice.

He has a Master's degree from the Kennedy School of Government, and a B.A. from the University of Pennsylvania. Mr. Blum, we are looking forward to your testimony.

STATEMENT OF JONATHAN BLUM, DEPUTY ADMINISTRATOR AND DIRECTOR OF THE CENTER FOR MEDICARE, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC

Mr. BLUM. Great. Chairman Whitehouse, Senator Kirk, thank you for the opportunity to talk about our work today to implement the Affordable Care Act to reduce Medicare costs and to change the delivery of care.

The Medicare program faces many challenges. I think what was raised during the opening statements highlight those challenges. But by and large, most Medicare beneficiaries receive care through the traditional fee for service program. The traditional fee for service program varies wildly by quality across the country, varies wildly by cost across the country. And I believe that our greatest challenge is to bring more consistency to how fee for service benefits are provided throughout the country.

More than a quarter of Medicare beneficiaries receive care through capitated health plans, Medicare Advantage plans. For the past several years, those plans have been paying more than the same services for traditional fee for service. And without great confidence, that Medicare beneficiary in capitated plans receive greater value for greater subsidies that were provided.

We understand we have many challenges to address these concerns, but the Affordable Care Act has provided the Medicare program with many new tools to address those challenges.

During my 5 minutes, I want to talk about some of the work to date, but also our priorities for the next 12 months.

In the past couple of weeks, CMS has put out some statistics that tell me that the program is moving in the right direction. We announced Part A, Part B, the MA, the Part D premiums for 2012. Across the board, Part A, the MA premiums, the Part D premiums are virtually flat for 2012, on average, relative to today. The Part B premium is growing much more slowly than previously projected, which tells us that we are seeing signs of lower spending growth and overall cost containment going on throughout the program.

We have millions of Medicare beneficiaries who are accessing preventive benefits at no charge to them. And also more than 2.2 million Medicare beneficiaries are saving dramatically out-of-pocket costs on their Part D drugs, brand name drugs provided during the so-called donut hole. This tells us that we are having more prevention, more compliance, focus on wellness. And the past couple of weeks have shown us very promising signs of a reformed Medicare program.

The Affordable Care Act has given us new tools, new programs to implement, and I am pleased to report on their progress to date.

Last month, CMS put out its final rule for the ACO, the Accountable Care Organization program, and we are very confident that this program will provide many new opportunities for health care providers, hospitals, physicians to come together to better coordinate care through the traditional fee for service program.

CMS responded to more than 1,300 comments that came in to CMS, all giving us very strong suggestions about how to improve the ACO program and CMS put out final rules last month. CMS will begin to be taking in applications from ACO potential organizations starting January 1. The ACO program will allow organizations to share in savings for those that can demonstrate that quality has been improved, and overall costs Part A—Part B costs have been lowered that those organizations will be able to share in the savings.

Earlier this year, CMS put out the final rules and the final program guidelines for the Hospital Value-Based Purchasing program. Starting in 2013, CMS will fundamentally change how it pays for inpatient hospital care to provide budget-neutral payment incentives for hospitals that improve their clinical performance and their overall patient's care experience. This is a new way to pay for hospital care, and we are fulfilling the goal to shift our payment rates from purely paying for volume to paying for value and the overall clinical care experiences that Medicare beneficiaries experience starting in 2013.

We have also changed fundamentally how we will pay for private capitated health plans starting in 2012. Using CMS's five-star quality rating system, those plans that have higher performance—four-star, five-star—for example, will receive higher reimbursements that can, in turn, provide better benefit levels. That quality star rating system takes into a whole host of different measures, quality of care measures, patient's care, and care satisfaction measures. We are already seeing more beneficiaries gravitate to higher quality plans that give us a positive sign for progress.

The Center for Innovation has been in operation for more than 12 months. They have put out a very strong policy agenda this year. Their focus has been in several areas. First, to complement

the overall ACO program, the Innovation Center will announce later this year the final pioneer ACOs. These are organizations that can take on greater risk and be accountable for greater quality results than today's ACO program.

The Innovation Center has put out a call for response in four bundled payment models that will incorporate both the acute care, the physician care, the post-acute care to a single episode of payment to create much more stronger incentives for care to be coordinated, for care to be managed during an entire episode of hospital care. We have seen already a tremendous response from hospital and other organizations that wish to participate with that bundled payment model.

[The prepared statement of Mr. Blum follows:]

PREPARED STATEMENT OF JONATHAN BLUM

Chairman Harkin, Senator Whitehouse, Ranking Member Enzi, and distinguished committee members, thank you for inviting me to discuss the Centers for Medicare & Medicaid Services' (CMS) initiatives to improve our Nation's health care delivery system.

In the 18 months since the Affordable Care Act became law, CMS has continued to strengthen the Medicare and Medicaid programs for the millions of Americans who rely on them, while implementing reforms that will ensure that we spend taxpayers' money wisely, improve health care quality, and control health care cost growth. Over the past year and a half, CMS has unveiled a series of rules and initiatives that will change the way Medicare pays hospitals, doctors, and other health care providers, to ensure that they are providing the kinds of high-quality care beneficiaries expect and deserve, at a cost our Nation can afford. These changes will provide Americans with better health care by rewarding what works—such as improved care coordination—while also giving Medicare the tools to control costs over the long run—such as changing the way we pay doctors and other providers to reward efficient, quality care. We hope the entire health care system will adopt these new delivery system reform initiatives.

We have made major progress in strengthening Medicare over the last 18 months while implementing the Affordable Care Act. At a time when other health care costs are rising faster than inflation, Medicare costs are stable. Following the implementation of the Affordable Care Act, growth in Medicare per capita spending has declined significantly. Overall, Medicare Part D, Medicare Advantage (MA), and Medicare Part A premiums will remain virtually the same for 2012 as in 2011, even as beneficiaries enjoy new benefits, and Medicare Part B premiums in 2012 will be lower than previously projected. Meanwhile, on November 4, 2011, CMS announced that so far this year, 22.6 million beneficiaries in fee-for-service Medicare have used preventive services that are now provided at no cost to them, including the new free Annual Wellness Visit.[1] Additionally, more than 22 million beneficiaries have saved in total over $1.2 billion (an average of $550 per person) on their prescription drugs, thanks to a 50 percent discount on their covered brand name prescription drugs in the donut hole.[2] For 2010, nearly 4 million seniors who reached the prescription drug donut hole received a $250 rebate check to help them afford the cost of their prescription drugs.[3] Thanks to these benefits and the reforms in the law, a senior enrolled in the fee-for-service Medicare program could save more than $3,500 over the next 10 years.[4]

With the new provisions in the Affordable Care Act, CMS has the opportunity to work with both the public and private sectors to make real advancements in the Nation's health care delivery system to improve the quality of life and quality of care for our beneficiaries and other Americans. With over 100 million people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), CMS has an important role to play in improving the delivery of health care in our Nation.

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[1] *http://www.cms.gov/apps/media/press/release.asp?Counter=4158&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&sr.*

[2] *http://www.cms.gov/apps/media/press/release.asp?Counter=4158&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&sr.*

[3] *http://www.hhs.gov/news/press/2011pres/03/20110322a.html.*

[4] *http://www.hhs.gov/news/press/2011pres/03/20110322a.html.*

OUR CURRENT DELIVERY SYSTEM IS FRAGMENTED AND EXPENSIVE

Our Nation has top-notch doctors and other health care providers, and leads the world in health care technology and cutting edge treatments. Yet the system in which these talented people work falls short far too often. Our delivery system is fragmented, leaving patients in the care of multiple doctors, each sometimes unaware of how the other is treating the patient. Medical errors can occur as a patient moves from one care setting to another, or is prescribed different medications that interact. For too long, our current system focused on caring for the sick, doing little to keep people healthy in the first place. As a result, our health care system is expensive and does not necessarily produce the best health care results. It is one of CMS' top priorities to lead the transformation of the delivery of care, so that all our beneficiaries receive high-quality care that is coordinated among their doctors and specialists, and which also avoids errors and saves money.

In order to achieve this goal, CMS has already established initiatives that encourage health care providers to deliver high-quality, coordinated care at lower costs. CMS is transforming from a passive payer of services into an active purchaser of high-quality, affordable care through these newly established initiatives. Since the passage of the Affordable Care Act, CMS has already rolled out many reforms that promote improved care, such as the Medicare Shared Savings Program, Hospital Value-Based Purchasing (VBP), and the strengthened Medicare Advantage 5-Star Rating program. Now that we have moved forward with these reforms, we expect further care improvements and cost savings over the next several years as these programs are implemented fully. Building on this work, CMS is focusing on the next set of priorities for reforming our care delivery system. Those priorities include new ways of rewarding efficiency and improving beneficiary care, investing in patient safety and care coordination, and improving the quality and lowering the cost of care for the millions of Americans enrolled in Medicare, Medicaid, and CHIP.

SUCCESS AT CMS: REWARDING QUALITY AND COORDINATING CARE

Thanks to the Affordable Care Act, Medicare beneficiaries will enjoy better quality of care and a more innovative care delivery system designed to improve their health outcomes and reduce costs. Below are a few examples of the delivery system reforms we have initiated since the passage of the Affordable Care Act.

Investing in Quality Care

Hospital payments account for the largest share of Medicare spending, and Medicare is the largest single payer for hospital services. Earlier this year, CMS established the new Hospital Value-Based Purchasing (VBP) Program, which will change how CMS pays hospitals for inpatient acute care. This program, which ties payment to value, is expected to foster higher-quality care for all hospital patients across our country's health system.

In fiscal year 2013, CMS will implement the new budget-neutral, value-based incentive payments. These payments will reward hospitals based on their overall performance on a set of quality measures that are linked to clinical processes of care and patients' experiences of care. National bodies of experts, including the National Quality Forum, have endorsed these measures, and CMS will post the hospitals' scores related to those measures on the Hospital Compare Web site.[5] The program aims to help patients receive higher-quality care and see better outcomes.

Under the program, CMS will score hospitals based on their performance on each measure relative to other hospitals, as well as on how a hospital's performance on each measure has improved over time. CMS will use the higher of a hospital's improvement and achievement score on each measure to determine a total performance score, which will then be translated into an incentive payment. In addition to rewarding excellence, hospitals will be given an incentive for continuous improvement of care delivery. In the future, CMS plans to add new measures that focus on improved patient outcomes and prevention of hospital-acquired conditions. CMS may replace measures that reach very high compliance scores, continuing to raise the bar and spur quality improvements. This redirection of funds will provide a strong incentive for quality improvement, which we expect will result in significant savings for Medicare, taxpayers, and enrollees over time.

Promoting Coordinated Care to Improve Care and Create Savings

CMS has established initiatives to ensure that Medicare patients get the right care, in the right place, at the right time. A key part of CMS' work in this area is a multi-part initiative built around Accountable Care Organizations (ACOs),

[5] *www.hospitalcompare.hhs.gov*.

which bring together doctors, hospitals and other health care providers to better coordinate care for patients. ACOs are an innovative service delivery model being used by CMS and in the private sector and communities across the country. If ACOs improve quality of care and lower costs, health care providers, as well as Medicare, can share in the savings. Those savings will help to shift payment incentives toward rewarding quality and value rather than volume of care. Provider participation in ACOs is purely voluntary, and beneficiaries will continue to have all their same benefits, including their ability to see any Medicare provider.

CMS released the Medicare Shared Savings Program final rule (CMS–1345–F) on October 20, 2011. Under this program, providers who voluntarily form an ACO and meet quality standards based upon patients' outcomes and care coordination, as well as other measures, may share in the savings they achieve for the Medicare program. ACOs that commit to share in savings and losses for the duration of the agreement may receive a higher share of any generated savings.

The publication of this rule followed months of soliciting feedback and receiving comments from stakeholders across the country. Stakeholder groups have generally responded favorably to the newly published rule. For example, the American Medical Association (AMA) stated that they are pleased that "the final rule on Medicare ACOs includes many of the important changes recommended by the AMA to allow all interested physicians to lead and participate in these new models of care."[6] The American Medical Group Association (AMGA) said that "AMGA is very pleased that CMS listened and responded with noteworthy changes. AMGA believes ACOs have the potential to improve quality of care while bending the cost curve."[7] The National Association of Public Hospitals and Health Systems said that the rule "will allow hospitals and other providers to more easily participate in the program, and should add to the success of this initiative and future innovations in health care delivery system reform."[8]

In addition, CMS is using its new authorities through the Center for Medicare and Medicaid Innovation (the Innovation Center) to test alternative payment models and prepare organizations to provide accountable care. These initiatives include:

- **The Pioneer ACO Model,** which is designed for health care organizations and providers with experience in coordinating care for patients across settings. The model will allow these provider groups to move more rapidly to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program. The model is designed to work in coordination with private payers, multiplying the effectiveness of the program and aligning provider incentives. This has the potential to improve quality and health outcomes for patients across the ACO, and achieve cost savings for Medicare and patients.
- **The Advance Payment ACO Model,** which will provide additional support to rural and physician-based ACOs who want to participate in the Medicare Shared Savings Program, but lack the startup resources to build the necessary infrastructure, such as new staff or information technology systems. The advance payments would be recovered from any future shared savings which ACO earns through performance.
- **The Accelerated Development Learning Sessions,** which are available for providers interested in learning more about the steps necessary to become an ACO. The Innovation Center is holding these convenient and free sessions in a variety of cities, with some sessions available online. To date, the Innovation Center has hosted two sessions: 67 organizations attended the first session held in Minneapolis in June 2011 and 39 attended the second session in San Francisco in September 2011. The Innovation Center will be hosting a third and final session on November 17 and 18, 2011 at CMS Headquarters in Baltimore.

Together, these initiatives provide a broad range of options and support that reflect the varying needs of providers embarking on delivery system reforms.

Improving Transparency to Empower Beneficiaries

Medicare Advantage

Enrollment in the Medicare Advantage (MA) program continues to grow. In 2012, MA plans project that MA enrollment will increase by 10 percent.[9] CMS is focused on strengthening and improving MA so that its plans provide good value to beneficiaries and the program remains robust. CMS has streamlined plan offerings so

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[6] *http://www.ama-assn.org/ama/pub/news/news/final-aco-rule.page.*
[7] *http://www.amga.org/AboutAMGA/News/article__news.asp?k=534.*
[8] *http://www.naph.org/Main-Menu-Category/Newsroom/2011-Press-Releases/NAPH-Supports-Final-ACO-Rule-Changes.aspx.*
[9] *http://www.hhs.gov/news/press/2011pres/09/20110915a.html.*

that beneficiaries have choices among plans that are meaningfully different from one another. In addition to improvements to the 5-star plan quality rating system, the Affordable Care Act allows CMS to deny a plan's bid should the total cost to beneficiaries, including premiums and out-of-pocket costs, increase more than 10 percent from the prior year.

The results show that when CMS strengthens our oversight and management of MA plans, seniors and people living with disabilities will have clearer plan choices offering better benefits. In 2012, MA premiums are, on average, 4 percent lower than in 2011 and 11 percent lower than in 2010.[10] As part of CMS' national strategy for implementing quality improvement in health care, CMS is also working to create new incentives for all MA plans to improve the care they offer to Medicare beneficiaries. For the first time in 2012, CMS will reward those MA plans with higher quality scores, based on its 5-Star rating system. CMS is also allowing 5-Star MA and Part D plans to continuously market and enroll beneficiaries throughout the year.

Our goal is for plans to improve their quality scores over the next several years and to encourage more beneficiaries to enroll in high-quality plans. In 2011, we have seen a 5 percent increase in enrollment among Medicare Advantage plans with a four- or five-star rating.[11]

Physician Quality

As part of CMS' broader strategy to encourage health care providers to adopt practices that can improve patient care, CMS is continuing to strengthen the Physician Quality Reporting System by rewarding physicians for reporting quality measurement data. The final physician fee schedule rule for 2012 (CMS–1524–FC) updates a number of physician incentive programs including the Physician Quality Reporting System, the e-Prescribing Incentive Program, and the Electronic Health Records Incentive Program.

Freeing Doctors to Focus on Patients, Not Paperwork

CMS and the Department of Health and Human Services (HHS) have also started work to help doctors begin using Electronic Health Records (EHRs) through the EHR Incentive Program. EHRs help providers communicate with each other about a patient's care. EHRs make it easier for physicians, hospitals, and others to assess a patient's medical status and make sure that care is appropriate. They can help doctors avoid redundant paperwork and ensure patients get the correct tests and medications. HHS also issued administrative simplification rules (CMS–0032–IFC) to improve the use of electronic standards to help eliminate inefficient manual processes.

We estimate that these changes will save providers and health plans $12 billion over the next 10 years.[12] More important, greater use of EHRs will free providers to spend more time with their patients. An April 2010 study in *Health Affairs* found that simplifying administrative systems could save 4 hours of professional time per physician and 5 hours of support staff time every week.[13] This commonsense streamlining means fewer phone calls between physicians and health plans, lower postage and paperwork costs, and fewer denied claims. Overall, adoption of EHRs means physicians can cut through the red tape and spend more time and resources administering quality care to their patients.

NEXT STEPS: INVESTING IN INNOVATION, IMPROVING CARE, AND SAVING MONEY

CMS has already made tremendous progress toward achieving the Affordable Care Act's goals of lowering Medicare costs and improving care—and we are doing even more. With the established foundation detailed above, CMS is moving forward to employ other new tools made available by the Affordable Care Act to reform our Nation's health care delivery system. The programs and initiatives described below will bring us closer to the goal we all share—a high-quality, affordable, patient-centered health care delivery system that effectively prevents or treats illness without waste or duplication.

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[10] *http://www.hhs.gov/news/press/2011pres/09/20110915a.html*.

[11] *http://www.healthcare.gov/news/factsheets/2011/02/Medicare02102011a.html*.

[12] *http://www.gpo.gov/fdsys/pkg/FR–2011–07–08/pdf/2011–16834.pdf*.

[13] Blanchfield, Bonnie, James Heffernan, Bradford Osgood, et. al. "Saving Billions of Dollars—And Physicians' Time—By Streamlining Billing Practices." *Health Affairs*. April 29, 2010. *http://content.healthaffairs.org/content/early/2010/04/29/hlthaff.2009.0075.full*.

Investing in Innovation to Deliver Quality Care

The key to building a sustainable health care system in our country will come from innovations and improvements in how we deliver health care. CMS has started this work by changing our hospital payment systems and Medicare Advantage programs to reward quality care and coordination, instead of simply paying providers for offering more services. We also recognize that there is a great richness of innovation occurring in local communities and through multiple efforts underway to provide care for people, often at a lower cost.

In section 3021 of the Affordable Care Act, Congress created the Innovation Center to test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care for those entitled to Medicare and Medicaid. The health reform law gives the Innovation Center flexibility in selecting and testing innovative payment and service delivery models, enables it to work with Medicare, Medicaid, and CHIP programs to better serve beneficiaries and reduce costs, and provides $10 billion in direct funding for activities initiated in fiscal years 2011 through 2019 to support this mission. The Affordable Care Act also allows the Secretary of HHS to expand, through rulemaking, the scope and duration of models proven effective after evaluation, including implementation on a nationwide basis. In order to expand a model, the Secretary must determine that the model improves the quality of patient care without increasing spending or reduces spending without reducing the quality of care, and the CMS Actuary must certify that expanding the program will lower costs (or at least not increase costs). The following sections describe, in more detail, the Innovation Center's initiatives.

Bundling Payments to Promote Efficient, Quality Care

Medicare currently makes separate payments to providers for each service related to an illness or course of treatment, often leading to fragmented care with minimal coordination across providers and health care settings. Under the Innovation Center's Bundled Payments for Care Improvement initiative, CMS will test various models to link payments for multiple services that patients receive during an episode of care. For example, instead of a surgical procedure and followup care generating multiple claims from multiple providers, the entire team will be compensated with a "bundled" payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. Research has shown that bundled payments can encourage providers to collaborate to improve the patient's experience of care during a stay in an acute care hospital and during post-discharge recovery.

Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. On August 25, 2011, CMS invited providers through a *Federal Register* notice (CMS–5504–N) to apply to test and develop four different models of bundling payments. Depending on the particular model, providers have flexibility in selecting conditions to include, developing the health care delivery structure, and determining how to allocate payments among participating providers. Because of the potential for reducing the cost of care through improvement, health care providers will be able to streamline and improve their coordination to provide savings to the Medicare Trust Funds. By giving providers the flexibility to determine which model of bundled payments works best for them, we believe it will be easier for health care providers of different sizes to participate in this initiative, thus encouraging more providers to test and develop innovative models to coordinate care and produce savings.

Preventing Costly Conditions and Complications

CMS launched the Partnership for Patients: Better Care, Lower Costs, a new public-private partnership, to improve the quality, safety, and affordability of health care for all Americans. More than 6,200 organizations, including over 2,800 hospitals, have joined the initiative. Partnership for Patients brings together leaders of major hospitals, employers, physicians, nurses, and patient advocates, along with State and Federal Governments, in a shared effort to make hospital care safer, more reliable, and less costly.

The two goals of this new partnership are to:

• **Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would decrease by 40 percent compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over 3 years.

• **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would decrease

so that hospital re-admissions would be reduced by 20 percent compared to 2010. Achieving this goal would mean more than 1.6 million patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

It is our belief that achieving these goals will save lives and prevent injuries to millions of Americans. They have the potential to save up to $35 billion across the health care system, including up to $10 billion in Medicare savings, over the next 3 years. Over the next 10 years, this partnership could reduce Medicare costs by about $50 billion and generate billions in Medicaid savings.[14] These improvements will help put our Nation on the path toward a more sustainable health care system.

Improving the Front Lines of Care

In recent months, CMS has launched several new initiatives that seek to partner with our colleagues on the front lines of health care delivery. Through investments in primary care and medical homes, and seeking direct feedback from clinicians in the field, we will move our health care system into the 21st century. The Innovation Center's current initiatives include:

- **The Comprehensive Primary Care (CPC) Initiative,** which fosters collaboration between public and private health care payers to strengthen primary care. The CPC initiative will test two models simultaneously—a service delivery model and a payment model—to see how primary care practices coordinate care for their patients.
- **The federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration,** which is operated by the Innovation Center in partnership with the Health Resources and Services Administration to test the effectiveness of teams of doctors and other health professionals working in community health centers to coordinate and improve care for up to 195,000 Medicare patients. Five hundred FQHCs in 44 States are participating in the demonstration, which will operate between November 2011 and October 2014.
- **The Innovation Advisors Initiative,** which is currently accepting applications for up to 200 health professionals to undertake intensive efforts to expand their health systems skills and knowledge, apply what they learn in their organizations and areas, and work with CMS to test new models of care delivery in their own organizations and communities. Developing these innovation leaders expands the reach of the Innovation Center and has the potential to improve patient care and reduce costs.

Expanding and Promoting Partnerships to Improve Care for Medicare-Medicaid Enrollees

A top priority for CMS is improving the quality and lowering the cost of care for the 9 million Americans enrolled in both Medicare and Medicaid (known as "dual eligibles" or Medicare-Medicaid enrollees). The Affordable Care Act created the new Federal Coordinated Health Care Office, referred to as the Medicare-Medicaid Coordination Office, to more effectively integrate benefits between the two programs and to improve the coordination between the Federal Government and States for Medicare-Medicaid enrollees. Through our work and with our State partners, our efforts are advancing access to seamless, coordinated care programs for Medicare-Medicaid enrollees.

Beneficiaries who are dually enrolled in Medicare and Medicaid are typically low-income seniors and people with disabilities. Although most have complex care needs, too often their care is fragmented, resulting in poor health outcomes and increased costs. These beneficiaries, their families, and their caregivers would be better served by improved coordination that ensures their complex care needs are met through seamless, person-centered approaches. To that end, the CMS Medicare-Medicaid Coordination Office has advanced new initiatives designed to align the two programs' rules and policies and develop and test demonstrations across the country.

Most recently, the Medicare-Medicaid Coordination Office announced a new opportunity for States to participate in demonstration projects designed to improve the quality of care for Medicare-Medicaid enrollees. These approaches provide States the opportunity to share in reduced costs that result from improved quality. CMS is pleased to report that 37 States and the District of Columbia have indicated interest in exploring ways to implement these demonstrations in their States. Across the country, States are proposing new ways to better serve their Medicare-Medicaid enrollees. These initiatives vary regionally and in their approach, ranging from using health homes that provide total care management to expanding existing programs

[14] *http://www.healthcare.gov/compare/partnership-for-patients/index.html*.

to meet all of an individual's needs by incorporating behavioral health and long-term supports and services, as well as making current coordinated care models available to new populations. Over the next several months, CMS will work with States to identify the most appropriate proposals for implementation that are most likely to reduce costs while improving quality of care for vulnerable beneficiaries.

LOOKING FORWARD

In a year and a half since the passage of the Affordable Care Act, CMS has made major progress in implementing its delivery system reforms. This effort is part of the Administration's commitment to making the health care system better for millions of Americans. Before the Affordable Care Act, we included investments in health information technology, prevention, and research in the Recovery Act to lay the foundation for this type of system. And since enactment, we have proposed additional ideas as part of the President's Plan for Economic Growth and Deficit Reduction. By strengthening our programs and making sure we are spending taxpayer dollars wisely, we are ushering in a new day for American health care consumers. We will continue to build on these reforms in the years to come.

The many new services, initiatives, and reforms I have highlighted are important and immediate steps to improve the coordination and affordability of health care for all Americans. CMS has a responsibility to improve access, quality, and efficiency of care for all our beneficiaries, while protecting the fiscal integrity of our programs in the long term. We are committed to working with our partners in the private sector, States, and beneficiaries to improve care coordination, increase patient safety, offer beneficiaries more information and more control over their care, and achieve better outcomes at a lower cost. As we tackle care fragmentation, we are moving toward better-aligned incentives for higher-quality, integrated care. These efforts to improve the quality of care will provide real improvements for CMS' beneficiaries and all Americans.

Senator WHITEHOUSE. Since your time has expired——

Mr. BLUM. I'm sorry.

Senator WHITEHOUSE. Let's cut to questions——

Mr. BLUM. Sure.

Senator WHITEHOUSE. If you don't mind. This is one of my favorite exhibits about our Medicare system and I think it applies more generally to our health care system, it is the relative state-by-state ranking on quality and cost metrics. And it shows, first of all, enormous variation State by State, but also a distinct link between the lower cost States and higher quality; i.e., an inverse relationship between cost and quality.

And when you have that broad of a discrepancy, it strikes me that there is a lot of room to have, let's say, Texas and Louisiana, which are highest cost and lowest quality move more toward Hawaii and New Hampshire which are at the other end of the—I don't think anybody thinks that Hawaii and New Hampshire are bad health care systems or that they are, frankly, significantly different than Texas or Louisiana. Yet, something is going on there that creates really massive cost discrepancies that the public pays for, not only with dollars, but also in the quality of care that they receive and with their lives.

You are familiar with this?

Mr. BLUM. Yes.

Senator WHITEHOUSE. This is the Medicare piece of information?

Mr. BLUM. Correct.

Senator WHITEHOUSE. Does Medicaid track the same way, to your knowledge?

Mr. BLUM. I believe that we see similar variation with States in cost on a per capita basis. Be careful to make the same comparisons to the chart you are showing. That is a fee for service chart and our benefits are consistent throughout the country in a fee for

service Medicare context. States have flexibility to provide benefits, but there is variation in State spending by State Medicaid programs.

Senator WHITEHOUSE. So since Medicare is a standard program, by and large, with the Medicare Advantage program kind of set aside within it, how do you pursue—and let me add another caveat. So often health care reform at the delivery system level is a community effort.

Mr. BLUM. Correct.

Senator WHITEHOUSE. It is the doctors getting together with the hospitals, getting together with the insurance companies, getting together with the business community saying, "We've got to do something different there," and getting to work on that.

So how is it that you can use Medicare to try to get a State to step up? What are the ways that you can bring attention to Louisiana, Texas, California, Florida, New Jersey, Oklahoma, Mississippi, some of the real high cost low-performers when what you have to offer is a standard national benefit?

Mr. BLUM. I think you need to look at each State, and the particular reasons why it is on the chart relative to where it is to the chart you presented. And I think an important consideration to keep in mind is while there is variation between States, there is as much variation within States. Meaning even in the low-cost States that you present, that you can see tremendous variation in use and spending by physicians, by hospitals. Even in the most efficient delivery systems, there is still variation within the care that is provided.

I think, first and foremost is that we need to tie payment to the quality, not by State, not by hospital, by the individual service that is being provided given both the variation between States, but also the variation within States.

Some of the spending difference that you present is due to fraud, and we need to have very strong strategies in some of the high-cost spending States that are driven by fraud and abuse. A lot of the very——

Senator WHITEHOUSE. Fraud varies dramatically by region as well, does it not?

Mr. BLUM. Absolutely. A lot of the spending variation comes not from hospital care/physician care, but in post-acute care services: home health, durable medical equipment, skilled nursing facility stays need to have strategies that just don't focus on the hospital care/physician care, but all the care that follows the patient once he or she leaves the hospital. But no one strategy, no one intervention will address that. We need to think of a wide variety and a wide mix, and——

Senator WHITEHOUSE. And is the affordable care organizations the primary vehicle for correlating from the national program down to the individual patient?

Mr. BLUM. The Accountable Care Organization program that we are implementing that Congress authorized is but one strategy. We need to look at payment reform. We need to make sure that payment is tied to the value, not the volume of services. We need to have very strong fraud and abuse controls.

But I agree. For too long, the Medicare program has had a pay-and-chase mentality. That has changed within CMS. We are now being much more sophisticated and smart to how we think about data to stop fraud before it happens.

Senator WHITEHOUSE. And too, my time is wrapped up, but just to Senator Kirk's observation earlier that in the last round, it took 8 months for questions for the record from Senators to get a response from CMS. We have had a discussion about this with your staff, and we have been informed that we will have as quick turnaround as your administrative process permits. I know it has to be cleared through OMB and things like that, but that we won't see those kind of delays for two FRs for this hearing. Is that a correct understanding?

Mr. BLUM. We will do our best to be as responsive as possible, and I will make sure that we are very responsive to the questions that come to us.

Senator WHITEHOUSE. I appreciate that.

Senator Kirk.

Senator KIRK. Thank you. I just have three questions real quick. Will the CMS Office of the Actuary certify the estimates of expected savings from one of the new delivery system demonstrations?

Mr. BLUM. Sorry, for which one? I am sorry, Senator.

Senator KIRK. Let me repeat. Will your Office of Actuary certify the estimates of expected savings for one of the new delivery system demonstrations?

Mr. BLUM. What the law requires the Office of the Actuary is that before any delivery reform can be expanded nationwide, a bundled payment, an ACO pilot test that the Actuary has to certify that it is budget neutral. To expand demonstrations are decisioned by the Secretary, but in order to take a pilot and expand it, the Office of the Actuary has to certify that it is at least budget neutral.

Senator KIRK. So that is a yes.

Mr. BLUM. I think it depends on kind of the situation. That it depends on whether or not——

Senator KIRK. Let me go through it again, now that you have given us the long wash. Will the CMS Office of the Actuary certify the estimates of expected savings in one of the delivery system methodologies?

Mr. BLUM. I think the answer—I think the issue that you are probably going to is the Partnership for Patients where the Administration made estimates for what could be possible if certain outcomes are achieved. We have very high goals that can reduce preventable hospital re-admission——

Senator KIRK. I am kind of going for a yes or no here.

Mr. BLUM. I think it depends. It depends.

Senator KIRK. So you won't back up your estimates with an actuary?

Mr. BLUM. What our actuaries have said in correspondence to Senator Enzi is if we can achieve dramatic reductions in——

Senator KIRK. I am actually asking not what you think you can do. I am asking: are you going to direct the actuary to do this or not?

Mr. BLUM. The actuary is independent. They don't serve from——

Senator KIRK. Are you going to ask them to do it?

Mr. BLUM. What we have shared with the Actuary's Office——

Senator KIRK. It is kind of a yes or no. You kind of want me to think maybe you are going to go with yes. Be a good answer, I'd recommend.

Mr. BLUM. What the current baseline that the actuaries produce don't include the savings that you cite. But they are not being double counted, but they are illustrations to what is possible.

Senator KIRK. So we really shouldn't trust what you say because you are not willing to back it up or even ask the actuary to do this.

Mr. BLUM. What I am saying is that if we can achieve a——

Senator KIRK. I mean, we are talking about tens of billions of dollars here. You already waste $60 billion a year, according to your own estimate. So if you are going to make a big change like Partnership for Patients, don't you think because the Government is already out of money, you might want to check with an actuary and report back to the Congress?

Mr. BLUM. I think what we're saying is that we have——

Senator KIRK. Wouldn't it be kind of malpractice if you didn't?

Mr. BLUM. I don't agree with that statement, Senator.

Senator KIRK. So you don't think you need to check with an actuary on this?

Mr. BLUM. The Office of the Actuary produces——

Senator KIRK. No, I am not talking about the Office, I am talking about you, personally, Mr. Blum. Are you going to write a letter to the actuary saying, "I just got grilled in the Senate and perhaps we need to know how much this thing costs according to you,"?

Mr. BLUM. I stand by the estimates that are in our testimony and——

Senator KIRK. No, but you didn't make the estimates. I mean, the actuary is saying to us, "I don't have a back up for this."

Mr. BLUM. What I think the actuary——

Senator KIRK. Which means we shouldn't believe what you say, and you are not even willing to send a letter to the actuary asking for them to back you up.

Mr. BLUM. What I am saying is——

Senator KIRK. The correct answer is, "Senator, yes. I am willing to send a letter to the actuary asking for this."

Mr. BLUM. I am willing to consult with our actuary's office regarding the estimates in the testimony, but I stand behind the——

Senator KIRK. Will you share the letter that you send to them asking for the back up so that we can see that you have requested an actuary estimate of the Partnership for Patients?

Mr. BLUM. I am now committed to sending a letter, but I——

Senator KIRK. How about yes or no? Will you commit to this committee that you will get the actuary to look at your savings estimates for the Partnership for Patients?

Mr. BLUM. We have shared our estimates with the Actuary's Office. What they have told us——

Senator KIRK. But you will not even do that. You are talking about tens of billions of dollars of a government that doesn't have enough money, and you are not willing to do that.

Mr. BLUM. I think what we are saying is that there are tremendous potential savings to be had if we can achieve——

Senator KIRK. But you are not willing to have an actuary back it up.

Mr. BLUM. I think what the actuaries have said is that if we can achieve that outcome——

Senator KIRK. I can read you what the actuary told Senator Enzi, which is why I am hoping you are going to use this opportunity, now the fourth opportunity I have given you to say, "Yes, Senator. I am going to go back and I am going to check with the actuary and ask him for a formal estimate of the savings that I have claimed but they won't back up."

Mr. BLUM. I will consult with the Actuary's Office and——

Senator KIRK. Look. So you will send a letter to the actuary asking for an estimate and you will share that with the committee because tens of billions of dollars of taxpayer money depends on this.

Mr. BLUM. Senator, with all due respect, I cannot commit to sending a letter——

Senator KIRK. No. Not that you cannot, that you will not commit.

Mr. BLUM. OK.

Senator KIRK. That's kind of sad. Mr. Chairman, over to you.

Senator WHITEHOUSE. We have 3 minutes left on the vote, so the hearing will stand in recess, subject to the call of the chair.

Thank you, Mr. Blum, for your testimony.

[Recessed.]

Senator WHITEHOUSE [resuming the chair]. All right. The hearing will come back to order, after that unfortunate delay. I apologize to all of the witnesses, if we could take our seats. So welcome, Senator Franken, to the continued proceedings. Please, if the witnesses could take their seats.

Thank you all for being here. This is really unfortunate about the timing here, but I appreciate so much the work that you all have done.

We are going to begin with Chris Koller, who is Rhode Island's Health Insurance Commissioner. It is a somewhat unique role, but Chris has done an exemplary job in it, and the office is now nationally recognized for its rate review process and its efforts, through that rate review process, to promote delivery system transformation.

The office is also the State's co-lead in planning for our health insurance exchange, which is an important piece of work. He is an adjunct professor of community health in the program in public health at Brown University.

He is a member of the Institute of Medicine's committee on essential health benefits. He serves in numerous national and State health policy advisory capacities. And prior to his current position, was the CEO of our neighborhood health plan in Rhode Island, and I welcome him.

Mr. Koller, please proceed with your testimony.

STATEMENT OF CHRISTOPHER F. KOLLER, COMMISSIONER, OFFICE OF THE HEALTH INSURANCE COMMISSIONER, PROVIDENCE, RI

Mr. KOLLER. Thank you very much, and thank you, members of the committee.

I appreciate the opportunity to address you on this important topic. I want to take the opportunity to particularly thank Senator Whitehouse for his lead on this area, and also acknowledge the work of Senator Reed, who was a former member of this committee. We are privileged to have them as our servants.

I want to cover three topics today regarding delivery system reform, the role of the health insurance commissioner, what work we are doing, and what some of our lessons have been.

The office was established by law in 2004. It focuses specifically on commercial health insurance and it was established, in part, in recognition of the fundamentally different nature of health insurance from other types of insurance. I am the only health insurance commissioner in the country and I would call to note particularly the basis for our work is a couple of different statutory charges that we have.

In addition to guarding the solvency of insurers and protecting the interests of consumers, my office is charged with ensuring the fair treatment of providers and seeing the health care system as a whole in directing insurers toward the policies that improve affordability. That has led us to use our capacities under rate review in very comprehensive ways to focus on delivery system reform.

Specifically, our rate review system is comprehensive, it covers both small and large group products. It looks at rate factors, the underlying cost drivers, not just product prices, and it is simultaneous for all carriers, public and transparent. So we can get a picture of what really the system costs are in Rhode Island and what is driving them. For instance, what hospital price increases are, and what might be the reasons why, in our case, hospital price increases are going up at 7 or 8 percent while inpatient utilization is only at a point.

So given this, we identified three facts coming out of this. That medical care costs are about 85 percent typical insurance premiums. That insurance, like Medicare, is looking at 8 to 10 percent annually, so the cost pressures are not unique to Medicare. We've talked about that before.

And then insurers have limited tools to change those trends given the prevailing fee for service system, provide us with market powers who resist insurance changes, fragmented providers, and patients who have no incentives to choose better performing systems of care.

With the help of my advisory council, a statutorily charged group of employers and providers, we developed four standards, or actions, that must be taken by commercial insurers in Rhode Island as a condition of receiving rates. These affordability standards represent the chance to take the theory of delivery system reform and put it into practice.

So these four affordability standards in Rhode Island consist of—No. 1, health insurers must increase the portion of their medical

expenses going to primary care by 1 percentage a point for the next 5 years.

Primary care is the only part of our medical care system where the more we have, the lower our costs, and the better our community's health. This is two-thirds of Dr. Berwick's triple aim. But nationally, we only spend about 7 percent of our medical care on primary care. So why is that? The answer has to do with how Medicare sets rates and who has economic power in private contract negotiations.

In Rhode Island, we set about to change these forces by telling insurers they have to invest in primary care on behalf of the community.

Three years later into this experiment, we are seeing the results. Money is being spent on things like establishing patient center medical homes, and primary care doctors in Rhode Island are happier and better able to recruit, and to come here and work. We want to make Rhode Island the best place for primary care in the country.

Our second affordability standard deals with health insurer support for the all-payer patient center medical home project. These are well publicized attempts to define what constitutes high-quality primary care capable of coordinating care for our most chronically ill patients.

This is hard work, but it can be done. And it must come from insurer payments, and it must be coordinated to pay for the same things. Providers do not like being jerked around in different directions by conflicting demands and different carriers.

So our all-payer initiative is 6 years old. It touches 70,000 patients and we have documented significant improvements in the quality of care provided, improved utilization, and a cadre of primary care leaders. Only possible because all of our insurers are asking the same thing of our primary care providers.

The third standard has to deal with health plan investment, and health information technology, building on the significant Federal investments that have been made in general and in Rhode Island in particular, health plans are required to support that with their own money so that they are not freeloading on Medicare's investment.

And then the fourth and final affordability standard addresses hospital payment reform. We have not significant hospital payment reform in this State for various reasons, and we use the authority of the office to dictate six different conditions which must be included in hospital contracts with health plans.

Specifically, we limit the rates of increase such as health—that hospitals can get from health insurers. We demand quality incentives to allow them to earn additional money. We require efficiency-based units of service, such as diagnosis-related groups or any of the proposed Medicare innovations. And we ask for standards related to administrative simplicity to transfers of care, and to public transparency of the information.

A year into this, in spite of the fact that my office got sued for putting this forward, our ability to do it was upheld, and we are seeing those payment reforms being implemented by the insurers in their contracts with hospitals.

So what have we learned from this? I want to point to three lessons that I think are important for anyone who is taking on this work of delivery system reform.

Mr. WHITEHOUSE. Mr. Koller, if you could summarize them fairly quickly.

Mr. KOLLER. Sure. First is that delivery system reform must make primary care infrastructure a priority. Second, this will not happen without public oversight. And third, this must be coordinated across payers. We simply have too many payers to make this work across different providers.

The implications for Congress? I think we have to make primary care a priority. We have to support Medicare payment innovation. We have to support multitier alignment. And we have to create incentives for patients to select high-value delivery systems. I think we have those opportunities in the Affordable Care Act. They bring good tools for the States to work with, and we continue to do that work in Rhode Island. Thank you.

[The prepared statement of Mr. Koller follows:]

PREPARED STATEMENT OF CHRISTOPHER F. KOLLER

SUMMARY

THE ROLE OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER

The Office of the Health Insurance Commissioner was established by law in 2004 in response to concerns about the behavior of Rhode Island health insurers and in recognition of the fundamentally different nature of health insurance from any other type of insurance. Statutorily, the Office is responsible for guarding the solvency of insurers, protecting the interests of consumers, assuring fair treatment of providers, and improving the affordability, accessibility and quality of the health care system.

CURRENT WORK ON DELIVERY SYSTEM REFORM IN RI

Delivery system reform is essential to slowing the rate of health insurance premium increases. The Office's primary tool for this work has been its annual rate review process, which has three components:

1. It is comprehensive and covers small group and large group business for all carriers;
2. It examines rate factors rather than product prices; and
3. It is simultaneous for all carriers, public, and transparent.

However, rate review alone will not reduce the rate of increase in commercial health insurance premiums. In order to address medical cost trends in the delivery system, the Office's Health Insurance Advisory Council identified four Affordability Standards—expectations for health plan conduct as a condition of having rates approved. These Standards are:

1. Increasing the portion of medical expenses going to primary care by 1 percentage point a year for 5 years;
2. Health insurer support of RI's all-payer, patient-centered medical home project;
3. Health plan investment in and support for health information technology; and
4. Hospital payment reform as demonstrated through six conditions to be included by insurers in their contracts with hospitals.

LESSONS LEARNED AND FUTURE DIRECTION

Two years since the implementation of these Affordability Standards, health insurers are implementing these changes and delivery system reform is happening in Rhode Island—primary care is being revitalized, our IT infrastructure is being built and hospital contracts are changing. There remain obstacles to overcome: health insurance premiums continue to rise, evaluation and measurement efforts are incomplete, and interagency coordination can be improved. To date, the following lessons have been learned:

• Delivery system reform must make primary care infrastructure development its first priority;

• Delivery system reform will not happen without public oversight; and
• Delivery system reform must be coordinated across payers.

In addition to the significant Federal investments being made in information technology, Congress can take the following actions to encourage further delivery system reform:

• Make primary care a systematic priority—in loan forgiveness and education, Medicare payments, health services research and NIH funding, and HRSA budgets.
• Support Medicare payment innovation in the ACA.
• Support multi-payer alignment at the State and national level.
• Create incentives for patients to select high-value delivery systems.

Despite the significant challenges that the U.S. multi-payer system presents, the work being accomplished in Rhode Island demonstrates that delivery system reform is necessary for lower rates of increase in our premiums. And it is possible.

Members of the committee, thank you for the opportunity to address you on this important topic. Thank you especially to Rhode Island's Senate Delegation—Senators Reed and Whitehouse. Senator Reed, formerly a member of this committee, is a strong advocate for preserving and enhancing insurance coverage, and Senator Whitehouse has immersed himself in the critical topic we are discussing today. Both are committed public servants. Rhode Island is fortunate and privileged to be represented by them.

In my address today, I want to cover three topics related to medical care delivery system reform: the role of the Office of Health Insurance Commissioner, our work on delivery system reform, and what some of our lessons learned have been.

The Office of the Health Insurance Commissioner was established by law in 2004 in response to concerns about the behavior of Rhode Island health insurers, and a recognition of the fundamentally different nature of health insurance from any other type of insurance. I have occupied the position since it was first filled in 2005. I am the only Health Insurance Commissioner in the country. Central to the Office are its statutory duties, which form the legal basis for our work. In addition to the customary insurance regulator responsibilities of guarding the solvency of insurers and protecting the interests of consumers are two broader and critical duties:

• To assure fair treatment of providers; and
• To see the Rhode Island's healthcare system as a whole and to direct insurers toward policies which improve the affordability, accessibility and quality of the system.

Although there is little statutory direction behind those stated duties, our actions in payment reform are firmly grounded in these standards.

The Office's primary tool for this work has been the annual review of rates of commercial insurers in the State. There are three components to that review:

• It is comprehensive—covering small group and large group business for all carriers—and prospective—rates must be approved before being used.
• It examines rate factors, not product prices. By rate factors we mean the carriers' estimated inflation rates for price and utilization for five medical service categories—hospital inpatient, hospital outpatient, primary care, pharmacy and all other medical. In addition, we look at their estimated administrative costs and projected profits.
• It is simultaneous for all carriers, public, and transparent. As a result, we can both educate the public about what is driving the increases in their health insurance premiums (documenting, for instance, last year's attributed inpatient price increases of about 7 percent, while utilization was almost flat) and query carriers about significant variations between them in inflation rates and administrative costs.

Rate review forms the basis for our systemic delivery system reform efforts. Specifically, after several years of this work, it became apparent to the Office's Health Insurance Advisory Council, a statutorily charged group of employers, consumers and providers who advise the Office, that rate review alone would not reduce the rate of increase in commercial health insurance premiums; that the true costs were in the delivery system and insurers would need direction and coordination in this work.

Specifically: transparent, comprehensive rate factor review highlighted that:

• Medical costs constitute about 85 percent of the typical insurance premium.
• Insurers were predicting medical cost increases of 8 to 10 percent annually, driven by increases in both price and utilization of services; and

• Insurers have limited tools to change those trends—given the prevailing fee for service payment system, medical providers with market power to resist insurer changes, fragmented providers who cannot coordinate care well, and patients who have no incentives to choose better performing systems of care.

Given these facts, the Advisory Council then worked to identify four Affordability Standards—actions which must be taken by any commercial insurer in Rhode Island as a condition of receiving rates. In brief, these Standards consist of:

1. Health insurers must increase the portion of their medical expenses going to primary care by 1 percentage point a year for 5 years.

Primary care is the only part of our medical care system where the more we have, the lower our population costs and better a community's health (two thirds of Dr. Berwick's triple aim). But nationally we only spend about 7 percent of our medical expenses on it. Why is this? The answer has to do with how Medicare sets rates and who has economic power in private contract negotiations. We did not like that answer in Rhode Island and so we have set about to change it by telling health plans they must invest in primary care on behalf of the community. We are seeing the results 2 years later—the money is being spent on things like establishing patient-centered medical homes and primary care docs in Rhode Island are happier and better able to recruit peers to come here and work.

2. Standard No. 2 deals with health insurer support of our all-payer, patient-centered medical home project.

Patient-centered medical homes are a well-publicized attempt to define what constitutes high-quality primary care, capable of coordinating the care of our most expensive chronically ill patients. They work, but take money and time to be built. The money must come from insurer payments and must be coordinated to pay for the same things—providers hate being jerked in different directions by the conflicting demands of different carriers. Rhode Island's Chronic Care Sustainability Initiative is 6 years old and touches 70,000 patients. We have documented significant improvements in the quality of care provided, have signs of improved utilization experience and built a cadre of primary care leaders.

3. The third affordability standard coordinates health plan investment in and support for health information technology.

Under the leadership of the Rhode Island Quality Institute and Senator Whitehouse, Rhode Island has used Federal ARRA money to make significant investments in Electronic Health Records adoption, a Health Information Exchange and—as a Beacon community—implementation of this work to improve the quality of care delivered. This Affordability Standard makes sure that your initial Federal investments in Rhode Island are matched and followed up by private insurer money as well, so we sustain this critical work.

4. The final Affordability Standard addressed hospital payment reform.

Work by my Office has documented private insurer payment variations of 100 percent to different hospitals for the same services. This difference appears to be driven only by hospital size and negotiating power. In addition, there is a marked gap between the theory of hospital payment reform and the practice in Rhode Island—with most payments occurring on a fee for service basis with little or no quality incentives. Given insurer inability or unwillingness to implement hospital payment reform, OHIC set forth six conditions which must be included in future health plan contracts with hospitals. These included limiting price increases to Medicare CPI, installing quality incentives, and facilitating efficiency-based payments such as Diagnosis Related Groups. One year in, and it appears insurers and hospitals are adopting these standards, and a recent court ruling upheld the Office's ability to change health plan contract terms with hospitals.

This is just a brief summary of the Office's attempts to promote delivery system reform. And we make no claims of success, yet. Our premiums still continue to climb. Our evaluation and measurement efforts are incomplete. Our interagency coordination could be better. But I would offer these lessons from our work to date.

1. Delivery system reform must make primary care infrastructure development its first priority.

Every high performing health system in the world has a fundamental commitment to primary care and puts their money in this direction. The United States does not. Delivery system reform of course must extend beyond this, but at the core of integrated, accountable delivery systems must be primary care.

Primary care is also the link or "hinge" to public health and the personal behaviors, which constitute a far greater driver of community health and community costs than the medical delivery system.

2. Delivery System Reform will not happen without public oversight.

Commercial insurance rate review is a good start for this oversight but is not sufficient. We have to make it in the economic interests of providers to change behaviors. In Rhode Island, I had to survive a court suit to nullify a contract term between a market-dominant hospital and a local insurer, which would have explicitly shifted all self-determined losses for Medicaid and Medicare back to the insurer and commercial rate payers. This term was only possible because of the hospital's market dominance.

We must change the rules of success for providers, while respecting how difficult it is for large institutions to change. This is not merely about government price controls, but using government authority to promote new provider payment methods—such as bundled payments and carefully monitored capitation—that change the success rules and encourage providers to coordinate high-quality care together, not just produce more volume alone.

3. Delivery system reform efforts must be coordinated across payers.

An iron law of commerce is that behavior follows reimbursement. But in Rhode Island and elsewhere, commercial health insurance only constitutes 20 percent of the population and money in the system—Medicaid and Medicare—are worth 50 percent, self-insured are worth 20 percent and the uninsured another 10 percent. As a result, in almost all instances, no payer by itself has enough economic influence to change provider behavior and promote delivery system reform and such efforts must be coordinated across payers. This is hard work, and involves changing contracting culture and providing antitrust protection. It also means coordinating with Medicare—no easy task. In Rhode Island, we are proud that our all-payer medical home effort has been selected by CMS to participate in the Medicare Advanced Primary Care Practice (MAPCP) demonstration project, and encourage expansion of this work. We are also looking for ways to coordinate commercial hospital contracting with the upcoming Medicare payment changes.

Finally, based on these lessons, what are some actions Congress could take to encourage further delivery system reform? I offer four areas, all of which build on the significant Federal investments being made in information technology:

1. Make primary care a systematic priority—in loan forgiveness and education, in Medicare payments, in health services research and NIH funding, in HRSA budgets. Our budgets are our values statements and the Federal Government does not value primary care.

2. Support Medicare payment innovation. Although not directly in this committee's jurisdiction, Medicare is a powerful force in delivery system reform. The ACA has numerous payment innovations and sets up structures for more. IPAB must be protected and the Center for Medicare and Medicaid Innovation encouraged, funded and allowed to put forth projects with long payoff estimates.

3. Support multipayer alignment.

- CMS must be directed to coordinate its efforts better across Medicaid and Medicare.
- More directly in this committee's responsibilities, States should be encouraged to expand rate review efforts to align commercial insurers with public payers. Finally, almost 30 percent of RI's population is enrolled in self-insured plans, which can exempt themselves from all-payer efforts. The ERISA pre-emption clause is a major barrier to delivery system reform.

4. Create incentives for patients to select high-value delivery systems. Because the costs of health insurance are subsidized by employers and the Government, individuals do not pay the full costs of wide provider choice, and undervalue the efficiencies and effectiveness of integrated delivery systems. Developing and standardizing effectiveness measures using resources such as the new Patient-Centered Outcome Research Institute, equalizing tax policies for health benefits, promoting individual purchase on exchanges, and designing Medicaid, Medicare and FEHBP benefits that promote price sensitivity will all create these incentives.

Since we pay for technical procedures and specialists, we should not be surprised that we get a lot of volume and specialty care, and less value than other countries. The U.S. multipayer system makes it hard to change, but our work in Rhode Island shows that it can be done. Innovating States need the help of Congress in these efforts.

Thank you again for the chance to address the committee. I look forward to answering your questions.

Senator WHITEHOUSE. Thank you, Commissioner.

The next witness is Dr. Gary Kaplan, who has served as the chairman and CEO of the Virginia Mason Health System since 2000. Virginia Mason is based in Seattle, WA, home State of our fellow HELP Committee Senator, Patty Murray, who sends her regards.

Virginia Mason is one of the first health systems to transform health care using the principles of the Toyota production system, and it is a recognized national leader in reducing costs and increasing efficiency while improving the patient experience.

Dr. Kaplan is a founding member of Health CEOs for Health Reform, and he practices internal medicine at Virginia Mason. He has been recognized nationally for his health care leadership, receiving awards from the National Quality Forum and the Joint Commission, as well as the medical group Management Association of the American College of Medical Practice Executives. We are delighted to have him here.

Please proceed, Dr. Kaplan.

STATEMENT OF GARY KAPLAN, M.D., FACP, FACMPE, FACPE, CHAIRMAN AND CEO, VIRGINIA MASON MEDICAL CENTER, SEATTLE, WA

Dr. KAPLAN. Thanks very much.

Good afternoon, Senator Whitehouse, Senator Franken, and members of the committee. I want to thank you for the opportunity to present the work of the Virginia Mason Health System, and our efforts to transform health care delivery. I hope this, my comments and our testimony, helps develop an understanding of what is truly possible.

Founded in 1920, Virginia Mason combines a primary and specialty care group practice of nearly 500 physicians with a 336-bed acute care hospital. We also operate eight clinics in the Puget Sound region. In addition to my duties as chairman and CEO, I continue to practice internal medicine, although perhaps not as much as I used to.

I am a product of American medicine and I am very proud of American health care. We produce some of the world's best health care in spite of a fragmented financially unsustainable health care system.

Although Virginia Mason has a longstanding reputation for innovation and clinical excellence, but our journey to design a better system of care actually began just over 10 years ago. It was prompted by a simple question from our board. Community leaders from companies like Microsoft, Starbucks, Boeing, they asked us, "Who is your customer?" And of course, our immediate response, just like everybody in health care was, "Our patients." But upon further reflection and challenge by our board, we realized that our systems were not designed for the safety and convenience of our patients, but based on the preferences of providers.

An example would be waiting rooms, where patients hurry up to be on time, and then they wait for us. We build that into our facilities. They have really been designed around us. So we got very clear.

And as you can see in this first poster here, this is our strategic plan. This was developed under the leadership of our board of di-

rectors, and really is an iconic graphic depiction of our plan. All of the elements of this plan support Virginia Mason's patients, who are at the top of the pyramid. The last decade has been about truly understanding what it means to put our patients first.

Also in 2001, we realized that we would not transform health care unless we challenged the deep assumptions held by physicians in our organization. And so, we put our Physician Compact together, codifying and aligning expectations, what every physician had every right to expect from our physicians, and what our physicians had every right to expect from our organization.

Our cultural transformation had begun, but we knew we needed a management method that supported high quality, safe care at a sustainable cost. And in our quest, we looked at other hospitals and institutions around the United States, and we didn't find a management system that we believe would help us execute on this plan.

Soon we discovered from our colleagues just down the street at the Boeing company what they have been doing with the Toyota production system over the past decade, taking the 737 construction from 22 days to 10 days. And in the process, improving quality, creating a safer product, and reducing the costs of production.

We adopted their methods and we adapted it to health care in what we call the Virginia Mason Production System. By using the tools and methods of this system, we have seen tremendous benefits for our patients, our staff, and our organization. Through this work, we have demonstrated that the path to higher quality, safer care is the same path to lower costs.

Since adopting the Virginia Mason Production System, we have saved millions of dollars in planned capital investment, we have dramatically reduced inventory costs, staff walking to some patient waiting, overtime labor costs.

We have also reduced professional liability costs in a State with no tort reform, our liability premiums were reduced by 56 percent, and our self-insured retention funds have been reduced over the past 7 years by 70 percent.

Because of our management system, we were able to find and fix problems before they translate into defects for our patients. We have, what we call, the Patient Safety Alert System, where every staff member is expected to be a safety inspector and stop the line, just like they do at Toyota. If a patient is at-risk, an investigation is launched immediately, not retrospectively. Since beginning the program, we have had over 20,000 PSAs, Patient Safety Alerts. I wish we had 30,000.

We are pleased that last year when, as a result of our improvement efforts, the Leapfrog Group, which represents employers across the country, named Virginia Mason as one of the top two hospitals of the decade. What this shows here on the X-axis is the quality score; on the vertical axis, stewardship of resources or costs. We are the dot in the upper right quadrant. That shows you that it is possible to improve quality and be wise stewards of resources.

We know that we can make these improvements, but just doing it on our own, we are going to sub-optimize in terms of our national delivery system. We need to partner with other organizations who

are proud to join other organizations like Intermountain in a high-value health care collaborative.

We believe that the market has a role to play in health care reform, and in 2004, we started working with some of our region's largest companies: Boeing, Starbucks, Costco, Alaska Airlines. In the first year of our marketplace collaborative on back pain, we saw 2,000 patients and purchasers saved $1.7 million just on back pain in little old Seattle.

As it turned out, the thought was we would lose money because the MRIs we eliminated were where we made money on back pain. But it turned out we increased throughput, it tripled in the same time the costs to deliver care was reduced.

Right now, we are working with the Intel Corporation in Portland, showing that these methods are transportable to other markets.

We know that to reach the full potential of these types of strategies requires realigning payment so that reimbursement is determined by value, not volume. We support approaches such as bundled payment, shared risk, capitated payment, and other pay for value programs.

It is a commonly shared belief that the current self-health care system is unsustainable, but we do believe that with the passage of the Patient Protection Affordable Care Act, we can finally turn our attention to a health care financing model that rewards quality and stops rewarding quantity in a fragmented system.

The law includes many provisions that will help us improve care delivery. Perhaps the most exciting component of this is the Center for Medicare and Medicaid innovation. Through our experience with the Virginia Mason Production System, we have demonstrated again that the path to better health and better health care is the same path to reduce costs.

I would like to thank you both and other members of the committee, and colleagues on the panel today for your role in reforming America's health care delivery systems. Sound legislation must support delivery system reform. That begins in our organizations and in our communities. Millions of Americans in our country are counting on us. They cannot wait any longer.

I will be happy to take questions and thank you.

[The prepared statement of Dr. Kaplan follows:]

PREPARED STATEMENT OF GARY S. KAPLAN, M.D., FACP, FACMPE, FACPE, CHAIRMAN AND CEO, VIRGINIA MASON HEALTH SYSTEM

SUMMARY

ABOUT VIRGINIA MASON*

Virginia Mason is a nonprofit health care organization founded in Seattle, WA, in 1920. An integrated system, Virginia Mason combines a primary and specialty care group practice of nearly 500 physicians with a 336-bed acute-care hospital. We also operate clinics in eight locations around the Puget Sound area.

*Health care is hungry for something truly new—less a fad than a new way to be. We are staggering under the burden of too many defects, too much cost, and too much variation in care, all described with scientific rigor and social commitment a decade ago in the landmark Institute of Medicine reports, *To Err is Human (1999)* and *Crossing the Quality Chasm (2001)*. Even one convincing example of a major health care organization that crossed the chasm might be enough to give us both the confidence and the template we need. Transformation, in that regard isn't

ACHIEVING RESULTS WITH THE VIRGINIA MASON PRODUCTION SYSTEM

Virginia Mason's costs are among the lowest in our market. We recognize skyrocketing cost escalation is a contributor to many of the problems associated with our health care system. We have worked hard to decrease our costs and, at the same time, increase the quality of care we provide to our patients. Our management methodology is based on principles of the Toyota Production System. We utilize the Virginia Mason Production System (VMPS) to identify and eliminate wasteful processes.

VMPS also provides a consistent approach for measuring performance across the organization. Virginia Mason teams have achieved significant organizational and departmental improvements since adopting VMPS:

- Saved $11 million in planned capital investment by using space more efficiently and freed an estimated 25,000 square feet of space using better space design.
- Reduced inventory costs by $2 million through supply chain expense reduction and standardization efforts.
- Reduced staff walking distance by 60 miles per day.
- Reduced labor expense in overtime and temporary labor by $500,000 in just 1 year.
- Reduced professional liability insurance 56 percent from 2004 to 2010.
- Reduced the time it takes to report lab test results to the patient by more than 85 percent.
- Reduced the time from when a patient first calls Virginia Mason's Breast Clinic with a concern to receiving a diagnosis from 21 days to 3 days. Many patients receive their results on the same day.

Through our experience with the Virginia Mason Production System, we have demonstrated that the path to higher quality care is the same path to lower costs.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The health reform law includes many provisions that will undoubtedly improve care delivery including an emphasis on primary care, coordination and innovative models of care.

An example of our experience with higher quality and lower cost in primary care is a pilot we began with Boeing in 2007. Virginia Mason worked with Boeing to reduce health care costs for their employees with the most expensive health conditions while improving their health status. The new model, intensive primary care, included detailed patient education, personal care plans, intensive and appropriate use of case managers, 24/7 phone and email access to providers, and the use of electronic medical records. Additionally, care was coordinated among primary care providers, specialists and the hospital. In partnership with Boeing, Virginia Mason reduced annual per capita claims by nearly 30 percent.

Virginia Mason's experience in delivery system improvement is a model for health care reform across the Nation. The patients in our communities deserve nothing less than high quality, safe care at an affordable cost.

Good afternoon, Chairman Harkin, Ranking Member Enzi and members of the committee. I want to thank you for this opportunity to present the work of Virginia Mason Health System and our efforts to transform the delivery of health care. I am Dr. Gary Kaplan, chairman and CEO of Virginia Mason Health System in Seattle, WA.

Virginia Mason was founded in 1920. Our founders came from the University of Virginia and the Mayo Clinic. Our organization is patterned after the Mayo model, combining a primary and specialty care group practice of nearly 500 physicians with a 336-bed acute-care hospital. We also operate clinics in eight locations around the Puget Sound area.

In addition to my duties as chairman and CEO, I continue to practice internal medicine at Virginia Mason. I am a product of American medicine and I am proud of American health care. We produce some of the world's best health care in spite of a fragmented, financially unsustainable health care system.

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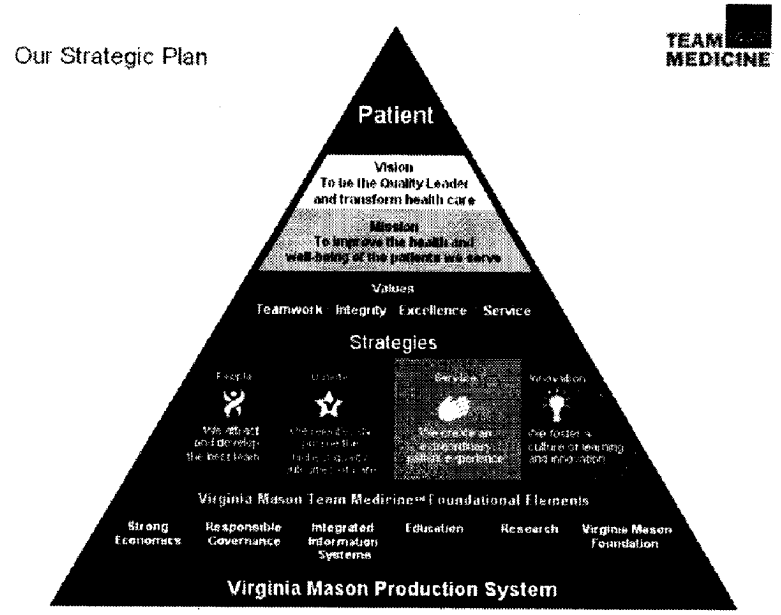
vague at all; it refers to results, unprecedented performance in all important dimensions of care, at a cost we can embrace as sustainable.

Virginia Mason Medical Center (VMMC) is not yet quite that beacon, but it has a better shot at becoming one than almost any other large health care organization in America today (Kenney, 2011, p. xii).—*Donald M. Berwick, M.D., MPP, Administrator of the Centers for Medicare and Medicaid Services.*

REDESIGNING CARE DELIVERY

Virginia Mason has a long-standing reputation for innovation and clinical excellence, but our journey to design a better system of care delivery began just over 10 years ago. Our cultural transformation was prompted by a simple question from our Board, "Who is your customer?" Of course, our immediate response was "It's the patient." However, upon reflection we realized that our systems were not designed for the safety and convenience of our patients but based on the preferences of our providers and designed around us, the doctors, nurses, technicians, managers and those of us working in health care. An example would be waiting rooms where patients hurry to be on time and then wait for us!

In 2001, Virginia Mason leadership developed a new strategic plan, accompanied by a graphic representation in the form of a pyramid. All of the elements of the plan, as depicted in the pyramid, support Virginia Mason's patients who are at the top of the pyramid, signifying our intention to place our patients first in all we do.



Also in 2001, Virginia Mason physician leadership developed a physician compact detailing the organization's responsibilities to physicians and each physician's responsibility to the organization, to each other and to their patients.

Our cultural transformation had begun but we knew we needed a management method that supported high quality, safe care at a sustainable cost. In our quest, we looked at what other hospitals were doing—and we looked at the very best out there. Yet we didn't find anything that we believed would truly transform health care.

When we were willing to look at companies outside of the health care industry, we discovered that Boeing had adopted the Toyota Production System as their management methodology. They shortened the lead time to make a 737 from 22 days to 10 days and we soon found that this methodology is applicable to just about any work that involves complex processes and systems.

So we adapted it to what we call the Virginia Mason Production System (VMPS). By using the tools and methods of VMPS, we've seen tremendous benefits for our patients, our staff and our organization. Patients benefit with greater safety, less delay in getting care, more timely results and treatment, and more time with their care providers. Our staff members benefit by having less rework and frustration, and greater opportunities and more time to care for patients; which, by the way, is the reason they chose health care as a profession in the first place. Virginia

Mason benefits by operating more efficiently, providing higher quality and safer care, at a lower cost.

ACHIEVING RESULTS WITH THE VIRGINIA MASON PRODUCTION SYSTEM

Today, Virginia Mason's costs are among the lowest in our market. We recognize skyrocketing cost escalation is a contributor to many of the problems associated with our health care system. We have worked hard to decrease our costs and, at the same time, increase the quality of care we provide to our patients. We utilize our management methodology to identify and eliminate wasteful processes.

An example of waste is waiting. Waiting rooms by design are places patients, who are on time, go to wait for providers who are running behind schedule. Not only do patients wait in the waiting room, they wait in the exam room, they wait for test results, they wait for diagnosis and treatment, and they even wait to receive their bill. All of that after an initial wait to see the doctor after their appointment has been scheduled.

VMPS also provides a consistent approach for measuring performance across the organization. Virginia Mason teams have achieved significant organizational and departmental improvements since adopting VMPS:

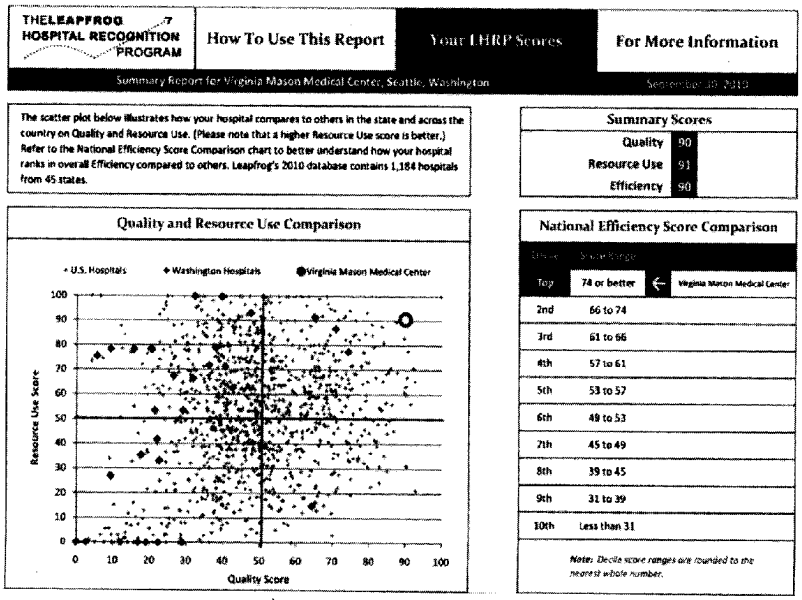
- Saved $11 million in planned capital investment by using space more efficiently and freed an estimated 25,000-square feet of space using better space design.
- Reduced inventory costs by $2 million through supply chain expense reduction and standardization efforts.
- Reduced staff walking distance by 60 miles per day.
- Reduced labor expense in overtime and temporary labor by $500,000 in just 1 year.
- Reduced professional liability insurance 56 percent from 2004 to 2010.
- Reduced the time it takes to report lab test results to the patient by more than 85 percent.
- Improved medication distribution from physician order to availability for administration from 2.5 hours to 10 minutes, and reduced incomplete inpatient medication orders from 20 to 40 percent to less than 0.2 percent; both were achieved through process improvement and computer physician order entry (CPOE) implementation.
- Reduced the time from when a patient first calls Virginia Mason's Breast Clinic with a concern to receiving a diagnosis from 21 days to 3 days. Many patients receive their results on the same day.

RECEIVING EXTERNAL RECOGNITION

Our efforts to provide higher quality, safer care at a lower cost have not gone unnoticed. Late last year, we were named one of two Top Hospitals of the Decade by the Leapfrog Group. The Leapfrog Group is a coalition of large employers who came together more than 10 years ago with the goal of influencing the quality and cost of health care. Today the Leapfrog Group produces the most respected indicator of efficiency and effectiveness in hospital care.

Efficiency is a Leapfrog measure that combines scores for quality and resource use. Leapfrog's 2010 data base contained 1,184 hospitals from 45 States. We know that better quality also means higher efficiency. Proving that rapid access to reliable systems delivering evidence-based care is less costly for all concerned.

As this fall 2010 diagram illustrates, Virginia Mason ranks among the top 1 percent of all hospitals measured for both quality and efficiency, according to the Leapfrog Hospital Recognition Program.



Fall 2010 Leapfrog Summary Report

APPLYING PRODUCTION SYSTEM PRINCIPLES TO FACILITY DESIGN

Another example of our success with adopting production system principles to health care is our new Emergency Department at our downtown Seattle location, which opened for the first time last week.

People typically come to emergency rooms because they are acutely ill. Making them wait just makes them sicker. We used the Virginia Mason Production System to design the ideal process and flows so we can efficiently move our patients from arrival to assessment, treatment and either discharge or admission to the hospital. Then, using a 3P process (Production Preparation Process), we brought together the construction team, the architects, our doctors and nurses, paramedics and most importantly our patients, to design the ideal physical facility to support that flow. This inclusive process revealed that a large waiting room is unnecessary.

A key to the efficiency of the new ED is the addition of what Virginia Mason calls the PACE unit—which stands for Patient Accelerated Care Environment. In most EDs, patients who are not acutely ill, but cannot be immediately discharged or admitted, are cared for in the ED as "observation" patients.

At Virginia Mason, those patients are moved to the adjacent PACE unit, where they receive individualized care to efficiently move them toward either discharge or inpatient admission. This not only provides better care for the patient, but removes the bottleneck from the ED and makes those resources available for more acutely ill patients who might otherwise be forced to wait.

As you may know, hospitals all over the country are spending millions of dollars to build huge emergency departments to cope with the rising demand for care—instead of putting resources into figuring out how to deliver the care that people need more efficiently.

Through the application of production system principles and the broad participation from all of those involved in patient care, we built a unique facility. We rethought everything—from how to eliminate waiting to the way people, information and supplies move through the building. I genuinely believe the care we provide in this emergency department will be a model for the entire Nation.

PARTNERING TO DELIVER GREATER VALUE

We know that we can make many improvements on our own, but to transform our Nation's health care delivery system, we need to partner with like-minded organizations.

We are working with health care organizations that share our vision of a value-driven system. In December 2010, Cleveland Clinic, Dartmouth-Hitchcock, Denver Health, Intermountain Healthcare, Mayo Clinic, and The Dartmouth Institute for Health Policy and Clinical Practice announced the formation of the High Value Healthcare Collaborative (HVHC) with the goal of improving care, lowering costs and sharing best practices nationally. On June 1, eight major health systems, including Virginia Mason, joined the Collaborative.

The medical groups will share data on outcomes and clinical protocols for selected conditions and treatments to arrive at optimal care models, which can then be implemented by many other health care systems. The Collaborative aims to see these best practices replicated across the country.

Currently, the HVHC is working together in nine areas that have wide variation in rates, costs and outcomes. These are total knee replacement, diabetes, asthma, hip surgery, heart failure, perinatal care, depression, spine surgery and weight loss surgery. In the future, the HVHC will expand their focus to additional high variation, high-cost conditions affecting diverse populations. The HVHC will determine best practices for delivering care for these conditions and will rapidly disseminate actionable recommendations to providers and health systems across the United States (Adams & Kimbell, 2011). We are hopeful that this work will ultimately be used by the Centers for Medicare and Medicaid Services to set Medicare payment rates.

COLLABORATING WITH THE MARKETPLACE

We also believe that the market has a place in driving health care reform. In 2004, we began working with some of our region's largest employers. Through that collaboration, we improved patient satisfaction and provided care more quickly and cost-effectively, all while realizing ever-better medical outcomes. We started working with employer and health plan representatives forming Marketplace Collaboratives to identify and align our interests, with the goal of reducing variation in quality and access.

We began by identifying the highest cost conditions; we developed quality measures, relied on evidence-based care and utilized VMPS. The collaborative developed five product specifications essentially defining quality from the customer/employer perspective:

- Same-day access;
- 100 percent patient satisfaction;
- Evidence-based care;
- Absence management; and
- Affordable price for purchasers and providers—reimbursement must be aligned with value.

In the first year of the back pain collaborative, we saw 2,000 patients and purchasers save $1.7 million. The time needed to complete care for back pain was reduced by 67 percent. Course of care went from 66 days to 12 days. We were very close to same-day access and increased available patient appointments from 500 to 2,000. Importantly, patient satisfaction was 98 percent.

We utilized evidence-based care, which we learned through this process, hadn't always been the case. Ninety-six percent of Virginia Mason patients required no work loss (beyond the time needed to receive care); of those who did miss work they lost 4.3 work days, compared to 9 work days lost for care delivered by other local providers.

We committed to doing the right thing, even though in the short term we would likely lose money. As it turned out, the margin to Virginia Mason increased because throughput quadrupled at the same time the cost to deliver care was reduced.

We also have value streams, in our marketplace collaborative work with employers, for breast nodules, headache, upper respiratory infection, screening and prevention, and shoulders, knees and hips. Payment for value, not volume, would accelerate this work across the country, allowing patients to receive better care, faster and more affordably.

Working with Intel, we have expanded Marketplace Collaboratives into the Portland, OR area. Intel is collaborating with a payor and providers in Portland to use clinical value streams developed at Virginia Mason. Intel's success is similar to ours and demonstrates that this methodology is portable and transferrable.

To reach the full potential of these types of strategies requires realigning payment so that reimbursement is determined by value not volume. Approaches such as bundled payment, shared risk, capitated payment and other pay-for-value programs are necessary in order to promote widespread, value-driven care innovations.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

In March 2010, the Patient Protection and Affordable Care Act, which was passed by Congress and signed by President Obama, became law. In addition to much-needed insurance industry reform, it incorporates incentives for delivery system reform. We can finally turn our attention from a health care financing model that rewards quantity in a fragmented system to one that encourages quality in a coordinated approach. The health reform law includes many provisions that will undoubtedly improve care delivery.

EMPHASIZING PRIMARY CARE

As a practicing physician, I've known for more than three decades that to shift the paradigm from a system that treats illness to one that promotes health requires a sharp focus on primary care.

Thankfully, the Patient Protection and Affordable Care Act requires incentive payments for primary care providers and reallocation of unused residency positions to primary care programs.

An example of our experience with higher quality and lower cost in primary care is a pilot we began with Boeing in 2007. Virginia Mason worked with Boeing to reduce health care costs for their employees with the most expensive health conditions while improving their health status. The new model, intensive primary care, included detailed patient education, personal care plans, intensive and appropriate use of case managers, 24/7 phone and email access to providers, and the use of electronic medical records. Additionally, care was coordinated among primary care providers, specialists and the hospital. In partnership with Boeing, Virginia Mason reduced annual per capita claims by nearly 30 percent.

The success of the Boeing project led to the implementation of the Virginia Mason's Intensive Primary Care program at all of our primary care sites. To appropriately align incentives, contractual arrangements for this expanded program include a per member/per month stipend, a mechanism for shared savings and payment for achievement of quality metrics.

ENSURING BETTER COORDINATION

Multi-specialty group practices and integrated delivery systems provide many of the attributes necessary for accountable patient care. Unfortunately fewer than 20 percent of physicians practice in groups with 11 or more doctors. As a result, fragmented care leads to unnecessary tests and treatments, emergency department over-utilization and alarmingly high hospital re-admission rates (*Washington Post*, 2010, p. 142).

The health reform law will encourage care coordination in a framework not unlike an integrated delivery system. Accountable Care Organizations will be rewarded for keeping patients healthy and out of both emergency rooms and hospitals. Patients will benefit from additional services such as intensive education, monitoring and medication management. A bundled fee per patient will translate into shared savings for Medicare and for providers.

My colleagues and I at Virginia Mason are pleased with the recently released ACO regulations and we are continuing to explore pursuit of an ACO designation for our organization.

PROMOTING INNOVATIVE MODELS OF CARE

Perhaps the most promising component in the health reform law is the Center for Medicare and Medicaid Innovation (CMMI) with its mission of better health care, better health and reduced cost.

Through our experience with the Virginia Mason Production System, we have demonstrated that the path to better health and better health care is the same path to reduced costs. As you might imagine, we are in conversation with CMMI regarding potential pilot projects.

In conclusion, I'd like to thank each of the committee members and my colleagues on the panel today for your role in reforming America's health care delivery system. Sound legislation must support delivery system reform that begins in each of our organizations, because our patients and communities are counting on us and can wait no longer.

I am happy to answer any questions.

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Senator WHITEHOUSE. Thank you, Dr. Kaplan. We will continue with the witnesses first, and then we will do questions selectively at the end.

Our next witness, Greg Poulsen, is the senior vice president for Intermountain Healthcare, which is based in Salt Lake City, UT, Senator Hatch's home State. He joined Intermountain Healthcare in 1982, and in his current position, he shares responsibility for the operational and strategic issues of the organization. He has had direct responsibility for strategic planning, research and development, and marketing and policy for over 20 years.

He is a Commissioner for the Commonwealth Fund in Washington, DC, focused on defining a high-performance health system for the United States. He has been a consultant and provided counsel on health policy development in other countries as well, and we are pleased to have him with us.

Mr. POULSEN.

STATEMENT OF GREG POULSEN, SENIOR VICE PRESIDENT AND CHIEF STRATEGY OFFICER, INTERMOUNTAIN HEALTHCARE, SALT LAKE CITY, UT

Mr. POULSEN. Thank you very much for the opportunity to be with you.

As you mentioned, Intermountain Healthcare is based in Salt Lake City. We have roughly 3,200 physicians, 23 hospitals, and are the largest insurer in the State.

I think we have become particularly well-known nationally and internationally for identifying best clinical practices, and then applying them consistently in much the same way that Virginia Mason has.

Dr. John Wennberg at Dartmouth summarized the results about a year and a half ago by saying, "Intermountain is the best model in the country of how you can actually change health care for the better."

If the Nation could reduce health care spending for acute and chronic illness by more than 40 percent if it practiced like Intermountain. However, we know that there remains much room for improvement at our organization and at others. The closer we look, the more we find areas where improvement can and must be made.

I know that other leading organizations see it the same way we do; we just heard about that. The primary challenge for us, and the main reason more organizations don't adopt high-value models discussed in this hearing is the underlying fee for service payment system, which predominates, of course, in the United States.

Intermountain and other organizations have shown that improving quality is compatible with lowering costs. And indeed, high-quality care is generally less expensive than substandard care. Unfortunately, such high-quality, low-cost care generally leads to lower revenues and lower incomes for providers. To put it bluntly, the current payment system rewards disorganized, inefficient, and often unnecessary care.

Experience demonstrates that effective, coordinated clinical practice can improve outcomes dramatically while reducing costs significantly. Let me give you a couple of examples.

One relates to patients coming to emergency rooms with sepsis, which is a deadly whole body medical condition generally associated with blood infections. By applying a carefully organized series of best practices every time, consistency here is the key, Intermountain's mortality rates have plunged to nearly 10-times lower than the national average, from roughly about 40 percent to about 5 percent. Because of much more rapid recoveries and fewer complications, costs were much lower as well in both national norms and our previous experience.

The reward? The revenue loss of more than $10 million per year to Intermountain hospitals and physicians, so a reward of a penalty, and if you will, for that kind of improvement. Similar results can occur with management of chronic diseases.

At Intermountain and other places, we have developed a coordinated, evidenced-based approach to managing patients with diabetes, for example, and have applied it across our entire system. The results are much better health, many fewer complications, and much lower cost. Indeed, what we have seen is a dramatic reduction in amputations, lower ER visits, lower rates of heart disease and other hospital treatments, and roughly a reduction of $5 million per year; again, a loss of revenue.

Sepsis care and diabetic care are just two examples of dramatic improvements that can be made to both costs and quality simultaneously. At Intermountain, we have seen the same dynamic play out in well over 100 other cases with services ranging from managing glucose in cardiac surgery, to defining the optimal time to induce labor for expectant mothers.

The magnitude of our health care value problem, and opportunity, can be seen in the expense data from across the country. Even after adjusting for differences in input costs like labor and building expense, similar populations of individuals with similar diseases cost Medicare substantially more than twice as much in some locations than in others. Much as you pointed out, Senator Whitehouse, on that graph you showed at the first of the meeting.

We even see huge variation within relatively small geographies like within Utah, or Washington, or Minnesota, or New York, even within New York City. And this variation does not correlate to quality of care. Indeed, the reverse is true.

Improving care value is hard work, and it takes time, and it takes resources. We believe that it is unrealistic to expect most providers to do these hard things when their reward is a financial penalty. For this reason, we believe that health care payments should move rapidly toward a payment mechanism that rewards value rather than volume, as all of us here have said.

As the largest payer in the Nation by far, Medicare can catalyze this change. We believe bold movement toward comprehensive prepayment to provider groups has the potential to yield dramatic improvements. Really, changing health care delivery requires changing incentives.

We believe that changing from fee for service to prepayment will be challenging, but the alternatives are much more difficult, and will not yield nearly the beneficial long-term results.

We have submitted a white paper that outlines five principles that we believe would foster this type of change and put health care, and Medicare, on a sustainable and affordable trajectory. We hope you will find it useful.

Thank you for the opportunity to be with you.

[The prepared statement of Mr. Poulsen follows:]

PREPARED STATEMENT OF GREG POULSEN

SUMMARY

Intermountain Healthcare is an integrated not-for-profit health system based in Salt Lake City, UT. Intermountain operates 23 hospitals in Utah and Idaho; more than 160 clinics; and an insurance plan, SelectHealth, which covers approximately 500,000 lives in Utah. Intermountain's Medical Group employs approximately 800 physicians, and about 2,300 other physicians affiliate with Intermountain.

Intermountain has become well-known nationally and internationally for identifying and consistently applying best clinical practices. Dr. John E. Wennberg of Dartmouth summarized the results, saying, "Intermountain is the best model in the country of how you can actually change health care for the better." Dartmouth has estimated that if healthcare were practiced nationally in the way it is provided at Intermountain, "the Nation could reduce healthcare spending for acute and chronic illnesses by more than 40 percent."

Intermountain's focus is on providing high-value healthcare. To that end, we:

- Have developed and structured physician-led clinical programs so that medicine at Intermountain is practiced by collaborative teams, and is based on the best available data.
- Establish specific clinical improvement goals, with accountability for accomplishing these goals reaching all the way to Intermountain's governing board.
- Have developed information technology that allows us to track, compare, and improve outcomes—and eliminate inappropriate variation.
- View variation as an opportunity to improve, whether we find it in our clinical outcomes, or our supply chain.

For example, by providing systematic, science-based treatment—prompted by good clinical decision support—to patients coming to Intermountain's emergency rooms with deadly blood infections (sepsis), we achieved mortality rates that were about one-tenth of the national average, with dramatic cost savings. The reward? A revenue loss of more than $10 million per year to Intermountain physicians and hospitals.

We know there remains much room for improvement; when we accurately measure our own performance, we consistently fall short. The primary challenge, and the main reason that more organizations don't adopt the high-value models discussed in this hearing, is the underlying fee-for-service payment system that predominates in the United States. Put bluntly, the current payment system rewards disorganized, inefficient and often unnecessary care.

We believe that healthcare should move rapidly toward a payment mechanism that rewards value rather than procedure volume. As the largest payer in the Nation—by far—Medicare can catalyze this change. We believe bold movement toward comprehensive prepayment to provider groups has the potential to yield dramatic cost and quality benefits to the Nation.

Intermountain has submitted a white paper to the committee that discusses much more fully the key components that we believe could move healthcare in the United States to sustainably higher value.

Intermountain Healthcare appreciates the opportunity to discuss improving quality and lowering the costs of health care from the delivery system perspective. My name is Greg Poulsen, and I am senior vice president and chief strategy officer of Intermountain Healthcare in Salt Lake City, UT. Intermountain operates 23 hospitals in Utah and Idaho; more than 160 clinics; and an insurance plan, SelectHealth, which covers approximately 500,000 lives in Utah. Intermountain's Medical Group employs approximately 800 physicians, and about 2,300 other physicians affiliate with Intermountain.

Intermountain has become well-known nationally and internationally for identifying best clinical practices and applying them consistently. Dr. John E. Wennberg of Dartmouth summarized the results, saying, "Intermountain is the best model in the country of how you can actually change health care for the better." Dartmouth estimated that if healthcare were practiced nationally in the way it is provided at Intermountain, "the Nation could reduce healthcare spending for acute and chronic illnesses by more than 40 percent."

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- Have developed and structured physician-led clinical programs so that medicine at Intermountain is practiced by collaborative teams, and is based on the best available data.
- Establish specific clinical improvement goals, with accountability for accomplishing these goals reaching all the way to Intermountain's governing board.
- Have developed information technology that allows us to track, compare, and improve outcomes—and eliminate inappropriate variation.
- View variation as an opportunity to improve, whether we find it in our clinical outcomes, or our supply chain.

However, we know there remains much room for improvement at Intermountain; the closer we look, the more we find areas where we can be better. The primary challenge for us, and the main reason that more organizations don't adopt the high-value models discussed in this hearing, is the underlying fee-for-service payment system that predominates in the United States. Intermountain and other organizations have shown that improving quality is compatible with lowering costs—indeed, high-quality care is generally less expensive than substandard care. Unfortunately, such high-quality, low-cost care generally leads to lower revenues and lower incomes for providers. Put bluntly, the current payment system rewards disorganized, inefficient and often unnecessary care.

Experience at Intermountain and elsewhere demonstrates that effective, coordinated clinical practice can improve outcomes dramatically while reducing costs significantly. One example relates to providing systematic, science-based treatment to patients coming to emergency rooms with sepsis (which is a deadly whole-body medical condition usually associated with blood infections). By applying a carefully organized series of best practices EVERY TIME—consistency is the key—Intermountain's mortality rates plunged to nearly one-tenth of the national average (roughly 40 percent mortality nationally vs. under 5 percent at Intermountain), and because of more rapid recoveries and fewer complications, costs were much lower than both national norms and our previous experience. The reward? A revenue loss of more than $10 million per year to Intermountain physicians and hospitals as a direct result of improving quality. This is a dramatic illustration of the need to retool payment systems to incentivize value.

Similar results can occur with management of chronic diseases. Intermountain has developed a coordinated, evidence-based approach to managing patients with diabetes, and it is applied across our entire system. The results are much better health, many fewer complications like heart disease and amputations, and much lower cost; my friend, Dr. Denis Cortese, who recently retired as the CEO of the Mayo Clinic, told KARE TV in Minneapolis, "If I were ever diagnosed with diabetes, I would want to be treated by Intermountain Healthcare. They have the best outcomes in the country—and the lowest costs." Again, unfortunately, the current payment system penalizes this success: our much lower rate of ER visits, amputations, heart disease and other hospital treatments costs Intermountain providers roughly $5 million in revenue per year.

Sepsis care and diabetic care are just two examples of the dramatic improvement that can be made to both quality and cost. At Intermountain, we have seen this same dynamic play out in well over 100 other case types across the spectrum of care, from the timing of elective inductions of labor for pregnant women to the selection and administration of the most effective antibiotics. Intermountain develops these "best-practice" protocols for those procedures and case types that we perform most often, that are the most expensive, or that have the widest variation in their performance—and we do it both through careful analysis of actual outcomes data

available through our electronic medical records and through review of the latest and best scientific evidence. At Intermountain, our clinicians are not required to follow the protocols absolutely. Actual practices may vary somewhat because of patient preferences and values or because of clinicians' best judgment. However, our clinicians have come to trust the data, and they rely on the decision support protocols as a valuable tool in the diagnosis and treatment of patients. And, it has been convincingly demonstrated that overall, both outcomes and costs improve.

The magnitude of the problem caused by the perverse incentives in the fee-for-service payment system—and the opportunity—can be seen in the expense data from across the country; even after adjusting for differences in input costs—like nursing salaries and building costs—similar populations of individuals with similar diseases cost Medicare much more than twice as much in some locations compared to other locations in the country. We even see huge variation within relatively small geographies (within Utah or Washington, for example). And this variation does not correlate to quality of care—indeed the reverse is frequently true. Generally speaking, people living in areas with low quality of care cost CMS and other payers more than those in areas where high-quality care is provided.

The perversity of our current payment system is also evident in the fact that we now have huge regulatory requirements built to prevent providers from succumbing to the enticements inherent in the fee-for-service payment system. Fraud and abuse, anti-kickback, RAC audits, re-admission tracking and many other regulatory instruments—which are hugely expensive for both the Government and providers—exist primarily to prevent providers from following the incentive to provide unnecessary care.

Improving care value is hard work, and takes time and resources. We believe that it is unrealistic to expect most providers to do these hard things when their reward is a financial *penalty*. For this reason, we believe that healthcare payment should move rapidly toward a payment mechanism that rewards value rather than procedure volume. As the largest payer in the Nation—by far—Medicare can catalyze this change. We believe bold movement toward comprehensive prepayment to provider groups has the potential to yield dramatic cost and quality benefits to the Nation.

We suggest five principles to foster this change:

- First, of course, is the development of a mechanism to pay providers for meeting the health needs of individuals in the most clinically and financially efficient way possible. Various permutations of prepayment, coupled with effective quality and patient satisfaction measures are, in our view, the most effective mechanism to do this.
- Second, we believe that government should require results—high quality at affordable cost—rather than requiring a given organization structure. Intermountain is structured differently than Virginia Mason, which is different than the Mayo Clinic, which is different than Geisinger, which is different than the medical community of Grand Junction Colorado, and so on. And yet, all of these have achieved dramatically better quality at lower cost than the Nation at large. It is often tempting to prescribe an approach—something that worked somewhere else, but it is much more effective to define and reward the desired outcome and unleash American creativity to achieve it. The best model may not have been tried yet.
- Third, we believe that people using the healthcare system should have appropriate incentives to use the system wisely and to do their part in maintaining their own health. Individuals should have financial as well as literal skin in the game.
- Fourth, the Federal Government generally, and CMS specifically, have huge amounts of information that can help providers of care to be more effective. One of Intermountain's keys to success has been a very robust data base of information that helps us to see what works and what doesn't. CMS could assist providers that lack our data capabilities to achieve similar benefits.
- Fifth, and finally, there should be a substantial reward mechanism for providers making the major changes needed to provide high-value care. Specifically, organizations and localities that are currently high-cost should be given very strong incentives to do the hard work necessary to change paradigms from volume-based care to value-based care. This means less incentive and reward for organizations like Virginia Mason and Intermountain, but then, we don't have to make as many hard changes. We believe that the benefits of giving substantial incentives to higher cost places to make the needed but difficult changes will provide dividends to the Nation for decades to come.

We are including in this submittal a much more detailed white paper outlining our thinking on the key components that we believe would move healthcare in the United States to sustainably higher value. The document speaks directly to Medicare, because it is the country's largest payer for health services, because it is di-

rectly under the purview of the Federal Government, and because it tends to set the direction for commercial payers. The ideas could be adapted to Medicaid and to commercial plans.

Thank you for the opportunity to present on this important topic today. Questions may be directed to Intermountain's Director of Federal Relations, Bill Barnes at *bill.barnes@imail.org* or at 801–442–3240.

RECOMMENDATIONS TO CONGRESS FOR BUILDING SUSTAINABLE MEDICARE VALUE
INTERMOUNTAIN HEALTHCARE

INTRODUCTION

Projected expenditures in government healthcare programs are the largest Federal deficit issue facing this country. The imbalance between the number of people paying into Medicare versus recipients, as well as the escalating cost of care for beneficiaries, is growing in ways not predicted—or even imagined—by the creators of Medicare. There is consensus that the Medicare spending trajectory is unsustainable and, unless checked, will be the leading contributor to the deficit in the future. Real deficit reduction is virtually impossible in the absence of healthcare improvement. It will require brave leaders to take on this divisive but critical issue.

MANY PROPOSED SOLUTIONS HAVE MAJOR CHALLENGES

Many less-than-ideal, insufficient, or politically unattractive alternatives to balancing the Medicare books have been proposed from all directions. The easiest option at the present is to "kick the can down the road" once more, opting to leave this issue out of the discussion entirely for the time being, but this would leave an ever-growing problem for the next generation of American citizens and leaders. We firmly hope that the necessity to finally address this problem substantively will be acknowledged.

Of course, taxes could be raised to cover the predicted gap. However, a modest change in Medicare payroll taxes would have little impact. Eliminating the Medicare shortfall would require that the Medicare tax be raised several fold, and this would be disastrous economically, politically, and from a fairness perspective. Additionally, if healthcare costs continue to grow at their current rate, a tax increase today might only serve as another temporary solution. If either ignoring the issue or raising revenue to unprecedented levels is not palatable, the only alternative is to reduce the Medicare cost trajectory.

Medicare spending could be reduced through reducing benefits, rationing services based on patient criteria, or queuing patients. While each of these options is used in other countries, they would currently be politically challenging to implement here. Opponents to these options, including most Americans, will respond that beneficiaries and their physicians, not the Federal Government, should be making medical (often "life or death") decisions for seniors. So, while we believe that evidence should impact how care is provided (and the Federal Government may well play a role in disseminating this evidence), we believe that more dramatic intrusions into care practice are likely to be very controversial. Spending could also be reduced by increasing the Medicare eligibility age to 67 or 70. Medicare benefits could be means-tested or tiered, with those who have higher incomes being made responsible for a larger percentage of their healthcare costs. All of these alternatives would likely result in public outcry, as Medicare was not initially constructed to be a safety-net program and those who have paid into it would feel they were not receiving what they have paid for.[1]

The most straightforward approach to reducing Medicare spending is to force across-the-board cuts to providers, such as the 2 percent reductions required if the Joint Select Committee and Congress cannot reach another solution. Although simple to impose and seemingly compatible with the need to reduce the overall cost of Medicare, this alternative would likely result in a cascade of negative consequences. Some providers that currently serve large Medicare patient populations and are unable to reduce their costs may be unable to survive on decreased margins and would eventually cease to exist. Other providers that have mixed practices may discontinue providing services to Medicare beneficiaries, resulting in access issues for America's most vulnerable seniors (we have already seen this in some parts of the country). Additionally, this may lead some providers to simply shift costs to other

[1] Actually, the average person pays far less into Medicare than s/he will receive (which is at the heart of the current problem). This is in large measure due to increases in both longevity and healthcare costs that were never anticipated by the creators of Medicare.

payer categories, increasing commercial insurance premiums at a time of economic vulnerability.

And perversely, the Nation's most efficient, value-oriented providers would be disproportionately impacted by these cuts, since they simply have less "fat" to cut. Furthermore, since one way to be successful in a world of reduced per-use payments is to increase utilization of profitable but questionable services, some providers may simply attempt to "make it up on volume," which would make a major problem worse. Any system, good or bad, will ultimately produce exactly the results it incentivizes. A payment system that continues to pay providers on a per-use basis, albeit at a reduced rate, is likely to result in an increase of per-person utilization in order to spread significant fixed costs over a larger pool. For this reason, we do not believe these cuts will necessarily result in meaningful deficit reduction in the intermediate and long term.

A BETTER OPPORTUNITY

Intermountain believes there is another option, an alternative with a significant upside for the Nation. This option addresses cost by improving clinical quality and avoiding waste. Implementation of this option can begin as early as 2013 through relatively simple changes to the current CMS payment model.

To understand the opportunity, it is important to recognize the massive variation in the way healthcare is provided within the United States—with per-capita cost differences of more than two-to-one among States for both Medicare beneficiaries and the rest of the population.[2] Additionally, for decades, research conducted by the Dartmouth Institute for Health Policy and many others has highlighted even greater variation in utilization and cost of healthcare services among smaller geographic regions within the United States.[3] Even after adjusting for age, sex, ethnicity, and local price variation, there is more than a threefold difference in cost per beneficiary.[4] Interestingly, the quality of medical care does not increase with the higher costs of healthcare. As shown in the following graph, States with higher costs of healthcare tend to have lower quality of care.

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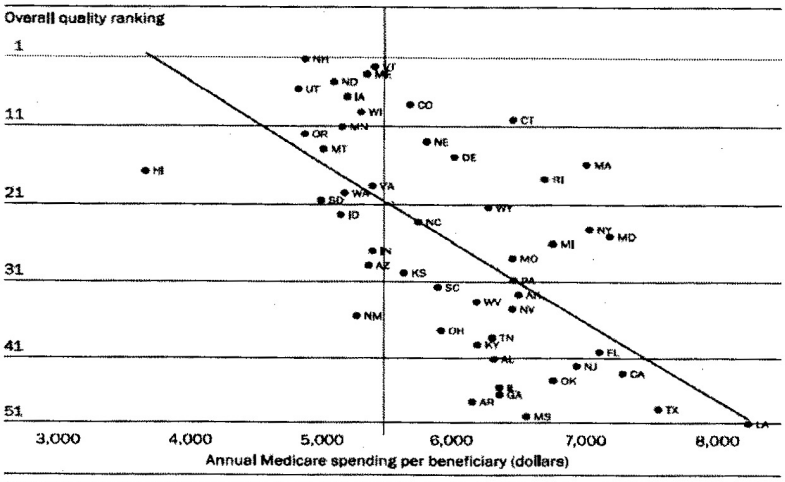
[2] Health Expenditure Data, Health Expenditures by State of Residence, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

[3] Jonathan Skinner, Elliott Fisher, and John E. Wennberg, "The Efficiency of Medicare" in David Wise (ed.) *Analyses in the Economics of Aging*. Chicago: University of Chicago Press and NBER, 2005: 129–57.

[4] Jonathan Skinner, et al., A New Series of Medicare Expenditure Measures by Hospital Referral Region: 2003–8, 21 June 2011. The Dartmouth Institute for Health Policy & Clinical Practice, *http://www.dartmouthatlas.org/downloads/reports/PA__Spending__Report__0611.pdf*.

Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001



SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTE: For quality ranking, smaller values equal higher quality.

Those areas with higher quality yet lower costs have accomplished this through providing care with greater effectiveness and consistency. A good example is the Dartmouth study of care provided at the end of life; the overtreatment associated with fragmented care (unfortunately all too common in the United States) results in much higher costs and poorer outcomes for patients.[5]

Collectively, this enormous variation in virtually every type of care provided in the United States, and the overutilization it represents, has significant cost and quality implications—*and provides an enormous opportunity for improvement in both cost and quality.* For example, based on the most recent Medicare data available (2008), the average spending on the over–65 Medicare population was just over $9,000 per person (priced-adjusted by geography). If we could simply move the highest-cost States down to this national average, the country would save $17 billion annually (and $209 billion over 10 years)[6]; if overall spending approached the performance levels demonstrated by the most cost-effective States ($7,000 per person), savings would be $94 billion per year and $1.13 trillion over 10 years. Of even greater note, if performance approached that demonstrated by high-performing organizations, including Intermountain Healthcare, savings would be $160 billion per year, with 10-year savings of $1.9 trillion.[7] Furthermore, because these savings are modeled on organizations performing in the current environment of perverse incentives (providers largely being paid for volume, rather than value), we believe the opportunity estimated here is likely conservative.

We call our proposed solution *Shared Accountability*. *Shared Accountability* requires partnerships and collaboration among all the important healthcare players: physicians, hospitals, other healthcare providers, and—critically—patients themselves. At the heart of the *Shared Accountability* concept is the alignment of incentives around the health of beneficiaries, rather than payment for the services they use. *Shared Accountability* payment models should move toward prepaid, outcomes-based arrangements as quickly as possible.

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[5] John Wennberg, et al., *Tracking the Care of Patients with Severe Chronic Illness*; The Dartmouth Atlas of Healthcare 2008.

[6] Based on price-adjusted Medicare spending per person, with a 4 percent growth in the aged population.

[7] John Wennberg, et al., *An Agenda for Change: Improving Quality and Curbing Health Care Spending* (Lebanon N.H.: Dartmouth Institute for Health Policy and Clinical Practice, 17 Dec. 2008).

We believe this solution can be practically realized, because history has repeatedly shown that healthcare providers are highly adaptable (e.g., the implementation of DRGs in 1983, the managed care revolution in the late 1980's, responses to even the possibility of reform in the first Clinton administration, alignment around EMR "meaningful use" requirements, etc.). The healthcare industry has great capacity to learn and evolve rapidly when incentivized to do so. Additionally, while many components of the *Patient Protection and Accountable Care Act* stirred controversy in the provider community, there was widespread concurrence across the country supporting the *concept* of "accountable care." Many healthcare providers throughout the United States now agree that changes in the delivery system are inevitable and necessary; the status quo is no longer a viable option. We need to change the regulatory and payment system to incentivize our intended outcomes (lower per-person expenditures and higher quality of care), something that across-the-board reductions in per-use payments will not accomplish. Only by fundamentally changing the system can we truly solve the Medicare deficit problem for future generations of Americans.

Shared Accountability: Key Principles

Through practical experience, Intermountain and other organizations have discovered and demonstrated a number of key principles that can deliver high-quality healthcare at the lowest appropriate cost. We believe that if Medicare and Medicaid programs align incentives in such a way as to be consistent with these principles, organizations across the country would be able to move healthcare in the United States to a much more effective paradigm.

1. Medicare (and other payers) should move from paying providers for volume to paying for what Americans really want: healthy beneficiaries. We suggest that the Federal Government should move to full prepaid, outcomes-based arrangements for Medicare beneficiaries as rapidly as possible.

The old cliché that "you get what you pay for" has proven true in healthcare, but not in a beneficial way. For decades, American health providers have been paid for the volume of care they provide to their patients. It is not surprising, therefore, that studies have shown substantial overutilization in many areas and that more intensive (and remunerative) procedures are frequently chosen over less intensive, but equally effective, alternatives. In our experience, this impact is often subliminal: many providers don't even recognize the incentive directly, but the very culture of care is impacted by it. We frequently adopted the mentality of "it probably won't hurt; we might as well try it."

If the fundamental Medicare payment mechanism were rebuilt around value—quality and cost measured at the beneficiary level—the beneficial impact would be enormous. And because Medicare, which is by far the largest healthcare purchaser in the country, tends to establish the payment mechanisms that others adopt, we can reasonably expect that these benefits would accrue to the rest of the population as well.

These general concepts have been proposed by both Democrats and Republicans, and there is much agreement that greater accountability, especially in the payment mechanism, is essential to making fundamental improvement in the way care is delivered. It makes sense from both a free-market and a social-conscience perspective. In spite of this, there has been little progress in this area. Currently, Medicare Part C is the only full prepayment arrangement for managing the totality of health for Medicare beneficiaries, and less than a quarter of Medicare beneficiaries are enrolled in this program. Additionally, because Medicare Advantage is designed primarily as an insurance program, most plans are not highly integrated with healthcare providers; so while the insurer is paid in a way that discourages unnecessary utilization among their beneficiaries, delivery systems and providers are still generally paid on per-use arrangements with few value-oriented incentives.

We believe this situation should be fundamentally changed. Accountability for Medicare beneficiaries should move toward prepayment in a deliberate but expeditious fashion. The following principles discuss some of the key components of such a course.

Congressional Action: *Congress should make it clear that the current Medicare payment trajectory will be significantly reduced and that providers will become accountable for the total cost of care for the population they serve. Prepayment for the care of "traditional" Medicare beneficiaries should be made available to willing provider organizations beginning in 2013.*

2. The best results come about when healthcare providers behave in an organized, collaborative fashion. Whenever possible, make use of existing healthcare infrastructure and relationships, while encouraging growth in beneficial relationships over time.

Repeated studies and analyses have shown that organized care delivery systems can be much more effective in providing high-quality, efficient care than the more common fragmented amalgam of healthcare providers. The logic behind this is clear: A system can reduce duplication, coordinate the services of different specialties, provide the most effective diagnostics at the most effective time, and reduce the likelihood of conflicting treatments. It is also more able to identify and eliminate quality and cost problems and to take effective action to fix them. Systematic, coordinated care is more consistent, more efficient, and more attractive to patients.

But while the benefits of systematic care are widely recognized, the question of how to move from our current fragmented approach to a coordinated system is still hotly debated. Some advocate moving entirely to organized systems with employed, salaried providers, while others advocate approaches that use independent practitioners. The collective experience of many high-value organizations suggests that if correct incentives are provided (as discussed above), many different organizational approaches have the potential to achieve dramatically improved performance. In a widely hailed article, well-known physician-teacher-author Atul Gawande pointed out sterling performance in coordinated care by two diametrically different organizational approaches: first, the Mayo Clinic, an organization with more than a century of history, a deep culture, and a very cohesive corporate structure, and, second, the medical community in Grand Junction, CO, which is constituted largely of independent physicians and an independent hospital that got together to create a virtually integrated system with a common electronic medical record, changed the payment structure, and put a coordinated focus on value improvement.[8]

High-value organizations across the Nation have come from markedly different communities, history, and culture, and yet have achieved national recognition for both quality and cost-effectiveness. We are convinced that many other existing and potential organizational types can also achieve great improvements in value. Therefore, we believe that any "reform" program that is rigidly prescriptive about organizational structure will miss an opportunity to make effective use of organizations that already exist, many of which have the potential to significantly improve healthcare value if appropriately incentivized. Furthermore, American ingenuity may develop beneficial structures and approaches that have not yet been envisioned. An inflexible design would push many willing and engaged participants out of the race before they even get to the starting line. What matters most is that existing or future healthcare organizations, regardless of their configuration, be rewarded for delivering on the promise of improved quality and reduced costs.

Regulations must make it safe and feasible for physicians and other providers to work together in ways that improve value to the community through the provision of optimal care. They must be able to share information, coordinate incentives for quality and efficiency, and receive payment collectively from Medicare and other payers. Many of today's regulations are designed to protect purchasers (the Federal Government in particular) from inappropriate utilization; for instance, extensive regulation is designed to prevent kickbacks from facilities to physicians for providing (potentially unnecessary) care at their institutions. Under a prepayment approach, however, this whole problem simply evaporates, since unnecessary utilization results in financial harm to the providers rather than to the payer (CMS in this case). Similarly, regulations should monitor competition among systems providing care, not among the individual providers within a system. Again, if CMS (and potentially others) prepay for all of an individual's care, then the costs of the individual components become the concern and accountability of the coordinated system itself. Only at the system level can care be coordinated in a way that maximizes value to the purchasers and, ultimately, to the community.

Congressional Action: *For organizations that accept prepayment, provide relief from the regulations that are designed to prevent overutilization. If an organization accepts prepayment, overutilization harms the organization rather than CMS, rendering the regulations unnecessary (since the organization will be motivated to police itself). Relief from these regulations would save a great deal of money for both providers and the Government and would be an attractive inducement to participate in prepayment.*

3. Flexibility should be allowed for organizations to develop new models of care that are not constrained by the walls of a hospital or clinic.

Government healthcare programs have, understandably, tended to regulate existing structures. The unintended consequence has been to entrench those structures, which often hinders trial and adoption of new and innovative care models. Historically, payment structures have reinforced traditional silos of care (e.g., physician

[8] Atul Gawande, "The Cost Conundrum," *The New Yorker* (1 June 2009).

care, inpatient care, outpatient acute care, hospice care, homecare, etc.), an approach that ultimately works against the patient's best interest. If organizations take on prepaid, outcomes-based arrangements with Medicare, they should be given the freedom to coordinate care in the way that best meets the needs of the beneficiaries they serve. For instance, innovative home-based and community-based models for advanced illness management and end-of-life care, including those that incorporate telemedicine and significant care management resources (which under current payment mechanisms are not compensated costs), are frequently just what the patient and family desire. Participating organizations should be given the flexibility to care for patients in the settings and with the approaches that best meet their individual patients' needs.

Congressional Action: *Legislation should direct CMS to allow organizations that accept prepayment and accountability for the health of Medicare beneficiaries to deliver care outside of traditional silos. Legislation should also direct CMS to view results (cost, quality, and service) as the key performance metrics, and process measures should be used only when an outcome measure (result) is unavailable or inadequate in a given area.*

4. The patient-provider relationship should be seen as a healthcare partnership. Both parties must be given the tools and incentives to work together to efficiently maintain and improve beneficiary health.

If either providers or Medicare beneficiaries feel they are being forced into a new Medicare program, even if evidence has shown such a program will improve quality and reduce costs, there will inevitably be backlash from the outset. Willingness to engage in a partnership and active participation of both parties will be critical. In our experience with innovative care models, we have seen that the majority of both patients and providers are agreeable to participation in something new when they are given the choice to do so, when the incentives (financial and otherwise) are aligned, and when they have the knowledge, skills, and tools they need to be successful. All three of these elements will be critical in building a viable program.

Both providers and Medicare beneficiaries will need to initially be given the option to participate in the new model. Traditional Medicare should still be an alternative for both providers and seniors, but the premiums and benefits to beneficiaries and the per-use payments to providers in the traditional program should reflect the fact that it will be a less-efficient paradigm than the new model. If no alternative model is offered, premium, benefit, and provider payment changes are inevitable as a means to rein in the Federal debt; this new model provides an option to avoid those across-the-board changes.

All Medicare beneficiaries opting for the new model will need to select a *Shared Accountability Organization* from which they will largely receive care, including a primary care provider or group of providers who will coordinate their care. This active and explicit selection process is necessary in order for *Shared Accountability Organizations* to identify the patients for whom they are accountable. This selection could be made easier for seniors if Medicare were to provide personalized information to beneficiaries about which *Shared Accountability Organizations* their existing providers participate in. To make this selection requirement politically palatable and to encourage competition among providers in an area, Medicare beneficiaries should be allowed to change their selection periodically if they are not pleased with the quality or service of the organization they have selected.

All providers who opt for the new model will accept accountability for each beneficiary's health and expense. It is not enough for providers to just consent to participate in a *Shared Accountability Organization* and continue to receive per-use payments for health services provided. The governing and organizing body of the *Shared Accountability Organization* will need to be required to build provider payments that incentivize high-value care, including maintaining beneficiary wellness and, when necessary, efficiently returning Medicare patients to health. This is critically important for the success of the program and to separate it from insurance-oriented programs that have not had the ability to motivate effective health-value improvement. So, while we don't believe the Federal Government should specify the details of these arrangements or the organizational structure, we believe it should be clear that individual providers and/or provider organizations must have major participation in the quality and expense incentives.

Similarly, while we believe individual organizations should be free to implement as they see fit, we believe tools for both physicians and beneficiaries that facilitate changing the conversations around care decisions will be important for successful programs. *Shared Decision-Making* is a good example. In *Shared Decision-Making*, patients are fully informed of the true risks and benefits of alternative courses of care, so they can play an active role in selecting the best treatment options to meet

their personal needs and values. (It is important to note that *Shared Decision-Making* tools work best when provider incentives are aligned around the health of beneficiaries, rather than the number and type of healthcare services provided, which is why both elements in concert need to be a part of the model.) Health literacy, price transparency, and other similar tools for both beneficiaries and providers will also likely be part of a comprehensive *Shared Accountability* model.

Congressional Action: *Beginning in 2014, Medicare beneficiaries should be given an incentive to enroll with a prepaid organization. This incentive should be small initially, but increase over the next 4 years (e.g., those opting out should pay increasingly higher premiums over that time).*

5. Accurate and timely data will need to be provided and used. Data are necessary for both managing the health of beneficiaries across the healthcare continuum and for holding *Shared Accountability Organizations* responsible for beneficiary health.

There is currently a great need for improved sharing of data and information in the healthcare industry. In order for this new program to be successful, CMS will need to provide comprehensive data to those providers agreeing to take on accountability for the totality of beneficiary health. Without accurate information, it is very difficult to identify whether best care is being provided, both from a quality and an efficiency perspective. Timely feedback is also critical. Access to the information must be reasonably rapid to impact care patterns. Meaningful, complete, and timely data must be provided to individual physicians and organizations that are willing to take on accountability for patient care and outcomes. If patients are not willing to have their data shared with their *Shared Accountability Organization*, it is impractical for these *Shared Accountability Organizations* to be held responsible for managing the healthcare costs and quality of these beneficiaries.

Additionally, providers (physicians, hospitals, homecare agencies, etc.) working in collaboration in a *Shared Accountability Organization* will need to be able to share data with one another. Currently, there are many barriers to data-sharing that need to be addressed before any successful programs can be built. Providers will need to be given license to share information with one another when the purpose is to improve beneficiary health.

Quality and performance metrics will be necessary to ensure *Shared Accountability Organizations* are not reducing healthcare costs at the expense of long-term outcomes (one of the major criticisms of the managed care movement of the 80s and 90s). Performance metrics should be consistent with those of other programs and payers. We are seeing a growing number of inconsistent (and sometimes incompatible) quality metrics being created by different oversight and purchaser organizations. Metrics need to be harmonized *both* in terms of what is measured *and* how success is achieved. We believe the greatest performance improvement will be achieved if a reasonable number of metrics (those validated as both actionable and important to individual and population health) are utilized across all government payers. The number of metrics required must be operationally feasible, which means a limited core measurement set. In order to motivate individuals and organizations, it is generally best to set goals upfront. Achievement thresholds, scientifically based on recent historical performance of organizations across the country, should be utilized for determining success within quality metrics. If goals are met, providers should logically be able to expect that rewards will follow. The consequences of achieving those goals should be clear.

Congressional Action: *Congress should designate one entity to develop a reasonable number of quality, service, and efficiency measures to reflect value provided to beneficiaries. These measures should be applied to all government programs (all forms of Medicare, Medicaid, FEHBP, CHAMPUS, etc.). This would not only reduce duplication and compliance costs but would also make improvement much more likely than in the current hodgepodge of different and occasionally conflicting measures.*

6. A successful program will give all participants the opportunity to succeed in the short-term, thereby cultivating trust and encouraging provider and public participation and acceptance.

There has been an historical standoff between providers (and geographic regions) that have had high historical per-beneficiary medical expense and those that have had low medical expense. There is more than a two-to-one variation between high-cost and low-cost providers (and regions), and much energy has been wasted in attempting to defend (or condemn) the performance of one by the other. Spokespersons for the low-cost organizations have argued that they deserve a bigger piece of the pie, while the high-cost organizations argue for defending the status quo. Of course, this leads to stalemate and, ultimately, continuation of traditional, unsustainable, cost increases.

We believe there is an approach that allows for a positive outcome for all participants who are willing (and able) to improve healthcare value, both for those who have had historically high cost and those with lower cost.

We suggest that a single, affordable, nationwide, average per-beneficiary rate be defined (lower than the current average rate). That national target rate would then be adjusted to reflect legitimate differences in the underlying cost of providing care in different regions and organizations (which CMS does today for geographic variation in wages and teaching, for example). Of course, prepayment amounts should appropriately reflect differences in underlying risk factors for the specific beneficiaries in each organization. Thus, each organization would have a specific target derived from the national target adjusted to reflect specific differences associated with the region, organization, and the beneficiaries they serve.

Then, over a period of years (5 to 7 seems reasonable), payment to an organization would move from their current per-beneficiary total payment to their organization's target. If an organization is able to improve more rapidly than this "glide slope," it can retain the entire difference in any given year. Of course, high-cost organizations and geographic regions have far more opportunity to improve than do low-cost organizations, so they have far more opportunity to receive major payments. On the other hand, they must work harder and make more changes in order to achieve these, and if changes are not made, they have a potential for significant downside. Low-cost providers, on the other hand, have much less opportunity to achieve large savings but are rewarded by not having to make as many difficult changes. (Appendix 1 has a step-by-step description of the recommended process.)

At the end of this period, the Federal Government would pay a consistent rate across the Nation (with variation only for legitimate input cost differences), which would be significantly lower than the current trend. As discussed earlier, this new, lower rate (and lower growth rate) could dramatically improve the Medicare unfunded shortfall without the need for increased payroll taxes or cuts to benefits.

Congressional Action: *Congress should designate an entity to establish a reasonable nationwide per-beneficiary payment and to define specific cost-adjustment and risk-adjustment mechanisms to reflect legitimate differences among regions and organizations. Congress should enact a program that designates movement from current total pay to this target; the program should allow organizations that are able to accelerate savings beyond this pathway to retain the additional savings. (Savings to the Government will be defined by the targets.)*[9]

7. A transitional period will be necessary.

Some organizations are ready to accept accountability for Medicare beneficiaries today. However, some communities don't have any organization that is remotely prepared to undertake such a challenge. As we noted earlier, we believe that creating correct incentives will unleash tremendous creativity and development activity that, if supported by an appropriate regulatory environment, will lead to surprisingly rapid development of *Shared Accountability Organizations*. If these organizations are then allowed to keep a portion of the savings they earn (as noted in the previous section) while on the path to affordable care, we believe success is very likely. And for every year during the transition, CMS will spend less than it otherwise would have under the traditional system.

This transitional period also can provide the motivation for providers to create the mechanisms necessary to accept shared accountability. Payment in a geographic area would move toward the target regardless of whether the providers in the area worked together to improve value, and CMS would withhold funds (from the fee-for-service payments to all providers) equivalent to this amount. For example, if a 2 percent reduction in spending is required during a year, then CMS would withhold 2 percent of all fee-for-service payments to providers. At the end of the year, if the providers had reduced unnecessary utilization by at least 2 percent, with resultant savings for CMS of at least 2 percent, then the per-use payment withhold would be returned. This would allow providers who reduce unnecessary utilization to avoid a reduction in payment for the services actually rendered. Of course, if utilization is not decreased by at least 2 percent, the withhold would be retained by CMS. *In either case, CMS saves at least 2 percent over what it would otherwise have spent, either through reductions in utilization or reductions in per-use payments.*[10]

Under this approach, providers are incentivized to reduce unnecessary utilization—regardless of their level of formal organization. However, this approach would motivate providers to work together (and to create *Shared Accountability Organiza-*

[9] See Appendix 1 for a more detailed description of the recommended process.

[10] Appendix 2 suggests a legislative approach using the methods discussed under this item that might be useful to achieve short-term cost-saving while this more detailed plan is under discussion and development.

tions of one form or another) so that they would have much better control of their joint performance. Either way, CMS is guaranteed to achieve targeted savings and over time would move toward the target rate. Providers would either have to make improvements in care patterns or simply be paid decreasing amounts based on the old metric. In the short term, this approach would also allow rapid congressional action that would be more strategic and beneficial than simple across-the-board cuts to all Medicare providers (but with the same beneficial impact on the Federal budget).

Congressional Action: *For next year, implement a withhold of 2 percent of payments for all Medicare providers across the country. If the providers in a given geographic region are able to reduce overall utilization by at least 2 percent relative to target, the withhold would be returned to the providers at the end of the year. If not, then the withhold would be retained by the Government. For future years, a targeted trajectory toward a national targeted per-beneficiary amount would be defined; this amount would be paid to organizations willing and able to accept prepayment. For those providers unwilling or unable to accept prepayment, this trajectory would be used to define a withhold percentage (which providers would receive if their utilization achieves equivalent savings).*

CONCLUDING THOUGHTS

This is a pivotal moment in our Nation's history and for the path we must build for a sustainable future. Many important items are up for discussion and debate in the effort to reduce the deficit, but none is more critical in size or scope than healthcare spending. We believe the Nation needs a new approach that will incentivize spending in the right places and for the right things, with a promise of significant savings without harming beneficiaries for whom we have a mutual responsibility. We hope these recommendations serve to launch a new dialog, an exchange of ideas that is perhaps different from what has come before, and a discussion in which there may be a winning option for the Federal Government, Medicare beneficiaries, and the country as a whole.

APPENDIX 1: A STEP-BY-STEP DESCRIPTION OF THE TRANSITION DESCRIBED IN PRINCIPLES 6 & 7

For the sake of clarity, we will examine the transition looking at two hypothetical, but representative communities: one is historically a high-utilizing community while the other is a low-utilizing community. Cost differences based on differences in input cost (e.g. wage differences) are adjusted. Exhibit 1 shows these communities and their cost to CMS on a per-beneficiary basis.

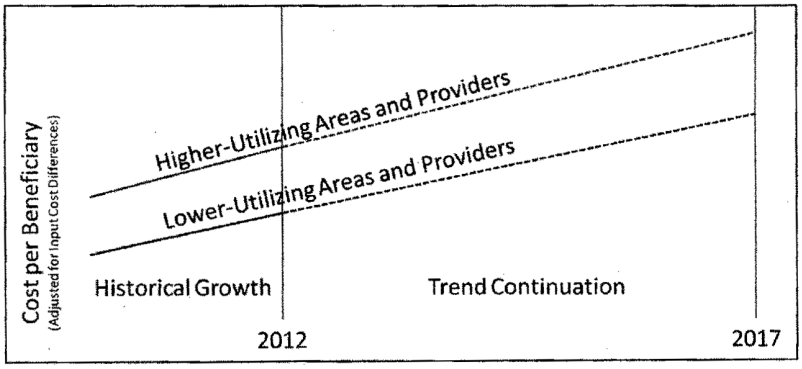

Figure 1

1. Define a target level for an average, national, per-beneficiary expense. This should be a level that would result in a sustainable expense for the Federal Government into the future.

2. Define adjustment factors that would accurately reflect legitimate differences in input costs of providing healthcare among geographic regions (similar to the adjusters to DRGs today).

3. Define adjustment factors for medical risk (Johns Hopkins ACGs are an example) to reflect differences in patient populations: illness, age, etc.

4. For a geographic region or a *Shared Accountability Organization*, apply the cost adjusters and the medical risk factors. This becomes the target for that region or organization. See Figure 2.

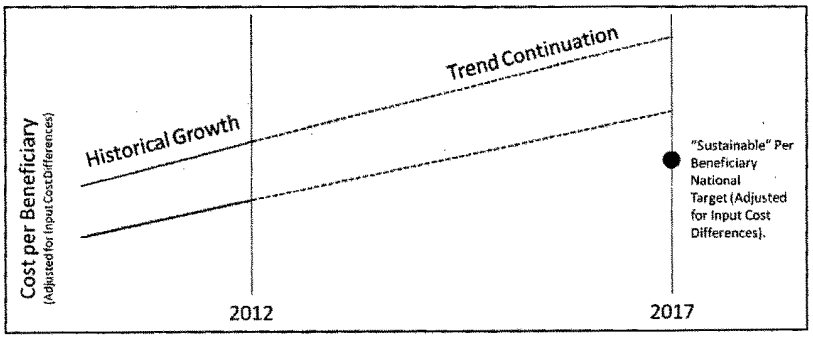

Figure 2

5. Over a defined period of time (we will use 2013 to 2017 as an example), the per-beneficiary paid amount would move from the current expense rate to the target. Figure 3 illustrates trajectories for both high and low utilizing communities (or organizations).

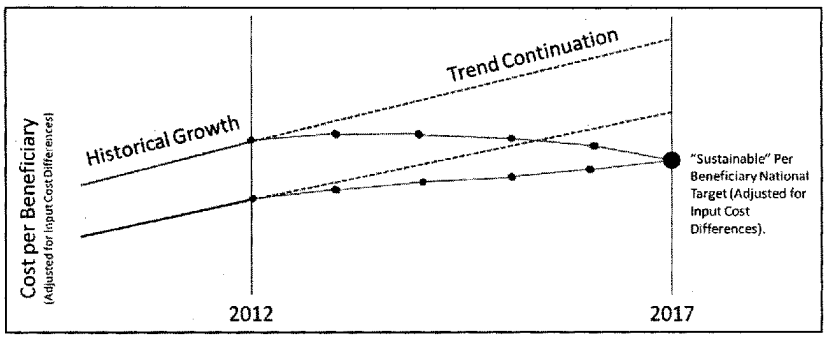

Figure 3

6. If the geographic region does not develop capabilities to accept prepayment, then these targets would be applied to fee-for-service payment (to bring spending into line with the national target). This could be done using a withhold approach. If at the end of the year, the providers had achieved savings in expenditures through utilization, then some or all of the withhold (and, potentially, additional funds) would be distributed (in the following year) to the providers. In this way, CMS could be reasonably assured of meeting the target level, but the providers could also have some control of their income by reducing utilization (which, in our example, would bring utilization closer to national norms).

7. This same example can be used to show how an organized provider group would be incentivized (as opposed to a non-organized geographic region as discussed in the previous step). An organized group could simply be (pre)paid the identified amount to care for those beneficiaries for whom they had accountability. If they are able to reduce expenses below that level, they would retain all of the savings. If they were able, through improvements in utilization (avoiding overtreatment, helping patients manage chronic disease, improving patient safety, reducing re-admissions, etc.), to achieve costs below the defined rate, the providers would retain the entire difference. This is a clear incentive to develop an organized mechanism to accept accountability for care of Medicare beneficiaries and to create mechanisms to provide care for those beneficiaries in an effective manner. *And, of course, the highest cost areas of the country have the greatest opportunity to generate savings (and, therefore, make the most money during the transition).* Figure 4 (which applies to both communities and organizations) shows the opportunity for providers in high-utilizing areas.

The shaded area shows potential opportunity, and this opportunity amounts to tens of billions of dollars—which should get the attention of providers.

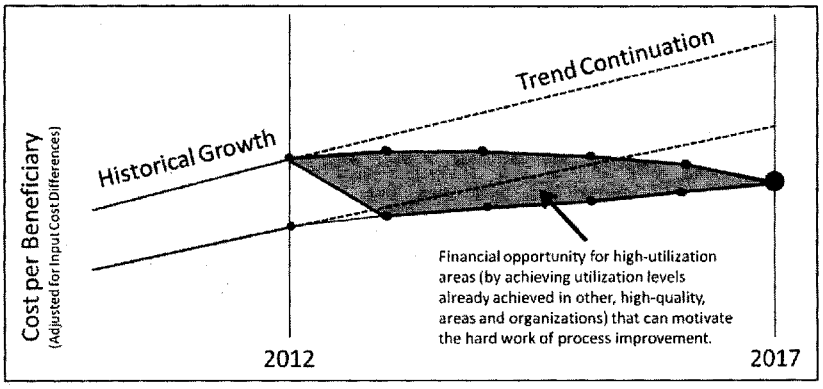

Figure 4

8. CMS would use consistent quality and satisfaction metrics to ensure that quality and efficiency were both being provided. These metrics would be used to generate either bonuses or penalties.

9. While there are potentially billions of dollars available to providers that work hard to manage ineffective or noncontributory utilization and reduce unnecessary costs, the real saver is CMS (and ultimately, the taxpayer). Figure 5 shows the savings as the shaded areas, generated from both low and high utilizing areas and organizations, compared to the historical trend. By simply moving toward practice patterns already demonstrated by high-value localities and organizations, savings to the Government can very realistically approach $100 billion per year by 2017. Indeed, appropriately set national targets would produce savings sufficient to place Medicare on a sound actuarial basis. And shared accountability—with beneficial incentives—could create a new (and sustainable) trend for the future.

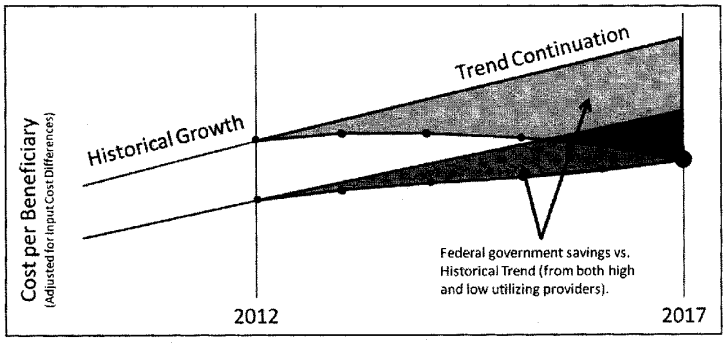

Figure 5

10. In our example, by 2017, all parts of the Nation would have a consistent, fair, sustainable, and affordable rate for Medicare beneficiaries. And as a byproduct, this more effective care delivery would become the model for care provided to non-Medicare consumers as well.

Appendix 2: A Short-Term Approach to Cost Reduction for Medicare

We recognize that the approach discussed in this paper will require substantial analysis and discussion, and that creating both legislation and subsequent regulation is likely to take some time. With this in mind, we also suggest a short-term solution that could be rapidly adopted and that incorporates some of the components discussed in this paper.

If the target is a reduction in per-beneficiary expense, we believe the concepts described in Principle 7 will be more effective than a simple across-the-board cut in fee-for-service payment rates. The enormous and unwarranted variation in treatment volumes in the United States makes it clear that the most powerful way to create major cost savings is through elimination of ineffective and unnecessary utilization. Not only is overtreatment expensive; it is often risky to patients and frequently leads to poor medical outcomes.

Therefore, we suggest that a target rate for per-beneficiary spending be set in each geographic region (based on historical expenditures in that region). Rather than simply lowering the fee-for-service payment rate across the board, we instead propose that CMS withhold a fixed percentage of total fee-for-service payments to physicians, hospitals, and other Medicare providers.

Suppose that in 2012 the initial withhold rate is 2 percent. If the providers in the region keep overall *utilization* at least 2 percent under the target rate, then the withhold money is returned. If the target utilization is not met, CMS keeps the withhold money and returns it to the Treasury. *In either case, CMS saves at least 2 percent over what would otherwise have been spent.* This proposal can therefore be scored by CBO without tenuous assumptions about behavioral responses to financial incentives. Indeed, there could be even greater savings (and shared saving with providers or consumers) if the region kept utilization further below the 2 percent target saving. With a little additional complexity, this same approach could be applied to specific institutions that care for large numbers of Medicare patients (rather than just to geographic regions).

The key benefit to this approach is that it begins to incentivize providers of care to work together to reduce unnecessary utilization. This could effectively prepare them for the next step suggested in this paper: joining together to accept accountability for the health (and associated quality and cost) of a group of beneficiaries.

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Senator WHITEHOUSE. Thank you so much, Mr. Poulsen.

Our final witness is Dr. Mark Fendrick, professor in the Department of Internal Medicine and Health Management Policy at the University of Michigan. He is one of three University of Michigan faculty that developed and named the concept "value-based insur-

ance design," and co-founded the University of Michigan Center for Value-Based Insurance Design.

He currently co-directs the Value-Based Insurance Design Center, which advocates for the development, implementation, evaluation of innovative health benefit plans. We are delighted to have him here.

Thank you, Dr. Fendrick.

STATEMENT OF A. MARK FENDRICK, PROFESSOR, M.D., DEPARTMENT OF INTERNAL MEDICINE AND DEPARTMENT OF HEALTH MANAGEMENT AND POLICY, UNIVERSITY OF MICHIGAN, AND CO-DIRECTOR, UNIVERSITY OF MICHIGAN CENTER FOR VALUE-BASED INSURANCE DESIGN, ANN ARBOR, MI

Dr. FENDRICK. Good afternoon and thank you, Senator Whitehouse. Good afternoon and thank you, Chairman Whitehouse, Senator Franken, and other members of the committee.

I am addressing you today not as a representative of the University of Michigan, but as a primary care physician, a medical educator, and a public health professional. I applaud you for holding this hearing because health care quality improvement and cost containment are among the most pressing issues for our national well-being and economic security.

While there is little disagreement over the fact that there is enough money in the U.S. health care system, research shows that if we spent our medical dollars more frequently on services for which there is clear benefit for improving health, we could enhance quality and contain costs.

Thus, instead of the focus on how much we spend, I suggest we shift our attention to how well we spend our health care dollars.

Moving from this volume-driven to value-based system that the other panelists talked about requires a change in how we pay for care, but it also requires a change in how we engage consumers to seek care. All of these earlier testimonies focused on the critical importance of reforming care delivery and payment policies. Far less attention, however, has been directed at how we can alter patient behavior. Today I propose that clinically nuanced patient incentives are essential for us to bend the health care cost curve.

Now most of us know that the most common approach to directly impact consumer behavior is cost shifting requiring all of us to pay more in the form of increased premiums, and also increased cost sharing at the point of service. Yet in every health plan across America, these cost sharing increases have been implemented in a one-size-fits-all way in that our patients are charged the same amount for every doctor visit, every diagnostic test, and every prescription drug.

Does it make sense to you, Mr. Chairman, that my patients pay the same out-of-pocket to see a cardiologist after a heart attack as to see a dermatologist for mild acne I could barely see. They pay the same co-payment for a drug that could save a life from cancer or heart disease as a drug that will make toenail fungus go away or my hair grow back.

As Americans are required to pay more and more to see all their clinicians and to fill all their prescription drugs, they use less, sig-

nificantly less essential care. Realizing that this lack of clinical nuance was available in all the health plans, the private sector began to implement a concept our team developed known as Value-Based Insurance Design or V–BID.

The central premise of V–BID is to reduce financial barriers to essential, high-value medical services. These are the services that I beg my patients to do such as recommended immunizations, preventive screenings, and critical treatments for chronic conditions that drive the vast majority of our health care spending. It must be stated clearly, though, that V–BID programs never determine what is covered and what is not.

If we are serious about controlling costs and improving health, we must change the incentives for consumers as well as for the providers that we've heard very much about today.

As a physician practicing in a medical home, I find it incomprehensible to realize that my patient's insurance plan does not offer easy access for those exact same services for which I am benchmarked. Does it make sense that I personally am offered a financial bonus to get my patient's diabetes under control when her benefit design makes it prohibitively expensive to fill her insulin prescription or afford the co-payment for her eye exam?

Momentum for the V–BID concept is rapidly growing in the private sector. Hundreds of self-insured employers, public organizations, unions, and insurance plans have designed and implemented V–BID programs. The Federal Government should not erect barriers to the adoption of V–BID. And maybe more importantly, it should encourage the expansion of V–BID principles into both public and private programs.

They could do this by avoiding rigid requirements for essential health benefit plans. By maintaining flexibility and benefit designs with respect to State health exchanges, revising Medicare's one-size-fits-all cost sharing, and allowing innovation such as variable copayments in strained Medicaid programs. Details for these specific recommendations are provided in my written testimony.

I will close by saying as a practicing clinician, I believe that the goal of our health care system is to produce health, not save money.

I strongly concur that health care cost containment is absolutely critical to our Nation's fiscal health. Importantly, the cost containment initiatives being considered by this panel should not produce reductions in quality of care.

That said, the use of these clinically nuanced incentives to encourage both providers and patients is an important step toward a more effective and efficient health system. This common sense, feasible approach will ultimately produce more health at any level health expenditure; 10 percent more the same, or 10 percent less. I believe this is an opportunity that we can't afford to miss.

Thank you, Mr. Chairman, and I will take questions from the panel as well.

[The prepared statement of Dr. Fendrick follows:]

PREPARED STATEMENT OF A. MARK FENDRICK, M.D.

SUMMARY

Research shows that if America spent its health care dollars on services with solid evidence of clinical benefit, we could simultaneously enhance quality and reduce costs. Thus, instead of focusing on *how much* we spend on health care, we should consider *how* we allocate our scarce health care dollars in order to maximize the amount of health produced for the money spent. While the critical importance of payment reform is well-described, far less attention has been directed to how we can alter patient behavior to bring about a more effective and efficient delivery system.

The most common approach to directly impact consumer behavior is cost shifting: requiring beneficiaries to pay more in the form of premiums and increased cost-sharing for clinician visits, diagnostic tests and prescription drugs. To date, patient cost-sharing has been implemented in a "one-size-fits-all" way, in that patients are charged the same amount for every doctor visit, diagnostic test, and prescription drug. However, *increases in patient cost-sharing lead to decreases in the use of both non-essential and essential care.* Peer-reviewed studies show that when patients are asked to pay more for high-value screenings, clinician visits and potentially life-saving drugs, they buy significantly less.

Realizing the lack of clinical nuance in available health plans, the private sector has driven the adoption of Value-Based Insurance Design, or V–BID, that simultaneously addresses quality improvement and cost containment—the two critical goals of health care reform. *The central premise of V–BID is to reduce financial barriers to essential, high-value health services*. A V–BID approach to benefit plans recognizes that different health services have different levels of clinical value. By reducing barriers to high-value treatments and discouraging low-value treatments, these plans result in better health at any level of health care expenditure. Studies show that when patient barriers are reduced, compliance goes up, and, depending on the intervention or service, total costs go down. If we are serious about "bending the cost curve" *and* improving health outcomes, we must change the incentives for consumers as well as those for providers. Any effort to control costs should include clinically nuanced, not price-driven, strategies such as V–BID.

V–BID is being widely implemented by health plans and employers; however, Federal Government programs are lagging far behind. The Federal Government should not erect barriers to the adoption of V–BID in the private market, and it should consider ways to expand V–BID in public programs. In particular, the Government should avoid rigid essential health benefit requirements that might have the unintended effect of prohibiting value-based principles. It should maintain flexibility and limit mandates in benefit designs with respect to State health exchanges. V–BID should be applied more broadly to include secondary prevention; allowing high-value secondary prevention services to be made available without patient cost-sharing would address the high costs of managing chronic disease—and could significantly impact aggregate medical spend. Finally, we should fix Medicare's "one-size-fits-all" cost-sharing that dates back to the 1960's and encourage the use of V–BID principles in Medicaid plans.

The goal of health reform should be to improve Americans' health *and* address rising costs. Approaches such as V–BID, that allow patient co-payments to vary based on whether an intervention is high-value or low-value, can help meet this goal. This is an opportunity we cannot miss.

Good afternoon and thank you, Chairman Harkin, Ranking Member Enzi, and members of the committee. I am Mark Fendrick, Professor of Internal Medicine and Health Management & Policy at the University of Michigan. I am addressing you today, not as a representative of the University, but as a practicing primary care physician, a medical educator, and a public health professional. I have devoted much of the past two decades to studying the clinical and economic impact of health care innovation, and founded the University's Center for Value-Based Insurance Design in 2005 to develop, implement and evaluate innovative health insurance designs to ensure efficient expenditure of health care dollars and maximize benefits of care.

Mr. Chairman, I applaud you for holding this hearing on "Improving Quality, Lowering Costs: The Role of Health Care Delivery System Reform" because quality improvement and health care cost containment are among the most pressing issues for our national well-being and economic security. We are well aware that the United States spends far more per capita on health care than any other country, yet lags behind other nations, that spend substantially less, on key health quality

metrics. However, research shows that if we spent our health care dollars wisely on services for which there is clear evidence for improving clinical outcomes, we could simultaneously enhance quality and reduce the amount we spend. Thus, instead of the unwavering focus on *how much* we spend—I suggest we shift our attention to *how* we spend our increasingly scarce health care dollars in order to maximize the amount of health produced for the dollar spent.

FROM A VOLUME-DRIVEN TO VALUE-BASED SYSTEM

Moving from a volume-driven to value-based system requires a change in both how we pay for care (supply side initiatives) and how we engage consumers to seek care (demand side initiatives). Other testimonies today and at earlier committee hearings have focused on the critical importance of reforming care delivery and payment policies. Far less attention has been directed to how we can alter patient behavior to bring about a more effective and efficient delivery system. While you have heard about the potential of Accountable Care Organizations, Patient-Centered Medical Homes, bundled payments, and other initiatives to influence providers, today I propose that similarly aligned patient incentives are essential for each of these programs to accomplish their objectives and for us to really "bend the cost curve" for health care.

Over the past few decades, payers have implemented multiple managerial tools to constrain health care cost growth. The most common approach to directly impact consumer behavior is cost shifting: requiring beneficiaries to pay more in the form of increased premiums and increased cost-sharing for clinician visits, diagnostic tests and prescription drugs. In nearly every health plan across America, *cost-sharing has been implemented in a "one-size-fits-all" way, in that patients are charged the same amount for every doctor visit, diagnostic test, and prescription drug* [within a specified formulary tier]. Cost-sharing increases are similarly passed on without any regard to clinical nuance. Does it make sense to you, Mr. Chairman, that my patients pay the same co-payment to see a cardiologist after a heart attack as a dermatologist for mild acne, or the same co-payment for a drug that could save a life from cancer or heart disease as a drug that would make toenail fungus go away or hair grow back? In the typical $5 generic drug tier available to most Americans, there are drugs so valuable I have often reached into my own pocket to help patients fill these prescriptions; while for the same price there are also drugs of such dubious safety and efficacy, I honestly would not give them to my dog. This "one-size-fits-all" system lacks any clinical nuance, and frankly, to me, makes no sense. *Such an approach fails to acknowledge the well-documented differences in clinical value among medical interventions.*

As Americans are required to pay more to visit their clinicians and fill their prescriptions, a growing body of evidence demonstrates that increases in patient cost-sharing lead to decreases in the use of both non-essential *and* essential care. Peer-reviewed studies reveal that when patients are asked to pay more for high-value cancer screenings, clinician visits and potentially life-saving drugs, they buy significantly less. A noteworthy example is a *New England Journal of Medicine* study that examined the effects of increases in copayments for doctor visits in Medicare Advantage plans.[1] As expected, individuals who were charged more to see their physician went less often; however, these patients were hospitalized more frequently and their total medical costs increased. This seemingly counterintuitive effect simply demonstrates that the age-old aphorism, "penny-wise and pound-foolish," applies to health care.

VALUE-BASED INSURANCE DESIGN [V–BID]

Realizing the lack of clinical nuance in available health plans, more than a decade ago the private sector began to implement a concept our team developed known as Value-Based Insurance Design, or V–BID, that simultaneously addresses quality improvement and cost containment—the two critical goals of health care reform. *The central premise of V–BID is to reduce financial barriers to essential, high-value health services.* These are the services I beg my patients to do, such as recommended immunizations, preventive screenings, and critical medications and treatments for individuals with chronic disease such as asthma, diabetes and mental illness.

A V–BID approach to benefit plans recognizes that different health services have different levels of value. It's common sense—by reducing barriers to high-value treatments (through lower costs to patients) and discouraging low-value treatments (through higher costs to patients), these plans result in better health at any level

[1] Trivedi, A. *N Engl J Med.* 2010 Jan 28;362(4):320–8.

of health care expenditure. Studies show that when patient barriers are reduced, compliance goes up, and, depending on the intervention or service, total costs go down.

To date, most V–BID programs have focused on lowering patient costs for high-value services. For example, these programs make drugs and services for chronic conditions such as diabetes, asthma and heart disease that drive the vast majority of our health care spending, less expensive and more accessible. Though less common, some V–BID programs designed to discourage use of low-value services, such as unnecessary imaging and procedures, have also been implemented. It must be stated clearly that *V–BID programs never determine what is covered and what is not*. Instead of having all branded drugs cost $30 out-of-pocket for the patient, a V–BID formulary would, for example, provide certain high-value drugs such as statins for high cholesterol or insulin for diabetes for $10, with other drugs for $50. This clinically nuanced reallocation of services is a necessary component in order to move from a volume-driven to value-based system.

IMPROVING QUALITY AND BENDING THE COST CURVE

Let me be clear, Mr. Chairman, I am not asserting that Value-Based Insurance Design is the solution to all of our health care system's problems. But, if we are serious about "bending the health care cost curve" *and* improving health outcomes, we must change the incentives for consumers as well as those for providers. Any effort to control costs should include clinically nuanced, not price-driven, strategies such as V–BID.

Your committee is currently examining many exciting, some unproven, supply side health reform initiatives such as bundled payments, pay for performance, Patient-Centered Medical Homes, and ACOs. If these initiatives provide incentives to *clinicians* to recommend the right care, it is of equal importance that incentives for the *patients* are aligned with these goals as well. As a physician practicing in a medical home, it is incomprehensible to realize that my patient's insurance plan does not offer easy access for those exact services for which I am benchmarked. Does it make sense that I am offered a financial bonus to get my patient's diabetes under control when the benefit design makes it prohibitively expensive to fill their insulin prescription or provide the co-payment for their eye examination?

I'm pleased to tell you that the intuitiveness of the V–BID concept is driving momentum at a rapid pace in the private sector, and we are truly at a "tipping point" in its adoption. Hundreds of private self-insured employers, public organizations, non-profits, and insurance plans have designed and tested value-based programs. Just a few recent examples include the Connecticut State Employees' Health Enhancement Program, UnitedHealth Group's Diabetes Health Plan, and Blue Shield of California's "Blue Groove" Plan, each of which provide incentives for individuals with chronic diseases to seek the right care at the right time, by the right provider.

But, despite recent advances in the Federal Employee Health Benefits Programs, and the requirement that private plans provide selected primary preventive services with no patient cost-sharing in Section 2713 of the Patient Protection and Affordable Care Act [PPACA], Federal Government programs are lagging far behind. *The Federal Government should not erect barriers to the adoption of V–BID in the private market, and it should consider ways to expand V–BID among public programs.*

Provided below are some potential policy approaches:

1. **Avoid Rigid Essential Health Benefit Requirements:** As stated above, there is substantial movement in the private market toward greater adoption of V–BID. Setting uniform requirements for co-pays and deductibles can have the unintended effect of prohibiting value-based principles. The potential result of strict cost-sharing requirements without clinical nuance would be underuse of high-value services and overuse of low-value services. Additionally, as the Institute of Medicine (IOM) argued in its recent report, the essential health benefit package should evolve to promote more value over time.

2. **Maintain Flexibility and Limit Mandates in Benefit Designs with Respect to State Health Exchanges:** Value-based designs generally raise the actuarial value of a plan, even though they may reduce health spending in the long run, because they lower the up-front cost and therefore lead to increased use of high-value services. Under PPACA, plans in each tier—platinum, gold, silver and bronze—have corresponding limits in actuarial value. Consequently, States and the Federal Government should take care when mandating specific benefits and services for plans. Too many prescribed benefits will exclude value-based designs, especially for the bronze and silver plans, which will be sold to the very low-income populations who have the potential to benefit most from V–BID.

3. **Expand Secondary Prevention:** While the removal of patient cost-sharing for preventive services is commendable, the V–BID premise of reduced patient cost-sharing for high-value, evidence-based care has important implications beyond preventive services as mandated in section 2713. The definition of preventive services in PPACA is narrow, focusing on primary prevention. Evidence-based services for those with identified chronic diseases, such as eye examinations for those with diabetes, behavioral therapy for individuals with depression, and long-acting inhalers for asthma sufferers, offer as much or more value than those preventive services identified in section 2713. These services, often referred to as "secondary prevention," are typically the foundation of quality improvement programs, such as pay for performance, disease management and health plan accreditation. Allowing high-value secondary prevention services that would be made available without patient cost-sharing, similar to those primary prevention services selected in Section 2713, would be an important extension of the health enhancing and cost containment goals of health reform.

4. **Fixing Medicare's "One-Size-Fits-All" Cost-Sharing**: The Medicare "one-size-fits-all" approach to copayments dates back to its inception in the 1960s. The Medicare Payment Advisory Commission (MedPAC) has repeatedly advocated the use of V–BID as a long-run measure for improving quality and lowering spending. For example, in its 2010 Report to Congress, MedPAC wrote that V–BID could be used to tailor Part D cost-sharing requirements to individuals' clinical needs. Additionally, Senators Stabenow and Hutchison introduced a bipartisan bill, S. 1040, "Seniors' Medication co-payment Reduction Act of 2009" to allow a demonstration of V–BID within Medicare Advantage plans. The Federal Government should remove the barriers to enable the implementation of this innovative approach.

5. **Encouraging Innovation in Medicaid:** Finally, within Medicaid we see States, under pressure to cut Medicaid spending, raising copayments on an extremely cost-sensitive population without any regard to clinical nuance. Research demonstrates that these co-payment increases will cause some patients with chronic conditions to forgo care and end up in an emergency room or hospital, which could result in higher overall spending.

CONCLUSION

It is my hope that as you consider changes to the delivery system, you will take the common-sense step of allowing co-payments to vary based on whether an intervention is high-value or low-value. As a practicing clinician, I believe that the goal of our health care system is to produce health, not to save money. That said, I strongly concur that health care cost containment is absolutely critical for our Nation's fiscal health. The goal of health reform should be to improve Americans' health *and* address rising costs by utilizing strategies that produce a more effective and efficient health system. Value-Based Insurance Design is one step toward reaching that promise. The use of clinically nuanced incentives (and disincentives) to encourage or discourage patient and provider behavior will ultimately produce more health at any level of health expenditure. This is an opportunity that we cannot miss.

Thank you.

Senator WHITEHOUSE. Thank you very much. I am really delighted that you all are here. We sometimes seem to be blundering through a cloud of mixed information here in Washington, and we are looking at the health care system as a real priority.

Admiral Mullen, who is the Head of the Joint Chiefs of Staff has said that our national debt is the No. 1 threat to our national security. And if you look at what the reason is for our national debt and deficit, whether you are looking at Congressman Ryan or President Obama, they agree that, at its heart, it is health care.

Solving this is a very short jump to recognize that solving the health care dilemma is vitally important to America's national security. Through this cloud of information and misinformation, your organizations are showing the way, showing they can actually, practically be accomplished. And that what Dr. Kaplan described as, "The path to better health and long-term health care is the path to lowered cost," is the secret.

We seem to have missed it. There is an awful lot of politics around this issue, as you may have noticed in Washington. But beneath all of that, there are some really practical solutions that you all are bringing to life. So it means a lot to me that you are here.

Dr. Kaplan, in your testimony you used the phrase "cultural transformation," about what happened at Virginia Mason, and I can appreciate that. One of the ways that you make cultural transformation happen is with extraordinary leadership and clearly you have shown that.

But in order to sustain cultural transformation, it helps to have something that has been mentioned a lot in this hearing, which is incentives. The incentives have to be aligned and pointing in the direction that you want to proceed, otherwise it is just going to be a lot more difficult.

We do our best here to try to figure out ways to realign those incentives, one of the problems that we face is that from your side, you face innumerable payers. The incentive signal gets confused by what private insurance companies, government programs, and other entities that are compensating you for care, or how they are sending those signals.

Out of that complex cloud of payer confusion, the sort of Babel of the payers, what are some of the simplest and clearest ways that you think we, in Congress, could have an effect? Dr. Kaplan first, then Mr. Poulsen.

Dr. KAPLAN. I think that the history of health care payment suggests that Medicare really does set the tone. It does more than set the tone, so that I believe it is, as Mr. Poulsen has suggested, that we do need to move much more expeditiously to modify a payment system in the public sector.

I think that Medicare and our State governments who have similar economic challenges have an opportunity to, in a substantive way, modify payment. And we will see the commercial private sector move as well.

But I think there is even a bigger issue and that has to do with transparency. We don't have transparency in this country. We don't actually—in health care. No other industry, as I see it, actually has the kind of veil or a camouflage between the buyer and seller of services that health care has today.

So I believe that if we had transparency, the potential of the kind of All Care Act, as I see it, is one of the last chances of a market-based system that could actually lead to a market whether it was Medicare and Medicare Advantage as part of Medicare, or the commercial sector. That we would actually be able to understand what we are buying, what we are paying for it.

Employers in this country are becoming increasingly noncompetitive in global economy because of, just like the Federal Government, line item health care costs. They don't even know today that their health plans are paying some providers more for certain services than others, actually for the same service with perhaps even inferior quality.

I think we need to use the power of the public sector, while also, whether it is mandates or whether it is some other vehicle to create more transparency. That it actually allows there to be an understanding between the buyer and seller of services, people paying

the bills, government, employers, and individuals increasingly understanding how much skin in the game they have, what they are paying, and what they are getting. And I think that will then drive a better alignment of incentives.

Senator WHITEHOUSE. And do you agree with Commissioner Koller that having 6 or 7 cents out of every health care dollar being spent on primary care is a sign of something gone wrong? And that we need to raise the proportion of the health care dollar that is spent on primary care, so that it is lower than, say, insurance company overhead, which is higher than 6 or 7 cents out of every health care dollar right now?

Dr. KAPLAN. Absolutely. I think that we need to take a look at what we are really spending our money on in this country, and where we are getting the benefit or not. And I think primary care is one of those areas that has been undervalued historically in the fee for service RVU-driven relative value unit-driven, procedurally driven, old economy of health care, which happens to be alive and well today.

We need to flip that paradigm because that is where tremendous value accrues prevention, partnering with communities, schools, churches, and senior centers. That all happens as an extension of, what many call, an accountable medical home. And I think we need to help support those, and then we can rationally use what is wonderful specialty care and procedural care system in our country. But primary care is disproportionately disadvantaged today.

Senator WHITEHOUSE. My time in this round has expired. I will turn to Senator Franken, but we will continue the discussion. Thank you.

Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Mr. Chairman. My State of Minnesota has been a national leader in providing high quality, low-cost care, yet receives extremely low Medicare reimbursements. The average reimbursement for Texas, for example, is about 50 percent more than in Minnesota per Medicare patient, but we have better outcomes.

This isn't about pitting Minnesota against Texas, but it is about incentivizing States to do the right things—the things that Minnesota has been doing and the right things that many hospitals have been doing.

So the Affordable Care Act applied the Value Index to Physicians and Clinics only, but not hospitals. And it seems to me that that approach hurts hospitals that are providing high care, high-value care because it reduces their payments.

Does anybody here have an opinion on that, Dr. Kaplan, Mr. Poulsen especially? Should hospitals be included in the value index?

Mr. POULSEN. I would be happy to address that. Maybe slightly indirectly and suggesting we think that the answer ultimately should yield similar costs across the country in all communities for care of Medicare patients.

Clearly, there are going to need to be adjustments for differences of input costs. It simply costs more to hire nurses, and build build-

ings, and maintain property and equipment in Manhattan than it does in Salt Lake City.

That said, the kind of discrepancies that you have discussed, we think, are best eliminated in the most effective way possible. We think that an effective way to do that over time is to reward the providers, all the providers, doctors and hospitals, for moving in the direction of most effective and efficient care. That is a slightly roundabout answer to the question, but that would clearly be our perspective.

Dr. KAPLAN. I would agree. I think that on the one hand we are saying we want physicians and hospitals to work together seamlessly. I want our patients to get all the care they need and only the care they need. I want it to be given in the right venue. And when you create an uneven playing field between the physicians and their hospital partners, who should be their partners or colleagues, I think that it creates artificial barriers to accomplishing just what we are trying to do.

I also think that it is important that we recognize that we, the providers—I am a physician and representing a hospital, a medical center—we have a big role to play. We have to do our part. We have to be willing to challenge our old assumptions, take out waste, change the way we think about our work, and redesign it, as I tried to describe, around patients, not around us.

But to do so in an environment that has these barriers and these disincentives, and unevenness through the forces, it is hard not to think about how we are going to change our mindsets and the paradigms in our culture, the cultures and our institutions. And then to have the payment environment and regulatory environment conspiring against us instead of trying to facilitate that, I think it makes it ever more difficult.

Senator FRANKEN. You are talking about the culture in a hospital where people are working together, right. And you have mentioned medical homes and how they work. I know that, for example—and Mayo is used maybe too often as an example from Minnesota because other hospitals in Minnesota do a very good job as well—but one thing Mayo does is its doctors are salaried.

Dr. KAPLAN. Correct.

Senator FRANKEN. So they don't receive any benefit for ordering more procedures. It is health care and not sick care, is sort of the cliché, but it really is. I think I am running out of time, so I will go back to the Chairman, and we will continue this, I guess.

Senator WHITEHOUSE. Absolutely. Chris, one of the things that Dr. Kaplan mentioned in his remarks just a moment ago about transparency was the different payments that are made to different providers for the actual same service. You have looked into that in Rhode Island. Could you let us know what you found?

Mr. KOLLER. As we were trying to understand why we are looking at 8 to 10 percent increases that do not make my stakeholders, the employers who are buying health insurance, very happy, we were struck by the significant increase that health plans were requesting in payments for hospitals. Price increases of 7 to 8 percent, outpatient price increases of something less than that, but high utilization increases. And we also heard from hospitals who said, "We're not getting enough money."

So we used our power as the regulator to collect information from the insurers, actual claims information about what health plans get paid, and then we indexed it to Medicare because Medicare makes adjustments for teaching. They make adjustments for severity. They make adjustments for charity care.

We found for inpatient medical surgical services, a subset, that there were some hospitals that were being paid by commercial insurers 80 percent of what Medicare would pay them. There were other hospitals that were being paid 160 percent of what Medicare would pay them.

The only differences that we could attribute to that was their negotiating power, which leads us to believe—to Dr. Kaplan's remarks about transparency—that to a certain extent, transparency should extend to pricing, particularly for those hospitals which have market power. The costs rise to the level of revenues that are capturable.

And it is on the basis of that, that we tried to intervene in classical, public tradition where there are price controls in place, a price authority in place. That was the basis for our contracting standards.

Mr. WHITEHOUSE. It is one of the strange things about the health care system that for most products, the customer actually brings the price with them. And the price is not found at the point of sale. If I go into a grocery store, then beans cost whatever they cost a pound, and they cost that much, and there is a sign that says, "$1.99 a pound," and that is what it costs, and it does not matter who you are.

When I show up in the health care system, what it cost me to have a particular procedure, has a lot to do with what kind of insurance I have and that the pricing is very disconnected depending on who you are.

Mr. KOLLER. We are inconsistent in our public policy. While on Medicare, we have a very deliberate public setting, rate setting policy with specific factors that we have agreed to. For the other half of the market, for the 50 percent that is private pay, we have a completely opaque system that rewards market dominance.

Mr. WHITEHOUSE. Dr. Kaplan.

Dr. KAPLAN. I just want to say that an unintended consequence of the Accountable Care Act and the movement to promote coordinated care has led to, as I am sure you know, a consolidation, a serious, a significant, what I would call serious, consolidation in many, many markets across the country.

Consolidation happens for different reasons. It may happen, as I believe it does in Intermountain, to create better coordinated, lower cost, higher value care opportunities for communities that otherwise would not have them.

But in many communities and Seattle, frankly, is no exception, Boston is much well-known for this, consolidation is occurring to create even greater market power. And I think there have been several studies done recently which document this, and just as Mr. Koller references, that spread is enormous.

What that does to a hospital that is focused on execution, and on patient experience, and on lowering costs and delivering better value, is it creates an uneven playing field. Now, we are getting

paid less, so we have to manage things in a very different way from the neighbor down the street who is part of a 26-hospital system.

That is a dangerous, unintended consequence of the Accountable Care Act, not legislated, but just market behavior, and I think we need to be vigilant as a society around this.

Mr. WHITEHOUSE. Commissioner Koller talked about the employers of Rhode Island as being his constituents. And Dr. Kaplan, you described some of the ways in which Virginia Mason has reached out to significant employers in your area. And I know, Mr. Poulsen, from our discussions that you try to engage with the business community in this area.

It has been a bit frustrating to find a really good model for business engagement on this issue. We have talked to our chambers of commerce in Rhode Island over and over again, and they sort of generally get it, but they have a lot going on. And to focus on this is sometimes more than they can bear.

The Leapfrog Program is very helpful. Bruce Bradley from the Leapfrog Program, you may remember, is a former Rhode Islander. We are very proud of him. But it is built on really big employers who have really big market share and can dictate behavior. And if you don't come from that environment, the Leapfrog model begins to slip in terms of its relevance.

For those of us who really are believers in the potential of reform in our health care system to deliver better quality care, that lowers the cost of the system, and better coordinated care that serves people better, what is the best that you can think of for advice for how to get the business community involved in a helpful way and direct into that path?

Mr. Poulsen.

Mr. POULSEN. I think we believe that, again, incentives are at the heart of what has historically been wrong with the current health care system. So we would encourage businesses to become active in getting it right.

As Dr. Kaplan said, Medicare certainly can lead the way. They are bigger than all of the commercial purchasers put together in most communities. So they can be a catalyst in doing this.

Employers and employer groups, we believe, can take the appropriate following step which is to encourage or demand that they purchase in the same way. Which is, they purchase health through their individual employees and their families rather than purchasing MRIs, and surgeries, and visits. If they will do that, then you've got something that is truly comparable.

One of the reasons that the current system is opaque is because there are thousands and thousands and thousands of items that nobody really understands outside of the medical community that are put together into an episode of care. And to try and tease that out is more difficult than trying to tease out the very detailed bill if you get your transmission replaced. And figure out, "Gee, did they really do that? Is that really necessary? Was that helpful? Could I have gotten it less somewhere else?"

But all understand when we are feeling well, when we are healthy, when we are treated with respect, when we have good outcomes, and to be able to make a comparison at that level is vastly

easier. And therefore, vastly less likely that people will abuse the system and play games.

Senator WHITEHOUSE. Dr. Kaplan, then Dr. Fendrick, then Mr. Koller.

Dr. KAPLAN. I think that employers in this community need to ask the right questions, and I think they have been isolated in some ways, again, from the marketplace, whether it is through their health plans who would prefer they don't talk to the providers. Or whether it is through the brokers, and intermediaries that see their role as packaging things in, all tied up with a nice bow, and giving it to the employer and says, "Your aggregate rate of increase this year will be 8 or 12 percent."

Employers have to ask some questions: what am I getting? What am I paying for? And what are you paying the provider community?

As we sit down at the table, I mean, it sounds very, almost naive but it is about having a simple conversation. When you can actually engage with a CEO or employee benefits vice president, you come to understand how they see quality, what they really want for their workforce.

In our marketplace, collaborative work was recently published in "Health Affairs" in September of this year. The employer community itself gave us five product specifications: same day access, evidence-based medicine, 100 percent patient satisfaction, rapid return to full function, and affordability.

Senator WHITEHOUSE. The article will be placed into the record of this proceeding by unanimous consent.

[The online version of this article may be found at *http://content.healthaffairs.org/content/30/9/1680.full.html*].

Dr. KAPLAN. I just want to say they do have within their means, they have under-leveraged their power in the marketplace. And I think today, they are beginning to feel the pain enough so they are willing to take a look.

And a company like Microsoft, 5 years, 10 years ago it was,

> "I want to manage my health care costs, but I am competing with Cisco, and Dell, and Google, and I will educate my employees, but I am going to give them 100 percent coverage everywhere."

Today they are saying,

> "We need to rethink how we manage our health care expenditures and whether we really want to give 100 percent open access to every single physician, every single hospital regardless of how much it costs."

We need to encourage them to be thinking differently.

Senator WHITEHOUSE. Dr. Fendrick.

Dr. FENDRICK. I think the reason why employers have been driving the value-based both supply and demand side systems is they finally realized that unlike any other sector, their business where they look at what they get for what they spend, for health care, they have historically looked at only what they spend. And they don't think that way when they buy real estate, or when they buy cars, or when they buy computers. And this idea of the product they should be buying, which is health, as opposed to just that

number what they spend is really driving this transformation, at least on the demand side.

Because of this narrow focus on health care costs alone, payers never really knew what the true value of the investment in health was to their firm. And now that we are starting to see these champion employers like Pitney Bowes, and Safeway, and Boeing, and Dell that understand that a healthier workforce doesn't just reduce the amount of patients who go to the hospital emergency room. But they are on disability less. They are on absenteeism less. And, in fact, they provide these nonmedical benefits like retention and morale, which are really hard for academics like myself to measure.

So the more the firms are starting to include these benefits, they are starting to realize the true value of their health care investments. And given that, if things go as planned, by 2014, many of these firms have to make a decision to stay in or stay out. Most of them don't have the information to make an informed decision on the value of their medical spend. And thankfully, I think, the impetus by this committee and the national debate is bringing this discussion to the forefront.

And the more we broaden the benefits in terms of what we get financially in health, in terms of the fiscal responsibility part, it will drive the value proposition that you described faster and higher.

Senator WHITEHOUSE. Thank you, doctor. Mr. Koller.

Mr. KOLLER. Yes, I would like to maybe get your question around how the Federal Government could address this. A couple points, one, the number of people who are getting their health insurance through their employers is decreasing. It is a steady decline. It is somewhere down south of 60 now, between 55 and 60 percent, and that number is not going back up. Once we have figured out—once the new players figure out how to operate without offering health insurance, they will continue to do so.

From a financial standpoint, we need that remaining money to make this system work. So it is very important for us to retain that money in the system.

In our work around developing a health insurance exchange in Rhode Island, we have gone and asked small businesses, "What do you want from an exchange?" And the answer is very clear for them, and it is actually consistent with what has been discussed here. They want employee choice. Because it turns out that if you give employees the choice, they will accept less choice of provider for more comprehensive benefits. That works for a high-value delivery system. It works for Intermountain Healthcare. It works for Virginia Mason teamed with a couple of other folks. And if you give that choice to employees, they will make it because it is their money that they are bringing with that.

So I think that the work around the design of the health insurance exchange will promote competition for high value. Any sort of individual purchase, employee purchase will make these guys more successful, which is exactly what we need.

But there are barriers to that sort of employee choice. They exist deep within the recesses of IRS rulings around tax benefits, and taxation and benefits. And understanding what those barriers are

so that we can make more people want them, because that is what we need, will be very important.

Senator WHITEHOUSE. One quick question, you talked about your Medicare Advanced Primary Care Practice initiative, and the problem you had going into it, to use your words, "Providers hate being jerked in different directions by the conflicting demands of different carriers." And what you were able to do with the Medicare Advanced Primary Care Practice was to get all the different payers together on the same payment model, so that everybody was being dragged in the same direction. And Medicare agreed to do that itself, did it not?

Mr. KOLLER. That is right.

Senator WHITEHOUSE. How easy was it to get them to come in and participate?

Mr. KOLLER. A heck of a lot easier post-Affordable Care Act. I think that Medicare has gotten a direction clearly from statute around the importance of, one, innovation. And two, innovation not just on their terms, but on collaborating with local States.

Medicare, for all of its strength, is only 40 percent of the local market. Our common goal here is delivery system change. So what we had done specifically was to get a group of commercial payers together, implement changes for the patients at our medical home, and then take advantage of Medicare actually changing its rules.

This was a real shift for Medicare. They came and said, "We will adopt to what's being done in the community, rather than the community adopting to what we are saying." You talk about a cultural shift, that is very significant.

I think Medicare, frankly, needs to learn how to do more of that. They are working hard, but I think direction from Congress in general and the appropriate committee becomes very important, because the all payer alignment is critical.

Senator WHITEHOUSE. Good, because part of why we are here today is to help send those messages. And one of the messages that I want to send is that I very much hope that the Administration will take a look at the delivery system reform elements in the Affordable Care Act, take a look at the implementation of them, the innovation center, the various ways in which they are moving forward. And come as quickly as they can to a target of savings that they are willing to point everybody at.

I have said over and over again that I think if President Kennedy had said we were going to bend the curve of space exploration, we never would have gotten to the moon. It was because he put a hard target out there that the whole Federal Government swung toward that target. So every chance I get, I urge the Administration to do that, and I will continue to communicate with Administrator Blum about that.

I know he got a hard time today for the difference between what an actuary can compute and what an administration goal is. But goal setting in every activity, whether it is a corporate activity or a family activity, setting clear goals is how you make yourself accountable for progress. I think that we need to set a lot clearer goals that bring this together.

I take from this hearing three strong messages. No. 1, is that incentives are critical, that the fee-for-service program sends all the

wrong ones, and that we need to figure out the way to get off of that as quickly as possible.

No. 2, that Medicare has a significant role in driving that behavior, just because of its size and scope, and because its billing system is the basis off of which a lot of other payors catch a free ride. So if you change that, they have to change as well as, I guess, payment reform. It boxes above its weight in payment reform because it is the baseline for so many other payers.

And finally that there really, really is true significant potential here for better care to be delivered at a lower cost by coordinating it better and providing the right incentives.

I sometimes bemoan how much I feel we are on the wrong track around here in our discussion of health care, which seems to be often more directed toward political benefit than to the realities of health care.

I had a meeting with George Halvorson back in September. He is the CEO of Kaiser Permanente, which is one of the biggest health care systems in the country. Like I said, he is the CEO. This is not somebody whose opinion one should take lightly. And in our conversation he said this, and I had it transcribed because he was introducing me, and so we have a record of it.

> "There are people right now who want to cut benefits, and ration care, and have that be the avenue to cost reduction in this country and that's wrong. It's so wrong, it's almost criminal."

It's an inept way of thinking about health care. And I will continue to call on it, I think it is really important.

People like me, we can stand in Congress, and talk, and fight to pass laws all day long. Regulators can do what regulators can do. But it is Virginia Mason, it is Intermountain, it is Gundersen Lutheran, and Geisinger, and Kaiser, and Mayo, and all of these organizations that are actually moving on this that are the force that is really going to be convincing to people ultimately here in Washington.

So I thank you very much for the time and the trouble you took to come here. The value of your testimony is considerable. The value of what you have accomplished is even more so. And I hope that you don't mind if I continue to try to work you in every way possible to see to it that the message that you and other CEOs, and managers of health systems have your experience.

The money you saved in addition to the lives you have saved from your sepsis changes. The money you saved as well as the lives you have saved from your diabetes treatment changes. The way you have worked with employers to bring their costs down. That is a message that is, frankly, not being heard in this town anywhere near enough. And if I can continue to drag you into hearings, and into forums, and to try and get you in front of the Administration, and to do whatever it takes to convince people that this is really a productive path to be going down, I want to do it. And if you have ideas for me, to help me do that, I would like to do that as well.

It is 4 o'clock, and I want to let everybody get to their planes and on their way. So the hearing will stay open for purposes of any fur-

ther comment or exhibits that anybody wants to add to the record for an additional week.

The live hearing is now adjourned.

[Additional material follows.]

PREPARED STATEMENT OF SENATOR MURRAY

I first want to thank both Senators Harkin and Whitehouse for holding and chairing for this hearing on how we can reform our health care delivery system.

As I have said before, this is such an important issue—particularly now as we continue to implement the Affordable Care Act law passed this past year. We all know that health care costs play a substantial role in the greater discussion of our national debt and deficit. Fortunately, this landmark legislation contained a variety of provisions specifically intended to improve the quality and delivery of care while at the same time working to bend the cost curve. One of these provisions was the establishment of the Innovation Center at the Centers for Medicare and Medicaid Services, an agency tasked with researching, developing, testing, and expanding innovative payment and delivery arrangements in order to see how we can begin to reward quality not quantity of care in our health care system.

We have already begun to see industry step up to the challenge. In my home State of Washington, the Virginia Mason Health System has been working hard to develop an innovative delivery system that tackles both the cost and quality of health care for its patients. I want to especially thank Dr. Gary Kaplan, chairman and CEO of Virginia Mason Health System, for his appearance today on the panel.

Founded in 1920, Virginia Mason serves as an example for hospitals across the country on how to develop systems of delivery that work to decrease costs and eliminate waste, while simultaneously maintaining high-quality care and patient safety. Through their Virginia Mason Production System (VMPS) management system, modeled after the Toyota Production System, they have achieved significant cost savings. For example, Virginia Mason has saved $11 million in capital investment by using their space more efficiently and reduced their inventory costs by $2 million through reductions in supply chain expenses and other standardization efforts. At the same time they have worked to reduce costs, Virginia Mason has seen an increase in the quality of care for their patients. They have reported an 85 percent reduction in the time it takes to report lab results, a decrease in the length of the course of overall care from 66 days to 12 days, and patient satisfaction increase to 98 percent. Virginia Mason also saw a reduction in the diagnosis time for patients at their Breast Clinic from 21 days after their initial call to just 3 days. In fact, Virginia Mason found that many of these Breast Clinic patients receive their results on the very same day of that initial call to the center.

I want to thank you again, Senators Whitehouse and Harkin for holding this hearing as well as Dr. Kaplan and Virginia Mason Health System for their continued leadership in this field. We need to continue to discuss ways we can reform the way in which we deliver health care so that we can reduce overall costs not only to the government and individuals, but also how to streamline and improve care. I look forward to working with my colleagues on the HELP Committee on this issue.

RESPONSE BY JONATHAN BLUM TO QUESTIONS OF SENATOR WHITEHOUSE, SENATOR ENZI, AND SENATOR ROBERTS

QUESTIONS OF SENATOR WHITEHOUSE

Question 1. What was the process for drafting the final rule of section 3022 of the Affordable Care Act (the Medicare Shared Savings Program for Accountable Care Organizations)? How was input from relevant health care stakeholders sought prior to making the draft rule public?

Answer 1. This Administration and CMS have been committed to a transparent process for implementing the Affordable Care Act that includes feedback from a wide range of stakeholders. We engaged the public and solicited comment and ideas on the Medicare Shared Savings Program regulation for more than a year. On October 5, 2010, we held a Workshop on Issues Related to ACOs that was co-hosted by the Federal Trade Commission and the Department of Health and Human Services' Office of Inspector General. The workshop solicited public comments on the legal issues raised by various ACO models being considered by health care providers. On November 17, 2010, we published a Request for Information in the Federal Register to obtain comment on specific ACO issues, including beneficiary attribution and the special needs of small practices. Information from both of these activities was used to prepare the Shared Savings Program proposed rule.

Published in the Federal Register on April 7, 2011, the proposed rule allowed for a 60-day public comment period. During that time we held a series of open-door forums and listening sessions to help the public understand what CMS proposed to do and to ensure that the public understood how to participate in the formal comment process.

We received over 1,300 comments on the proposed rule and we took all of these comments into consideration in drafting the final rule. Commenters were very helpful in suggesting ways to improve the Shared Savings Program policies, and we have revised many of our policies as a result of those comments. For example, in the proposed rule, ACOs could choose from two "tracks," each of which has at least 1 year of two-sided risk (the ACO would share in some portion of any savings but also be at risk for a portion of any spending over the target). We received comments that some ACOs were not ready to accept two-sided risk. In the final rule, ACOs may still choose from two tracks for their first agreement period; however, the first track does not include two-sided risk. This change encourages participation in the program for ACOs at different levels of readiness.

In the proposed rule, we explained our plan to assess the quality of each ACO using 65 quality measures in 5 domains. Commenters urged us to focus on the most important quality measures and to reduce the number of quality measures. In the final rule, we streamlined the quality measurement to 33 measures in 4 domains to reduce the reporting burden and focus on the important measures.

In the proposed rule, entities eligible to form ACOs independently were limited to the four groups specified by the statute as well as certain critical access hospitals. Commenters urged us to find a way to allow federally qualified health centers and rural health clinics to have a more significant role in ACOs, due to the importance of these providers in providing access to care in underserved areas. In the final rule, we were able to expand the entities eligible to form an ACO independently beyond the four groups specified in the statute and certain critical access hospitals to include federally qualified health centers and rural health clinics. We anticipate that this change will increase the participation in the Shared Savings Program. These are just a few of the changes we made to the final rule in response to public comment. We have greatly appreciated the robust engagement of the stakeholder community in the development of the Shared Savings Program, and we believe that engagement is reflected in the provisions of the final rule.

Question 2. I have long advocated for the Administration to set a cost-savings goal and timeline for the delivery system reform provisions of the Affordable Care Act. Having specific, accountable goals will spur bureaucratic and regulatory efforts to implement, or even expand upon, the ACA's delivery system reforms. Does the Administration have a cost-savings goal, patient outcomes target, or timeline for the implementation of the ACA's delivery system reforms? If not, would the Administration consider setting such goals?

Answer 2. The Administration is committed to reducing costs and improving care in our Nation's health care system. This goal will not be reached all at once or with one single solution. Instead, agencies across the Administration are working to achieve this goal. CMS, with over 100 million people enrolled in our programs, is working to change the current incentives in Medicare, Medicaid and the Children's Health Insurance Program. For example, we are introducing bundled payments so

that provider payments are based on quality, not quantity. We are also launching new initiatives using Accountable Care Organizations and targeted initiatives for Medicare-Medicaid beneficiaries to encourage more coordinated care. Other partners within HHS are focused on prevention, outreach, and performing cutting-edge research.

Achieving delivery system reform requires multiple, simultaneous innovations because the current system is a complex arrangement that delivers a wide range of health care services over many types of settings. Therefore, CMS has not established one goal or target for all of these diverse initiatives. Nevertheless, we are committed to ambitious goals that will revolutionize how health care is delivered in this country where we are able to identify and quantify such goals. For example, CMS set aggressive goals for the Partnership for Patients initiative: a 40 percent reduction in preventable hospital-acquired conditions and a 20 percent reduction in unnecessary re-admissions to hospitals by the end of 2013.

Question 3. Your written testimony noted that following the implementation of the ACA, growth in Medicare per capita spending has declined significantly and Medicare Part D, Medicare Advantage, and Medicare Part A premiums will remain nearly the same for 2012 as 2011. Can this stabilization in cost growth be attributed, in any part, to the Centers for Medicare and Medicaid Services' (CMS) implementation of the ACA's delivery system reforms?

Answer 3. While the reasons behind any change in Medicare cost growth can be complex, it is important to note that overall Medicare cost growth dropped from 7.9 to 4.5 percent between 2009 and 2010; this slow-down occurred at the same time that many seniors with Medicare received cheaper prescription drugs. Many of the expected benefits and savings of delivery system reforms included in the Affordable Care Act have not yet been fully considered in this analysis. We expect that many of these reforms, including Accountable Care Organizations, bundled payment programs, and demonstrations launched by the Innovation Center, will save money for the health care system in the coming years.

Question 4. Is CMS undertaking an analysis of the effect of the ACA's delivery systems reform provisions on health care cost growth? How is the agency evaluating the effect of delivery system reform initiatives when they are implemented (aside from pilots and demonstrations where evaluation is required by statute)? And against what goals or benchmarks?

Answer 4. The Independent Office of the Actuary in CMS annually produces projections for health care spending for multiple categories of National Health Expenditures, including private health insurance, Medicare, and Medicaid. These National Health Expenditures projections would capture any changes in health care cost growth that result from delivery system reforms.

We agree that establishing benchmarks to gauge our progress toward improving the health care delivery system are crucial. Each component of delivery system reform has different goals, targets, and benchmarks to measure success based on the aims of each specific initiative. For example, the Partnership for Patients Initiative is seeking to achieve two goals: reducing preventable hospital-acquired conditions by 40 percent and reducing hospital re-admissions by 20 percent between 2010 and 2013. These goals are associated with specific cost reduction estimates. Further, CMS plans to measure quality across 4 domains in the Medicare Shared Savings program with 33 quality measures spanning Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventative Health, and At Risk Population. CMS expects ACOs to generate estimated savings of up to $940 million over the first 3 performance years as they put in place the infrastructure and redesign processes to focus on coordinating care for populations proactively.

Question 5. What are the Administration's priorities for ACA delivery system reform that have not yet been fully implemented?

Answer 5. The Center for Medicare and Medicaid Innovation (Innovation Center) is beginning to test a variety of different payment and service delivery models to improve health care quality and lower cost. In addition to Accountable Care Organization models, on August 23, 2011, the Innovation Center invited providers to apply to test and develop four different models on bundled payments. Depending on the model selected, providers have flexibility in the Bundled Payments for Care Improvement initiative in selecting conditions to bundle, developing the health care delivery structure, and determining how to allocate payments among participating providers. The Bundled Payments initiative is a key delivery system reform centered on improving quality and efficient care delivery, while reducing costs and increasing care coordination. The Innovation Center has also launched a Comprehensive Primary Care initiative, which is a new multi-payer initiative fostering collabo-

ration between public and private health care payers to strengthen primary care. The CPC will test a comprehensive primary care model for service delivery as well as a payment model that includes a monthly care management fee paid to the selected primary care practices on behalf of their fee-for-service Medicare beneficiaries.

In the last year alone, the Innovation Center has implemented a number of initiatives and models, including those described above as well as the Partnership for Patients, the State Demonstrations to Integrate Care for Dual Eligible Individuals, the Innovation Advisors Program, Federally Qualified Health Centers Advanced Primary Care demonstration, and the CMS Health Care Innovation Challenge. Naturally, as we learn from these early models and demonstrations, we will determine what other areas of research and innovation may be necessary to achieve the further reforms in our health care system.

Question 6. At the hearing, several of the witnesses on the second panel recommend that CMS better coordinate its payment reform efforts across Medicare and Medicaid. Is CMS taking steps to align payment structures between Medicare and Medicaid? If so, what reforms have been undertaken to this end?

Answer 6. CMS is committed to better coordinating care for individuals eligible for both Medicare and Medicaid. Better alignment of the administrative, regulatory, statutory, and financing aspects of Medicare and Medicaid promises to improve the quality and cost of care for this complex population.

On May 11, 2011, the Medicare-Medicaid Coordination Office launched the Alignment Initiative, an effort to more effectively integrate benefits under the Medicare and Medicaid programs. The Alignment Initiative is not simply an effort to catalogue the differences between Medicare and Medicaid, nor is it an effort to make the two programs identical. Rather, it is an effort to advance beneficiaries' understanding of, interaction with, and access to seamless, high-quality care that is as effective and efficient as possible.

The first step in the Alignment Initiative was to identify opportunities to align potentially conflicting Medicare and Medicaid requirements. The Medicare-Medicaid Coordination Office compiled a list of opportunities for legislative and regulatory alignment, grouping ideas into the following broad categories: care coordination, fee-for-service benefits, prescription drugs, cost-sharing, enrollment, and appeals. This list was published in the Federal Register on May 16, 2011, and the public comment period closed on July 11, 2011, bringing in over 100 responses from beneficiaries, advocates, professional health associations, plans, and States. In addition, CMS conducted local listening sessions, which were attended by over 500 stakeholders.

The Medicare-Medicaid Coordination Office has also partnered with the Innovation Center on initiatives designed to improve care for people eligible for Medicare and Medicaid, awarding contracts of up to $1 million each to 15 States to design person-centered approaches to coordinate care across primary, acute, behavioral health, and long-term supports and services for Medicare-Medicaid enrollees. CMS provided information to States about the "State Demonstrations to Integrate Care for Dual Eligible Individuals" via an Informational Bulletin (*http://www.cms.gov/CMCSBulletins/downloads/12–10–2010-Federal-Coordinated-Health-Care-Office.pdf*) and contracts were awarded in April 2011. This initiative was designed to improve care and lower costs for Medicare-Medicaid beneficiaries and identify delivery system and payment integration models that can be rapidly tested and, upon successful demonstration, replicated in other States.

CMS is also taking steps to test models to align payment structures between Medicare and Medicaid. In July 2011, the Medicare-Medicaid Coordination Office, in cooperation with the Innovation Center, advised States of a separate initiative that offers them the opportunity to test models to align financing between the Medicare and Medicaid programs while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees (*https://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf*). The purpose of the Financial Alignment Initiative is to develop, test, and validate fully integrated delivery system and care coordination models that can be replicated in other States. The Medicare-Medicaid Coordination office identified a capitated model and managed fee-for-service (FFS) model as the choices for States interested and committed itself to providing technical assistance to States that meet the minimum standards for participation. Interested States were required to submit a Letter of Intent to participate by October 1, 2011, and 38 States and the District of Columbia expressed interest.

QUESTIONS OF SENATOR ENZI

Question 1. What are the metrics CMS will use to evaluate new delivery system reform models, such as the Bundled Payments for Care Initiative? Specifically, how will you measure savings and quality improvements?

Answer 1. We agree that establishing benchmarks to gauge our progress toward improving the health care delivery system is crucial. Each component of delivery system reform will have different goals, targets and benchmarks to measure success based on the aims of each specific initiative.

For example, in the Bundled Payments for Care Improvement Initiative, CMS is allowing applicants to propose the quality measures by which their care will be tracked, though all applicants will be required to report current Hospital Inpatient Quality (IQr) measures at a minimum. CMS will ultimately establish a standardized set of measures that will be aligned to the greatest extent possible with measures in other CMS programs. Three of the models being tested under this initiative would involve a retrospective bundled payment arrangement, in which a target price for a defined episode of care is set based on applying a discount to total costs for a similar episode of care as determined by historical data. Each delivery system reform initiative will have unique metrics based on the characteristics of the model or initiative being tested.

Question 2. How does CMS plan to expand implementation of coordinated care models that have demonstrated success at integrating care and lowering costs for the Medicare program? Does CMS have a national strategy to scale up successful models?

Answer 2. CMS is committed to expanding successful models, and has a team of staff who can do outreach and spread information on new ideas. For example, CMS recently hosted several Advanced Development Learning Sessions to provide stakeholder organizations with knowledge about what it takes to become an Accountable Care Organization. These events were open to all interested provider organizations and the information is still available on the Innovation Center Web site. Similar learning opportunities will be available for each initiative the Innovation Center announces, and are an important component in CMS' efforts to educate stakeholders and spread successful delivery system models.

Question 3. Mr. Blum, in the final accountable care organization (ACO) rule, CMS chose to exclude indirect medical education and disproportionate share hospital payments from the calculation of a provider's expenditures. However, it included additional payments made to rural providers in this calculation, which sets a higher bar for eligible providers who might want to participate or join an ACO in certain areas. Why did CMS elect to exclude some payments, but not others? Won't this make it more difficult to form ACOs in rural areas?

Answer 3. In both the proposed and final rules, we considered whether to include or exclude a number of different payments from the ACOs benchmark and performance year expenditures. We proposed not to make any adjustments to either the benchmark or expenditure calculations; however, we were persuaded by commenters who suggested that not adjusting for Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payments had the potential to create an incentive for ACOs to avoid appropriate referrals to particular hospitals or providers, for example teaching hospitals. We were concerned that this could deter the provision of care in the most appropriate setting. Therefore, our final rule adjusts ACO benchmark and performance expenditures for IME and DSH payments. Unlike IME and DSH adjustments, however, we do not believe other payments that are included in Part A and B expenditures (such as geographic payment adjustments or other incentive payments) would result in a significant incentive to steer patients away from particular hospitals or providers since ACOs will be compared to their own historical expenditure benchmark that is updated by a national factor. Since each ACO is compared to its own historical expenditure benchmark, we do not believe including such payments will make it more difficult for ACOs to form in rural areas or deter participation of rural providers in ACOs. Furthermore, we announced our advance payment initiative that will provide the opportunity for organizations such as rural- and/or physician-only ACOs with limited revenue and access to capital to receive a portion of their anticipated shared savings up front as a way to encourage the development of ACOs with the infrastructure and expertise to improve and deliver high-quality care while slowing the growth in health care spending.

Question 4. Mr. Blum, does CMS have plans to extend the nationwide Medicare Advantage star demonstration program after 2014? How many other demonstration programs have CMS implemented that were started on a nationwide basis?

Answer 4. The Quality Bonus Payment (QBP) demonstration builds on the bonus payments authorized in the Affordable Care Act by providing stronger incentives for plans to improve their performance thereby accelerating quality improvements. This demonstration will begin in 2012 and will run for 3 years through 2014. Beginning in 2015, the current law provisions for computing QBP will be in effect.

CMS initiated several demonstrations on a national basis since the passage of the Medicare Modernization Act of 2003. These include demonstrations to enhance the Part D program as well as Medical Savings Account (MSA) products.

Question 5. Expatriate plans provide a valuable service to Americans living and working overseas. Often expatriate plans have a much greater administrative burden for the insurance company because there is the need for translation services as well as making overseas claims and setting up overseas networks. It would serve to logic then, that these plans be exempted from the Minimum Loss Ratio (MLR) requirement.

While most expatriate plans have received a short-term MLR waiver, they have not received a permanent exemption. Several companies have contacted the Centers for Medicare and Medicaid asking them to permanently extend the MLR waiver. Without an extension many of these companies have said they will have to move their expatriate plans overseas, which, according to news reports, would result in over 1,100 U.S. jobs lost.

This is not the time for the Federal Government to force regulations on businesses that result in lost jobs for Americans. What are the Centers for Medicare and Medicaid planning to do to ensure that those jobs remain in the United States? Will CMS provide for a permanent expatriate plan MLR exemption? If not, please elaborate.

Answer 5. CMS does not have the statutory authority to exempt certain types of plans from the MLR standard. The statute, however, does allow CMS to take into account the special circumstances of smaller plans, different types of plans, and newer plans. In the interim final rule with comment period, CMS used this authority to implement a multiplier of 2.0 to the MLR numerator for expatriate policies; this adjustment acknowledges the higher administrative costs and volatility of experience in these plans when compared to typical insurance plans, as expatriate plans cover care in all parts of the world in a wide variety of health care systems.

CMS believes that a multiplier of 2.0 is appropriate to ensure that issuers remain in the expatriate market. CMS also believes that the MLR requirements continue to allow U.S. issuers to offer expatriate policies to U.S. employers that want to provide their employees who are working abroad and their dependents with comprehensive health insurance that meets the unique needs of expatriates and provides benefits that are at a minimum comparable to the coverage of their U.S.-based employees.

Question 6. Recent media reports have revealed that parents and other individuals who serve as caregivers for disabled individuals and receive Medicaid subsidies to provide care to these family members are classified as "public employees" by certain State agencies. This classification results in the State, in conjunction with the Service Employees International Union (SEIU), deducting a portion of the monthly Medicaid subsidy provided to these families as "union dues." Is CMS aware of this practice? How many States operate this type or similar arrangements? Please describe CMS' current oversight plan for State Medicaid agencies to ensure that Federal dollars are being spent appropriately on health care services and supports.

Answer 6. CMS takes our Medicaid oversight responsibilities seriously, and works to ensure that Federal dollars are spent appropriately through our oversight and approval of State Medicaid plans, waivers, estimated and actual State expenditures, and other State actions.

The 1915(c) Home and Community Based Services (HCBS) waiver program allows for a State to make payment to "legally responsible" relatives (spouses, parents or legal guardians of minors) under specific circumstances per the terms of the State's waiver application; however, this is an individual decision of each State. Federal Medicaid law and regulations impose certain restrictions or conditions that must be met for States to allow legally responsible relatives to be paid caregivers, which CMS enforces through the State Medicaid plan amendment and HCBS waiver approval processes.

CMS does not keep statistics or otherwise become involved in issues related to the unionization of home care or other health care workers.

Question 7. How is the Administration planning to communicate actions the Secretary will take to establish and operate a Federal Exchange within States that do not create State exchanges? Is the Administration planning to initiate a rulemaking

or issue guidance pertaining to the Secretary establishing a Federal exchange? If so, when does the Administration anticipate publishing a proposed rule or guidance?

Answer 7. When CMS operates an Exchange in a State that does not establish its own, the same regulations apply as for State-based Exchanges. The comment period on the Exchange proposed rules closed October 31, 2011. CMS is currently reviewing the comments received and is working toward finalizing the rules in the near future. We understand that States and issuers are anxious for information and we are diligently working to provide guidance and certainty to accommodate these concerns; we plan to release additional guidance on various topics over the next several months.

Question 8. From what accounts has the Secretary funded the $52,294,545 contract with Booz Allen Hamilton for "Implementation Support" and the $55,744,081 contract with CGI Federal for the "Federal Exchange?" What is the anticipated value of the contract that the Administration is considering for the "data services hub" and from what account will that contract be funded?

Answer 8. The $55,744,081 million CGI Federal contract to build and support the information technology systems for the Federally Facilitated Exchange (FFE), and the tasks on the Booz Allen Hamilton contract for implementation support related to the FFE, were obligated from the Health Insurance Reform Implementation Fund and HHS General Departmental Management as the Booz Allen Hamilton contract supports other CMS initiatives in addition to the Exchanges. Approximately $30 million is also obligated from these funds for the pending award for the data services hub contract.

Question 9. Please provide a detailed accounting (e.g., expenditures by date, payee, purpose, etc.) of how the Administration has spent the $1 billion appropriated to the Health Insurance Reform Implementation Fund created in section 1005 of Public Law 111–152. Do any funds remain in this account?

Answer 9. We recognize that the committee is interested in understanding these figures and will provide them to the committee under separate cover.

QUESTIONS OF SENATOR ROBERTS

Question 1. We have been made aware that there have been over 200,000 comments in response to the preventive regulations, these are the two regulations issued by HHS, Treasury, and Labor implementing section 2713 of the Public Health Service Act (one was issued last summer and one was issued in early August). Does the Administration plan to respond to these comments and if so when?

Answer 1. Given the large volume of comments received, all three agencies are still working to review and understand them. When issued, the final rules will respond to the comments received.

Question 2. Both preventive regulations were implemented through an interim final rule (IFR) process. Does the Administration plan to finalize these IFRs and if so what is the timeline for doing so?

Answer 2. The Administration is working to meet the effective dates that are in the Affordable Care Act. The Administration continues to address comments received on IFRs and will finalize rules as appropriate.

Question 3. Does the Administration plan to finalize any of the interim final rules that were put forth to implement the Patient Protection and Affordable Care Act and if so what is the timeline for doing so?

Answer 3. Because of the timing of statutory deadlines, in some cases we issued interim final rules requesting public comment for 60 days. We have read the public comments that have been submitted and, where appropriate, we adopted the comments in sub-regulatory guidance. The Administration continues to address comments received on IFRs and will finalize rules as appropriate. We also note that recent agency rulemaking has utilized proposed rules, solicited comments, and finalized rules.

Attachment

Health Reform Implementation Fund—Obligations and Outlays as of September 30, 2011

Fiscal year 2011	Through September 30, 2011	
Organization	Obligations	Outlays
Internal Revenue Service	$188,861,953	$112,093,091
Office of Personnel Management	$1,855,701	$435,770

Health Reform Implementation Fund—Obligations and Outlays as of September 30, 2011—Continued

Fiscal year 2011	Through September 30, 2011	
Organization	Obligations	Outlays
Department of Labor	$1,640,450	$1,640,450
Department of Health and Human Services	$242,617,622	$116,469,245
Total Health Reform Implementation Fund	$434,975,726	$230,638,556

RESPONSE BY GARY S. KAPLAN, M.D., FACP, FACMPE, FACPE TO QUESTIONS OF THE HELP COMMITTEE

Question 1. Do you believe that a fee-for-service system is a sustainable model for delivering [financing] health care?

Answer 1. A health care financing system based predominantly on a fee-for-service model is unsustainable. Three years ago, I was one of several chief executives of prominent health care organizations interviewed for a *Washington Post* article about the problems with our country's health care system. The story's headline summed up the CEOs' opinions: "U.S. Not Getting What We Pay For." Sadly, 3 years later, Americans are still paying for a lot of things that aren't necessary when it comes to health care. In fact, of the $2.6 trillion spent on health care in the United States, nearly half of it is waste that adds no value for patients and sometimes even causes harm.

The current health care system is fraught with waste. A fundamental problem with the system is how providers of health care are paid. Under the current fee-for-service model, there are few incentives to keep people out of doctors' offices and hospitals. From the health care provider's perspective, the more you do, the more money you make. More tests lead to more procedures, which can lead to mistakes, complications, misdiagnoses and the use of unproven therapies.

Those picking up the skyrocketing tab include the Centers for Medicare and Medicaid Services (CMS), along with commercial payors and employers. Sadly, our patients pay the highest price as the recipients of substandard care.

Although the fee-for-service model contributes to the ills of our current system, there may be limited small community or service-specific subsets in which it is appropriate.

I hope and anticipate we will get to the point where the U.S. health care system pays providers to rely on the very best evidence, to deliver the right care at the right time, and only the care that is required to improve health.

Question 2. How can we shift Federal health care delivery systems from systems that are based on volume to systems based on value? How can we realign incentives for care?

Answer 2. The shift from volume to value starts with payment reform. At Virginia Mason Medical Center, we're demonstrating now that health care organizations can provide the highest quality care to patients at the lowest cost. In our American culture, this is counterintuitive. We're conditioned to believe that to get the best quality you have to pay top dollar. That's not the case in health care.

In their Health Affairs article, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care," Katherine Baicker and Amitabh Chandra report:

> "The quality of care received by Medicare beneficiaries varies across areas . . . States with higher Medicare spending have lower-quality care. This negative relationship may be driven by the use of intensive, costly care that crowds out the use of more effective care" (2004, W5–185).

Our country can't afford health care costs to continue escalating at current rates. Inevitably, advances in medicine and clinical technology contribute to the costs of care, but these increases in cost can be offset significantly by eliminating variation, including unnecessary and excessive testing, as well as treatments that lead to no benefit.

As Virginia Mason's experience demonstrates, higher quality care is associated with lower costs. In December 2011, Virginia Mason was named a Top Hospital by The Leapfrog Group for our accomplishments in the areas of patient safety and efficiency. Virginia Mason joined the University of Maryland Medical Center-Baltimore as the only two hospitals to receive Top Hospital distinction every year since the recognition program's inception in 2006. For 2011, Virginia Mason is 1 of 52 hos-

pitals in the country to meet Leapfrog criteria for highest performing urban hospitals.

With approximately 1 percent of America's hospitals meeting Leapfrog's quality and resource use criteria, there is work to be done. An important first step is moving from a fee-for-service payment structure to evidence-based care financed by bundled payment, shared savings or provider risk-bearing approaches that require provider accountability for patient outcomes.

The Physician Quality Reporting System, which was established in the 2006 Tax Relief and Health Care Act, was a move toward payment for value. This initiative benefits patients because it provides financial incentives to those providers who achieve the highest quality results.

Further, the rollout of the Patient Protection and Affordable Care Act will include innovative payment approaches, such as bundled payments in preventive services, surgical episodes of care and chronic disease management. Additionally, delivery model innovations, such as Accountable Care Organizations, will promote hospital/physician integration and coordinated patient care across the continuum. Similar models, including shared risk and shared savings, would support better care and ultimately better population health. Further, multi-payor demonstration projects that don't allow cost shifting from CMS to commercial payors hold promise for realigning incentives for care.

As a clinician, I know that my patients are vitally important and often underutilized members of their own care teams. Shared decisionmaking tools offer patients resources for a thorough understanding of treatment options. Additionally, patients who have the information to make informed decisions about their care are more likely to choose less care.

David E. Wennberg, M.D., MPH; Amy Marr, Ph.D.; Lance Lang, M.D.; Stephen O'Malley, MSc; and George Bennett, Ph.D., in their article, "Randomized Trial of a Telephone Care-Management Strategy," in the *New England Journal of Medicine*, stated: "Provider-based studies of preference-sensitive care have consistently shown that decision-making support results in fewer interventions than usual support" (2010). Not only is honoring patient preference the most respectful approach to patient care, it may well be less expensive.

Shifting the delivery system focus from volume to value will require financial incentives, such as strict adherence to quality standards, as a condition of payment. It will also require delivery system reforms and patient engagement.

Additionally, by using efficient, integrated providers as models to set the rates for reasonable cost and quality standards, we all can benefit from the experience of those organizations demonstrating that higher quality care at a lower cost should be the expectation. Finally and most importantly, we must listen to our patients and provide all the care they need and only the care they need.

RESOURCES

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INTERMOUNTAIN HEALTHCARE,
SALT LAKE CITY, UT 84111–1486,
December 5, 2011.

Hon. TOM HARKIN,
U.S. Senate,
731 Hart Building,
Washington, DC 20510.

DEAR SENATOR HARKIN: Thank you for the opportunity to have Greg Poulsen, lntermountain Healthcare's senior vice president and chief strategy officer, testify before the Health, Education, Labor, and Pensions Committee at the November 10,

2011 hearing entitled "Improving Quality, Lowering Costs: The Role of Health Care Delivery System." We applaud the committee for tackling this critical issue and we look forward to further discussions with the committee about how best to transform the delivery system to incentivize high-value health care.

Below are Greg Paulsen's responses to the questions posed subsequent to the hearing.

RESPONSE TO QUESTIONS OF THE HELP COMMITTEE BY GREG POULSEN

Question 1. Do you believe that a fee-for-service system is a sustainable model for delivering health care?

Answer 1. No, the fee-for-service payment mechanism is at the heart of the problem, and any meaningful solution must reduce and ultimately eliminate fee-for-service in order to remove the inherent perverse incentives.

Question 2. How can we shift Federal health care delivery systems from systems that are based on volume to systems based on value? How can we realign incentives for care?

Answer 2. lntermountain Healthcare believes that additional pre-payment mechanisms should be made available as rapidly as possible. Medicare Advantage exists today, but is insurance-centric rather than provider-centric, and generally yields a fee-for-service payment to providers. Providers and beneficiaries should be encouraged to move to pre-payment with a combination of incentives (to develop care management capabilities and to accept prepayment) and penalties (lower fee-for-service payment rates). We spell this out in greater detail in the white paper entitled "Recommendations to Congress for Building Sustainable Medicare Value" that we submitted with our written testimony.

Question 3. Mr. Poulsen, can you discuss in more detail the recommendations lntermountain would make to Congress for constructing a sustainable health care delivery system? How can we best pay for a system that delivers high-quality, low-cost outcomes?

Answer 3. lntermountain's white paper, referenced above, gives greater detail on this as well. The principles for "shared accountability" discuss in greater detail the way we think such an approach could be implemented. Ultimately, risk-adjusted per-beneficiary prepayment is the mechanism we believe would be most effective. And if we use this mechanism to rationalize regional differences in Medicare spending (as described in Appendix 1 on page 16), the savings could place Medicare on a solvent and sustainable footing for decades to come.

Question 4. Mr. Poulsen, will Intermountain apply to be an accountable care organization?

Answer 4. lntermountain is not planning to apply to be an accountable care organization at this time. There are significant structural barriers in the current ACO regulations that we view as highly problematic. lntermountain is concerned about issues of governance and compliance, and we have communicated these concerns to CMS. However, our greatest concern is in the area of attributing beneficiaries to ACOs. We believe that a small minority will be extremely unhappy with being attributed (without the opportunity to opt out, except by changing physicians—to one that doesn't participate in ACOs). We have learned by sad experience that a small subset of outspoken people can do incalculable damage—in this case, both to the Government program, but also to the provider involved. lntermountain believes that participation must be voluntary, and that beneficiaries should be able to opt out (albeit, as we noted before, at a higher cost).

We believe, based on our experience, that the potential exists for outspoken hostility disproportionate to the number of people with negative feelings. For these reasons, lntermountain Healthcare does not plan to apply to be an ACO at this time.

Please let us know if you have any additional questions and please know that lntermountain stands ready to assist the HELP Committee as it continues this vital work.

Sincerely,

BILL BARNES,
Director, Federal Government Relations.

RESPONSES BY A. MARK FENDRICK, M.D. TO QUESTIONS OF THE HELP COMMITTEE

Question 1. Do you believe that a fee-for-service system is a sustainable model for delivering health care?

Answer 1. As we aim to create an efficient and effective system with a goal of optimizing health, I strongly believe that a fee-for-service system is not a sustainable model due to its lack of clinical nuance in the volume-based incentives it provides to clinicians. The current payment model is designed to encourage overuse of both high- and low-value services. While I believe alternative payment mechanisms need be explored, it is essential that we include patient engagement programs whose goals are clinically aligned with payment reform initiatives. While new payment models are being implemented and tested, we should reform the existing fee-for-service system to include programs that provide incentives for providers—through quality bonuses, and patients—through value-based insurance design (V–BID) to increase the use of medical services for which there is strong evidence. For example, Medicare Advantage plans could easily replicate clinically nuanced incentive programs administered by private insurers that demonstrate improved clinical outcomes and lower disease-specific costs. Reforms to make Federal health spending more effective and efficient must not wait for dramatic changes in the payment system. Intuitive and feasible consumer engagement concepts such as V–BID that are proven successful should be included in future payment reform efforts.

Question 2. How can we shift Federal health care delivery systems from systems that are based on volume to systems based on value? How can we realign incentives for care?

Answer 2. Moving from a volume-driven to value-based system requires a change in both how we pay for care (supply side initiatives) and how we engage consumers to seek care (demand side initiatives). The well-documented differences in clinical value among medical interventions must be acknowledged. *Thus, the incorporation of clinical nuance into supply and demand side reform initiatives is critical.* To encourage providers to increase the use of high-value interventions requires a payment methodology that explicitly identifies specific services and quality metrics for which clinicians can be rewarded for their use. Consumer engagement activities, including shared decisionmaking programs and clinically nuanced benefit [V–BID] plans must be developed that encourage patients to use high-value services more often, and discourage those services that are harmful or unnecessary.

Question 3. Dr. Fendrick, does a value-based insurance system penalize or disadvantage patients or beneficiaries in any way? Why don't more organizations adopt this system?

Answer 3. In public and private health plans across America, patient cost-sharing is implemented in a "one-size-fits-all" way, in that patients are charged the same amount for every doctor visit, diagnostic test, and prescription drug. As Americans are required to pay more to visit their clinicians and fill their prescriptions, a growing body of evidence demonstrates that increases in patient cost-sharing leads to decreases in the use of both non-essential *and* essential care. The resultant decreased use of potentially life-saving interventions leads to worse health outcomes and increased total costs in certain circumstances. This clinical and financial effect is amplified in chronic conditions that fuel a majority of medical expenditures.

Instead of the status quo where plans implement indiscriminate cost-sharing increases without clinical nuance, V–BID programs remove patient barriers to high-value services to mitigate decreased use secondary to patient out-of-pocket costs. Nearly all V–BID programs implemented to date reduce co-payments for certain preventive services and evidence-based treatments for chronic conditions (e.g., heart disease, depression, diabetes, asthma, etc.) For example, the University of Michigan and UnitedHealth Care implemented a V–BID program for individuals with diabetes; General Electric is among several organizations that offers free tobacco cessation services, and provides bonuses to employees for quitting smoking. Consumer response has been overwhelmingly positive, including those who are not using subsidized services.

The ultimate goal of V–BID is to ensure that beneficiaries get more of the care they need, and less of the care they don't. It must be noted that V–BID programs never determine what treatments are covered and those that are not—they simply provide a clinically nuanced approach to patient cost-sharing for services already offered by a health plan. A properly designed V–BID program will always include an appeals process and provide safe harbors for individuals with special circumstances. V–BID has received broad support from health care stakeholders from across the advocacy spectrum, including labor, employers, patient advocates, clinician groups, insurance plans, and policymakers on both sides of the aisle. We do not believe such a broad coalition would be possible if V–BID were in some way disadvantaging patients.

The interest in V–BID is growing rapidly as employers and insurers develop V–BID plans and published research confirms its clinical and economic merits. The prestigious *New England Journal of Medicine* recently published a trial demonstrating a V–BID program for patients with a history of heart attacks improved outcomes at no increased cost to the insurer. An accompanying editorial recommended that private plans should quickly adopt V–BIDs. Aetna, Blue Shield of California, and SeeChange Health have followed suit and announced new V–BID products. Additionally, the Governor of Connecticut and labor leaders recently agreed to adopt a health plan for State employees based on V–BID principles. While the private market has taken the lead, we believe that public programs should join the private sector to encourage V–BID and other innovations that will result in healthier Americans and a more efficient delivery system. We would look forward to opportunities to explore these possibilities with you, as outlined in my earlier testimony.

[Whereupon, at 4:03 p.m., the hearing was adjourned.]

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