EXAMINING PAY-FOR-PERFORMANCE MEASURES AND OTHER TRENDS IN EMPLOYER-SPONSORED HEALTHCARE

HEARING

BEFORE THE

SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

OF THE

COMMITTEE ON EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

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C O N T E N T S

EXAMINING PAY-FOR-PERFORMANCE MEASURES AND OTHER TRENDS IN EMPLOYER-SPONSORED HEALTH CARE

Tuesday, May 17, 2005

U.S. House of Representatives

Subcommittee on Employer-Employee Relations

Committee on Education and the Workforce

Washington, DC

The subcommittee met, pursuant to call, at 2:02 p.m., in room 2175, Rayburn House Office Building, Hon. Sam Johnson [chairman of the subcommittee] Presiding.

Present: Representatives Johnson, Kline, Boustany, Andrews, Kildee, Payne, Tierney, Holt and McCollum.

Also Present: Representative Norwood.

Staff Present: Kevin Frank, Professional Staff Member; Ed Gilroy, Director of Workforce Policy; Aron Griffin, Professional Staff Member; Richard Hoar, Staff Assistant; Jim Paretti, Workforce Policy Counsel; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Deborah L. Emerson Samantar, Committee Clerk/Intern Coordinator; Kevin Smith, Senior Communications Advisor; Jody Calemine, Minority Counsel, Employer-Employee Relations; Margo Hennigan, Minority Legislative Assistant/Labor; and Michele Varnhagen, Minority Labor Counsel/Coordinator.

Chairman JOHNSON. A quorum being present, the Subcommittee on Employer-Employee Relations of the Committee on Education and the Workforce will come to order. We are holding this hearing today to hear testimony of Examining Pay-For-Performance Measures and Other Trends in Employer-Sponsored Health Care under committee Rule 12(b).

Opening statements are limited to the chairman and ranking minority member of the subcommittee. Therefore, if other members have statements, they will be included in the hearing record. With that, I ask unanimous consent for the hearing record to remain open for 14 days to allow member statements and other extraneous material referenced during the hearing to be submitted in the official hearing record.

Hearing no objection, so ordered.

STATEMENT OF HON. SAM JOHNSON, CHAIRMAN, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Chairman JOHNSON. Good afternoon to you all, and thank you for being here.

Employers serve as the backbone of health insurance in the United States, voluntarily providing health coverage to nearly two-thirds of Americans with health insurance under the age of 65. Without their commitment to keep their employees healthy, the population of the uninsured would surely change dramatically.

This afternoon's hearing will focus on ways that employers are moving and, in some cases, dragging the health care industry into the 21st century. The fact is, even with all of today's technology, all too often people are getting the wrong care at the wrong time. Most of us have heard what the Institute of Medicine inferred, based on available data in 1999, that as many as 98,000 people die in hospitals each year because of preventable medical errors.

I can't think of a single industry where it is standard business practice to pay the same rate to people who provide good services as to people who provide bad ones.

Mr. ANDREWS. Major League Baseball.

Chairman JOHNSON. He said Major League Baseball. Well, maybe we can all get on steroids, and we all won't have to worry about it.

That is the way the government and purchasers of other health care do business, which does not provide much of an incentive to improve care. Shouldn't we reward doctors and hospitals for delivering high-quality results for patients, rather than paying them the same amount regardless of how well they deliver services to patients?

Some innovative employers and insurers decided to do just that, to become better purchasers of their health care and to seek out the providers that had figured out how to increase quality while keeping costs at a minimum. Our witnesses today will tell us about a few of the programs that came out of that decision to become smarter shoppers. It is worth mentioning that this move toward better purchasing comes at a crucial time in the development of consumer-driven health insurance products.

Since we put the spotlight on quality, we found out that hospitals that spend more money aren't necessarily those that are the highest quality. In fact, more money is a pretty good indication of a lack of efficiency. Our consumers need to know information like that in order to get the most out of their ability to choose.

The best thing about pay for performance, though, is not that it saves money, it saves lives.

Medicare is one example of the success of improved quality—improvement. Mark McClellan, the man responsible for making sure Medicare and Medicaid are working properly—and that is not an enviable job—recently announced that all of the 270 hospitals participating in their pay-for-performance demonstration program reported improved quality of care. That is just in the first year.

Today we want to hear from a few of the pioneers of pay for performance and find out what your experience has been, including any predicted or unforeseen challenges that you face.

I now yield to the distinguished ranking minority member of the subcommittee, Mr. Andrews, for whatever opening statement you wish to make.

[The prepared statement of Chairman Johnson follows:]

Statement of Hon. Sam Johnson, Chairman, Subcommittee on Employer–Employee Relations, Committee on Education and the Workforce

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But that is the way the government and other purchasers of health care do business—which does not provide much of an incentive to improve your care.

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Some innovative employers and insurers decided to do just that—to become better purchasers of their health care, and to seek out the providers that had figured out how to increase quality, while keeping costs at a minimum.

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It is worth mentioning that this move towards better purchasing comes at a crucial time in the development of consumer-driven health insurance products.

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In fact, more money is a pretty good indication of a lack of efficiency. Our consumers need to know information like that in order to get the most out of their ability to choose.

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And that's just in the first year.

Today we want to hear from a few of the pioneers of pay-for-performance and find out what their experience has been—including any predicted or unforeseen challenges that you've faced.

STATEMENT OF ROBERT E. ANDREWS, RANKING MEMBER, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Mr. ANDREWS. Thank you, Mr. Chairman.

I wish to thank the witnesses for their preparation today and for what will no doubt be an informative and lively discussion and like to thank you for calling us together.

We are in the midst of a productivity revolution in our economy. A handful of people are now able to do the work that dozens or even hundreds used to do. The advent of technology has made down time or dead time almost nonexistent in many occupations.

We are able to measure quality and progress in ways that we could not before. I think that across the board we benefited from that in manufacturing, in telecommunications, medicine and education. So I think this hearing is timely as a way of understanding how this productivity revolution can be brought in the most effective and humane way to the healing arts and to the medical arts.

One of the other things that we have learned in this productivity revolution is that a technology or a process can either be a tool or a weapon. If it is used properly, it empowers a better result. It benefits the entire community because we invest relatively fewer resources for a relatively better result.

But if the tool is misused and used as a way to exploit a situation or to unfairly characterize a situation, it can have negative results for all those involved.

I think with this concept, for which I have great sympathy, with respect to the issue of pay for performance and health care, I think the key issue is designing measurements that are fair and comprehensive. I think that is a uniquely apolitical exercise. I think it has political consequences, but the exercises itself should be apolitical.

We ought to be able to draw together the best thinkers—which I believe we have this afternoon—to help us think through the problem of how we can devise fair, comprehensive and accurate measures of quality and productivity improvement and then use those in such a way that they empower the provider of health care services, the payer for health care services and, most importantly, the recipient of health care services, the patient.

So whether it is health club memberships that help deal with the obesity problem or whether it is sessions that would help people see the early warning signs of mental illness or substance abuse or whether it is regular screenings for malignancies, there are already examples of this productivity revolution already happening in America. It makes perfect sense for us to find a way in the marketplace to link the intelligent use of those methods with better outcomes and reward people for doing so.

So I look forward to hearing from the witnesses this afternoon. I approach this enterprise in the spirit of understanding ways that we can fashion tools that help us bring this beneficent productivity revolution to healers and patients and payers.

I thank you for this opportunity.

Chairman JOHNSON. Thank you, Rob.

We have got a distinguished panel of witnesses before us today, and I thank all of you for being here.

We will hear from Ms. Karen Ignagni—is that correct?

Ms. IGNAGNI. Close.

Chairman JOHNSON.—CEO of America's Health Insurance Plans located right here in Washington.

Following her will be Dr. Robert Galvin, Director of Corporate Health Care and Medical Programs at General Electric. Dr. Galvin will be testifying on behalf of the Human Resources Policy Association today.

Next, Dr. Meredith Rosenthal, Assistant Professor of Health Economics and Policy at Harvard School of Public Health.

Finally, from Mr. Jeffrey Hanson, President of Bridges to Excellence, a group of employers, physicians, health plans and patients, the purpose of which is to create programs that realign health incentives around higher quality.

I want to thank you all for being here. If you understand our light system, green is go; yellow is watch out, you got a minute; and red, we would like for you to get it closed off if you can.

Chairman JOHNSON. With that, Ms. Ignagni, you are welcome to begin.

STATEMENT OF KAREN IGNAGNI, CHIEF EXECUTIVE OFFICER, AMERICA'S HEALTH INSURANCE PLANS, WASHINGTON, DC

Ms. IGNAGNI. Thank you, Mr. Chairman, Mr. Andrews, members of the subcommittee. We appreciate the opportunity to testify today.

My written testimony focuses on four areas, and I would like to briefly summarize them now.

First, rising health care costs are placing a growing burden on employers, small and large, State governments, the Federal Government and consumers and making it difficult to address the growing problem of the uninsured.

A significant contributor, as the committee has already identified, to this cost problem is the fact that we are devoting a greater share of resources, payroll, personal savings and State and Federal budgets to a system that has uneven quality across the country and where only 55 percent of treatments are in accordance with best practice. We think there are opportunities to give purchasers and consumers a value for their investment by redesigning payment mechanisms and also by focusing government policy on this objective.

There is broad recognition that paying for health care services without measuring their effectiveness and efficiency has prevented the health care system from performing optimally. In other words, paying the same for good quality and bad quality has provided little incentive for the system to do better. This approach has rewarded over-utilization and misuse of service and resulted in higher payments when health care complications arise.

Our written testimony outlines numerous examples of initiatives our members have launched, including financial rewards to physicians in the form of increased payments or nonfinancial rewards—also equally important—in the form of public recognition, preferential marketing or streamlining administrative procedure.

Additionally, some members are offering consumers reduced copayments, deductibles and premiums in exchange for using providers, leading to higher quality based on specific performance measurements.

Lessons learned. I apologize, Mr. Chairman, for the voice. I have allergies. It is the time of the year. So please——

Chairman JOHNSON. You need some health care——

Ms. IGNAGNI. No, I have excellent health care, I assure you. I just need the weather to change.

Chairman JOHNSON.—and treat that.

Ms. IGNAGNI. We have shared with the committee key principles approved by the board of directors in terms of lessons we have

learned to encourage the transition to a quality based system. I would like to highlight several.

First, a critically important issue in the development of pay for performance is a uniform, coordinated strategy for measuring, aggregating and recording a provider performance. If we continue the proliferation of measurement systems, there will be no clarity or consistency in what is done. I believe both of you in your opening statements indicated that you are concerned about this.

As a member of the Ambulatory Care Quality Alliance, AQA, AHIP has been working with other stakeholders, particularly the American College of Physicians and the Academy of Family Physicians. We recently reached consensus on a common set of 26 ambulatory care performance measures as a starter set. It is a beginning, targeting conditions on which significant resources are spent, including heart disease, diabetes and depression; and more measures are now being adopted and will be ready in the future.

AQA has also worked on the plan to combine public and private data. This is particularly important because it would provide stakeholders with a more comprehensive view of performance across marketplaces.

Such an initiative would have three positive results: It will give the consumers more clout, because they will be allowed to make more informed decisions about their health care treatments. It will insure fairness for clinicians, because they would be evaluated based on their entire practice, not simply patients covered by a particular insurer. It will focus attention on health care outcomes, raising the quality bar and allowing physicians to be recognized for good results.

In addition, involvement of physicians, hospitals and other health care professionals and the design and implementation of programs that reward quality is essential, in our view, to their feasibility and sustainability. Our members believe these programs need to be transparent, and they need to be predictable. Reporting of reliable, aggregated performance information will promote accountability for all stakeholders and facilitate informed consumer decisionmaking.

Indeed, the importance of these principles is highlighted by a recent physician survey showing an overwhelming majority of physicians supporting pay for performance if the performance measures are developed by physicians in that particular medical specialty, if they are communicated ahead of time to physicians so that the rules are clear and that the performance measures are often based and grounded in science.

Finally, I would like to briefly identify a number of additional steps our members support as part of a broad-based strategy for further improving quality and efficiency in the U.S. health care system. Let me highlight several.

First, Mr. Chairman, as you know, Mr. Andrews, the Nation now spends roughly $30 billion in the most robust health care research apparatus in the world through the National Institutes of Health. We spend only $300 million in terms of our investment in health care effectiveness analysis through AQHR, through the Agency for Quality Healthcare and Research. So $30 billion versus $3 million, this is an R&D issue that I believe both of you were probing. We

do need to do more in terms of shedding a spotlight on what works under what conditions and when.

Second, there is a diffusion issue. Notwithstanding that robust expenditure through the National Institutes of Health, there is very little organized and effective approaches to translate that quickly into practice. So physicians at the bedside are asking for more help in getting access to information that is developed through clinical trials quickly and effectively.

Third, there is a need, in our view, to develop the framework for evaluating technology for effectiveness and efficiency. We are on the verge of a brave new world in pharmaceuticals, in devices, in bios. There is a great deal to celebrate, but without a mechanism to assess the usefulness of these procedures, again, under what conditions and at what time, employers and consumers will be left in the dark in terms of how to proceed. So we think that is an important issue that should be teed up as we go forward with moving a delivery system to a quality-based system.

Fourth, encouraging the development of a connected health care system. The committee has done a great deal of work and probing in that regard. We think it is very important to have uniform standards with respect to an interconnected health care system so we can look across the country and, again, have uniformity with respect to rules, with respect to the transmission of data, to be sure that consumers being treated in one region are getting the same level and effectiveness of care as would be the case in another region and that doctors and hospitals and other clinicians in those different regions can confer with one another.

Finally, overhauling the medical liability system. There has been a great deal of discussion in this Congress about the need to do that. We firmly believe in that. We are spending $30 billion on direct liability expenses and another $100 billion on defensive medicine, which goes hand in hand with reducing defensive medicine, moving the system toward an outcome-based, quality-based system.

So I hope, Mr. Chairman, this short version of our testimony has been helpful to the committee. Again, I apologize for the voice, and I appreciate your indulgence in that regard. Thank you.

Chairman JOHNSON. Your voice sounds fine to us. Thank you, Ms. Ignagni.

[The prepared statement of Ms. Ignagni follows:]

Statement of Karen Ignagni, Chief Executive Officer, America's Health Insurance Plans, Washington, DC

I. INTRODUCTION

Good morning, Mr. Chairman and members of the subcommittee. I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national trade association representing nearly 1,300 private sector companies providing health insurance coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify about initiatives that reward health care providers for quality performance. Our member companies have demonstrated strong leadership by designing and implementing a range of provider payment arrangements—often referred to as pay-for-performance programs—that are promoting high quality and efficiency throughout the U.S. health care system.

Our members" experiences clearly indicate that paying for quality is a promising strategy for improving overall wellness and advancing evidence-based medicine,

which translates into better health outcomes and greater value for employers and consumers. To provide context for a discussion of these innovative programs, our testimony today will focus on four broad areas:

- The challenges posed by rising health care costs and uneven quality throughout the health care system and how redesigned payment mechanisms can be an integral part of improving the value that purchasers and consumers receive;
- The importance of pay-for-performance programs as part of a broad-based strategy for meeting the cost and quality challenges;
- Examples of pay-for-performance initiatives our members individually have chosen to implement and a core set of principles AHIP's Board of Directors has embraced to provide ideas for aligning payment incentives with quality; and
- Parallel steps that should be taken in several other areas—in addition to pay-for-performance programs—to further improve the quality and affordability of health care.

II. CHALLENGES FACING THE U.S. HEALTH CARE SYSTEM

As we enter the 21st Century, the U.S. health care system faces a number of significant challenges. Rising health care costs are threatening to make health coverage unaffordable for more Americans, and are complicating efforts to meet the needs of the uninsured. One of the factors contributing to this cost problem is the serious concern that health care quality and patient safety are not optimal for many consumers. Moreover, traditional payment systems in some instances have created disincentives to control costs and improve quality.

We believe bold, but thoughtful strategies are needed to directly address the root causes of these problems. Before offering our recommendations, we would like to review the background of these cost and quality issues.

Rising Costs

The most recent data from the Department of Health and Human Services (HHS) project that national health care spending increased by an estimated 7.5 percent in 2004. Although this is the lowest rate of increase since 2000, health care costs still are growing faster than the overall economy and, as a result, large and small employers are finding it more difficult to provide or maintain coverage for their employees.

AHIP and our members are encouraged about what we can do in the private sector to reduce growth in health care spending. From 1994 through 1999, national health expenditures were in line with overall economic growth, because health insurance plans implemented a variety of tools to constrain costs. This had a direct impact on the ability of employers to purchase affordable coverage for their employees. Indeed, the Lewin Group estimated that up to 5 million people [1] who otherwise would have been uninsured were able to receive coverage as a result of these costs being restrained.

More recently, as the policy debate shifted away from containing costs, legislative proposals at both the federal and state levels focused on rolling back the mechanisms that were keeping health care affordable. This led to a new cycle of accelerating health care costs that has had an impact on purchasers and consumers.

Recognizing this challenge, our members have developed a new generation of cost containment tools that already are having a positive impact and showing promise for the future. For example, the rates of increase in pharmaceutical expenditures have significantly declined as a result of our members" implementation of programs to encourage greater use of generic drugs and other measures that encourage case management of chronic conditions. The Center for Studying Health System Change has reported [2] that growth in prescription drug spending fell to 8.8 percent in the first half of 2004, down from almost 20 percent in the second half of 1999.

The Center also has noted that hospital prices continue to be a major factor behind increased spending, accounting for almost half of the annual rate of increase in health care expenditures. At the same time, innovative drugs, devices and other therapies—while they can provide undeniable benefits in life expectancy and improved quality of life—are significant cost drivers. Without any organized way to assess the impact of this technology or compare the effectiveness of various therapies, employers and their employees are absorbing these higher costs without information about what works and the conditions under which certain therapies are effective.

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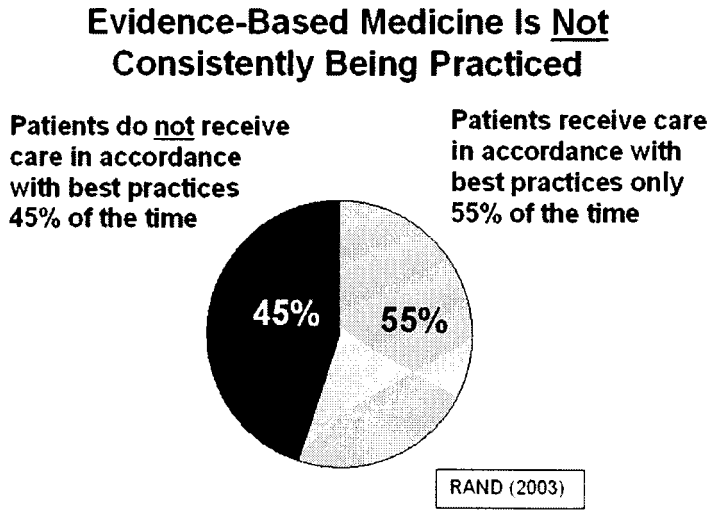
[1] The Lewin Group LLC, Managed Care Savings for Employers and Households: 1990 through 2000; 1997

[2] Strunk, B., & Ginsburg, P. (December 2004). Tracking Health Care Costs: Spending Growth Slowdown Stalls in First Half of 2004. Center for Studying Health System Change. Issue Brief No. 91. Washington, D.C.

As purchasers assess the impact of these rising health care costs, they also are questioning whether they are receiving the best value for their health care investment.

Quality Concerns

Through its landmark reports released in 1999, To Err is Human, and in 2001, Crossing the Quality Chasm, the Institute of Medicine (IOM) focused the nation on the critical need to improve health care quality and patient safety, coordinate chronic care, and support evidence-based medicine. Variation in medical decision-making has led to disparities in the quality and safety of care delivered to Americans. The 1999 IOM report[3] found that medical errors could result in as many as 98,000 deaths annually, and a 2003 RAND study[4] found that patients received only 55 percent of recommended care for their medical conditions.



A wide range of additional studies indicate that Americans frequently receive inappropriate care in a variety of settings and for many different medical procedures, tests, and treatments. Such inappropriate care includes the overuse, underuse or misuse of medical services. Studies also show that patterns of medical care vary widely from one location to another, even among contiguous areas and within a single metropolitan area—with no association between higher intensity care and better outcomes. For example:

- The Dartmouth Atlas of Health Care[5] documents wide variation in the use of diagnostic and surgical procedures for patients with coronary artery disease, prostate cancer, breast cancer, diabetes, and back pain. For example, the rates of coronary artery bypass graft (CABG) surgery were found to vary from a low of 2.1 per 1,000 persons in the Grand Junction, Colorado hospital referral area, to a high of 8.5 per 1,000 persons in the Joliet, Illinois region. The Atlas" most recent findings[6] reveal wide variation in hospital care and outcomes for chronically ill Medicare patients. For example, the length of hospital stays varied—depending on a patient's geographic location—by a ratio of 2.7 to 1 for cancer patients and by a ratio of 3.6 to 1 for congestive heart failure patients. Other examples of wide-ranging variations in care are illustrated in the visual below.

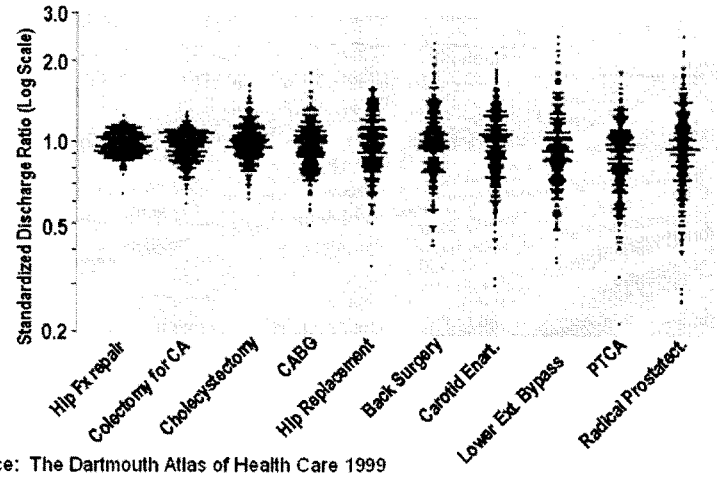
[3] "To Err is Human," Institute of Medicine, 1999

[4] "The Quality of Health Care Delivered to Adults in the United States.," Elizabeth A. McGlynn, RAND, June 25, 2003

[5] Center for the Evaluative Clinical Sciences, Dartmouth Medical School, The Dartmouth Atlas of Health Care, "The Quality of Medical Care in the United States: A Report on the Medicare Program," 1999

[6] Fisher, E., Health Affairs, October 7, 2004

Profiles of Surgical Variation for 10 Common Procedures



Source: The Dartmouth Atlas of Health Care 1999

- The longstanding nature of quality problems in the U.S. health care system is evidenced by a 1999 article[7] in The New England Journal of Medicine, which stated: "A number of studies have demonstrated overuse of health care services; for example, from 8 to 86 percent of operations—depending on the type—have been found to be unnecessary and have caused substantial avoidable death and disability."
- The National Committee for Quality Assurance (NCQA)[8] documents the state of health care quality annually, reporting in 2004 that "enormous "quality gaps"' persist as "the majority of Americans still receive less than optimal care" with between 42,000 and 79,000 avoidable deaths occurring each year. While health care quality is improving in some areas, the health care system remains "deeply polarized, delivering excellent care to some people, and generally poor care to many others."

These research findings clearly indicate the need for innovative strategies to improve quality and efficiency throughout the U.S. health care system. Decisive action is needed to address these wide-ranging variations in medical decision-making, as well as the overuse, underuse and misuse of health care services.

Traditional Payment Models

Having reviewed the challenges posed by cost and quality concerns, we now turn to the issue of payment arrangements.

In general, health care practitioners have not been paid based on the quality of care they deliver. Until recently, clinical outcomes, patient satisfaction, and improvements in processes typically have not been rewarded. Instead, reimbursement has been based on the volume and technical complexity of services rendered. This approach has rewarded the over-utilization and misuse of services, and resulted in higher payments when health care complications arise, creating disincentives to improve quality and efficiency.

Physicians have expressed concerns about not being recognized and rewarded for providing high quality care. A 2004 survey[9] of 400 primary care and specialty physicians, conducted on behalf of AHIP by Ayres, McHenry & Associates, found that 86 percent of physicians are concerned that the current payment system does not reward practitioners for providing high quality medical care. Other findings of this survey indicate that 71 percent of physicians favor payments based in part on the quality of care they provide, and 62 percent believe that information on the quality of care provided by a physician should be made available to the public.

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[7] Dr. Bodenheimer, T., The New England Journal of Medicine, Vol. 340, No. 6, pp. 488–492, 1999

[8] NCQA, The State of Health Care Quality: 2004, 2004

[9] "National Survey of Physicians Regarding Pay-for–Performance," Ayres, McHenry & Associates, Inc., September/October 2004

III. MEETING THE COST AND QUALITY CHALLENGES BY
REWARDING QUALITY PERFORMANCE

Health insurance plans have long been at the forefront of developing innovative payment arrangements that have promoted population-based health care, improved care for the chronically ill, and emphasized systematic investment in prevention.

Many of our members currently are offering financial awards to physicians in the form of increased per-member-per-month payments or non-financial rewards in the form of public recognition, preferential marketing or streamlined administrative procedures. Additionally, some plans are offering consumers reduced co-payments, deductibles, and/or premiums in exchange for using providers deemed to be of higher quality, based on specific performance measures. The categories of performance measures most commonly reported include clinical quality, utilization experience/efficiency, patient satisfaction, and information technology infrastructure.

Common Features of Programs That Reward Quality Performance

Based on the experiences of our member companies, we know that programs for rewarding quality performance have a number of common features:

- Reason for Implementation: To enhance and sustain clinical quality, facilitate excellence across provider networks, and improve and promote patient safety.
- Role of Clinicians: Nearly all plans indicate that clinicians are actively involved in key aspects of rewarding quality performance programs, including program development, selection of performance measures, and determination of how rewards are linked to provider performance.
- Emphasis on Specific Measures: In rewarding quality performance programs for physicians and medical groups, achieving clinical quality goals plays the most significant role in the formula for determining financial rewards. In programs for hospitals, utilization experience/efficiency and patient safety objectives tend to play equivalent roles.
- Consumer Incentives: Efforts are being launched to encourage consumers through reduced co-payments, deductibles, and/or premiums to use providers that are achieving quality performance.

IV. SPECIFIC INITIATIVES AND PRINCIPLES FOR REWARDING
QUALITY PERFORMANCE

To provide a better understanding of pay-for-performance initiatives in the private sector, we are providing brief examples of programs being implemented by our members across the country.

- Aetna has launched a network of specialist physicians who demonstrate effectiveness based on certain clinical measures, such as hospital readmission rates over a 30-day period, reduced rates of unexpected complications by hospitalized patients, and efficient use of health care resources. Consumers who choose these specialists benefit through lower co-payments, and providers benefit through increased patient volume. The Aexcel network, which is currently available in nine markets across the country, includes physicians in twelve medical specialties—cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics/gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, vascular surgery, and urology.
- HealthPartners has implemented an Outcomes Recognition Program that offers annual bonuses to primary care clinics that achieve superior results in effectively promoting health and preventing disease. Since 1997, this program has awarded more than $3.95 million in bonuses to primary care groups that meet performance goals focusing on diabetes, coronary artery disease, tobacco cessation, generic prescribing, and consumer satisfaction.
- Highmark Blue Cross Blue Shield has adopted a Quality Incentive Payment System that rewards primary care physicians for demonstrating improvement in measures for preventive screenings, treatment of chronic conditions, and other quality and service issues. In the tenth year of the program (2003), more than $12 million in bonuses were paid to primary care physicians who exceeded the average performance measure on various indicators.
- Independent Health uses a Quality Management Incentive Award Program that involves a physician advisory group in developing performance targets for key issues such as patient satisfaction, emergency room utilization/access, office visits, breast and colorectal screening, immunizations, and treatment for diabetes and asthma. In addition to paying bonuses to physicians who exceed these targets, this program has documented significant improvements in clinical care for enrollees.
- PacifiCare Health Systems has developed a Quality Index" profile that uses clinical, service, and data indicators to rank medical groups. Enrollees pay

lower co-payments for office visits if they select physicians from a "value network" of higher quality, lower cost providers. Additionally, PacifiCare's Quality Incentive Program incorporates a subset of the Quality Index profile and has demonstrated an average improvement of 20 percent in 17 of 20 measures, with rewards to high performing physicians exceeding $15 million in the past three years.

- WellPoint's quality programs provide increased reimbursement to hospitals and physicians based, in part, on achieving improved quality measures. For example, hospitals selected for Anthem Blue Cross and Blue Shield's Coronary Services Centers program in Indiana, Kentucky, and Ohio must meet stringent clinical quality standards for patient care and outcomes for certain cardiac procedures. Anthem Blue Cross and Blue Shield of Virginia's Quality-in–Sights Hospital Incentive Program (QHIP) rewards hospitals for improvements in patient safety, patient health, and patient satisfaction. The 16 hospitals that participated in the first year of QHIP in 2004 are receiving a total of $6 million for actively working to implement nationally recognized care and safety practices that can save lives. Blue Cross of California has a comprehensive physician pay-for-performance program that paid $57 million in bonus payments to 134 medical groups based on quality criteria in 2003. Blue Cross of California also has a PPO Physician Quality and Incentive Program (PQIP) that allows more than 4,000 physicians in six counties in the San Francisco area to receive financial bonuses for superior performance on clinical quality, service quality, and pharmacy measures.

Importance of Uniform Performance Measurement, Data Aggregation and Reporting

A critically important step in moving forward with programs that reward quality performance is the development of a uniform, coordinated strategy for measuring, aggregating and reporting clinical performance. Disseminating information derived from aggregated performance data—which provides stakeholders with a more comprehensive view of performance across marketplaces—would yield benefits on several levels. Consumers would be allowed to make more informed decisions about their health care treatments. Physicians, hospitals and other health care professionals would be better able to improve the quality of care they provide. Purchasers would receive greater value for their investment in health care benefits. Health insurance plans could continue to develop innovative products that meet consumer and purchaser needs.

AHIP has been working with the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), and other stakeholders to identify what should be measured for ambulatory care and how, and develop an effective and efficient data aggregation model that would comprehensively assess provider performance.

The collaborative effort now called the Ambulatory Care Quality Alliance (AQA) recently reached consensus on a common set of 26 ambulatory care performance measures. These measures are grouped under eight separate categories: (1) prevention; (2) coronary artery disease; (3) heart failure; (4) diabetes; (5) asthma; (6) depression; (7) prenatal care; and (8) overuse or misuse of medical services. Many of the measures under these categories are "bundled" measures—i.e., multiple measures which if used collectively, have the potential to more comprehensively and accurately assess physician performance and provide improved outcomes for patients.

These measures are intended to serve as a "starter set" that will provide clinicians, consumers, and purchasers with a set of quality indicators that can be used for quality improvement, public reporting, and pay-for-performance programs. This starter set will be expanded in a multi-phase process, resulting in a more complete set of measures which address a wide range of additional quality indicators addressing efficiency, patient experience, sub-specialties and other key areas.

In addition to working toward a strategy for performance measurement, AQA is developing a uniform data aggregation strategy. The aggregation model developed by this alliance would include the following key attributes:

- trusted, third party data aggregator(s) capable of maintaining appropriate restrictions on privacy and confidentiality;
- an independent governing structure that would establish rules, policies and standards for data aggregation;
- a process that allows provider performance to be compared against both national and regional benchmarks;
- collection of both public and private data so that physician performance can be assessed as comprehensively as possible;

- standardized and uniform rules associated with measurement and data collection;
- transparency with respect to framework, process and rules;
- protection of privacy and confidentiality of data while ensuring necessary access to appropriate stakeholders; and
- systems or processes to share, collect, aggregate and report quality and efficiency performance data that are affordable and that minimize burdens.

Lastly, AQA is exploring strategies for reporting reliable and useful quality information to consumers, providers and other stakeholders. The Alliance recently developed two sets of fundamental principles for reporting. The first set of principles, which addresses reporting to consumers and purchasers, aims to facilitate more informed decision-making about health care treatments and investment. The second set of principles, which addresses reporting to physicians and hospitals, is designed to facilitate quality improvement and informing providers of their performance.

The AQA will continue to move forward in the areas of measurement, aggregation and reporting, and encourage various stakeholders to become involved in this important effort to improve health care quality and patient safety.

Principles for Rewarding Quality Performance

AHIP's members are committed to working with stakeholders across the health care community, particularly health care professionals who work on the frontlines every day, to develop a strategy that accounts for the quality of care delivered to patients. In November 2004, AHIP's Board of Directors demonstrated this commitment by approving principles for guiding the development and implementation of programs that advance a quality-based payment system. They include eight key elements:

- Programs that reward quality performance should promote medical practice that is based on scientific evidence and aligned with the six aims of the IOM for advancing quality (safe, beneficial, timely, patient-centered, efficient, and equitable).
- Research is urgently needed to inform clinical practice in priority areas currently lacking a sufficient evidence-based foundation.
- The involvement of physicians, hospitals and other health care professionals in the design and implementation of programs that reward quality performance is essential to their feasibility and sustainability.
- Collaboration with key stakeholders, including consumers, public and private purchasers, providers, and nationally recognized organizations, to develop a common set of performance measures—process, outcome and efficiency measures—and a strategy for implementing those measures will drive improvement in clinically relevant priority areas that yield the greatest impact across the health care system.
- Reporting of reliable, aggregated performance information will promote accountability for all stakeholders and facilitate informed consumer decision-making.
- The establishment of an infrastructure and appropriate processes to aggregate—across public and private payers—performance information obtained through evidence-based measures will facilitate the reporting of meaningful quality information for physicians, hospitals, other health care professionals, and consumers.
- Disclosure of the methodologies used in programs that reward quality performance will engage physicians, hospitals, and other health care professionals so they can continue to improve health care delivery.
- Rewards, based upon reliable performance assessment, should be sufficient to produce a measurable impact on clinical practice and consumer behavior, and result in improved quality and more efficient use of health care resources.

Significantly, these principles recognize the views that physicians have expressed on pay-for-performance. The physician survey we previously noted—conducted by Ayres, McHenry & Associates in September/October 2004—included additional findings showing that an overwhelming majority of physicians would support pay-for-performance programs if the performance measures were developed with physicians in that particular medical specialty (87 percent), if the performance measures were clearly communicated to physicians before they were used in payment arrangements (84 percent), and if the performance measures were evidence-based and grounded in science (83 percent).

V. OTHER ELEMENTS OF A QUALITY IMPROVEMENT STRATEGY

While programs that reward quality performance can go a long way toward address cost and quality challenges, this is only one component of a broad-based strategy for transforming the health care system. Policymakers should at the same time

encourage and pursue a variety of other programs and initiatives to further advance quality and efficiency.

Invest in Cost Effectiveness and Translational Research

While the federal government invests heavily in clinical research, it makes only modest investments in research that compares the relative effectiveness of existing versus new therapies that are designed to treat the same condition. The federal government should assign a high priority to this kind of research and also direct more funding to promote the widespread adoption of best practices and reduce the overuse and misuse of health care.

A National Center for Effective Practices should be created to ensure that the results of cost effectiveness research are translated into usable information for providers and consumers. This new entity could identify and make publicly available the latest advances in evidence-based medical practices, and also shed light on procedures determined to be less effective.

Develop a Framework for Evaluating Technologies for Effectiveness and Efficiency

To address the rapid development of new procedures, devices and other technologies, a public-private framework should be established to evaluate and compare the effectiveness and efficiency of these technologies. Moreover, new post-marketing surveillance models should be developed to assess the appropriate use and long-term value of certain breakthrough drugs, devices and biologicals.

Encourage the Development of an Interconnected Health Care System and Uniform Standards

The delivery of health care in America is complex with individuals seeking care from a variety of physicians, hospitals, and specialists. The ultimate goal of modernizing the health care system is to improve personal health and the delivery of care by providing meaningful personalized information to consumers and providers in a usable form and in a timely manner. To achieve this aim, we need uniform, national standards that enable the exchange of health information by and between clinical electronic health record (EHR) systems and consumer-centric individual health records.

Overhaul the Medical Liability System to Ensure Effective Dispute Resolution and Promote Safety and Value

The flaws in the current medical liability system should be addressed with reforms that place reasonable limits on health care litigation. Additionally, patient safety legislation is needed to establish legal protections for medical error information reported by health care providers, and to permit the aggregation of data that can be used to determine the causes of medical errors and develop strategies for improving patient safety. Also needed is a uniform, national administrative process to resolve malpractice disputes between patients and health care providers in a fair and efficient manner, thus avoiding the need for litigation as often as possible.

Modernize and Maximize the Effectiveness of the Regulatory System.

- Encourage choice with uniform rules in the small group market: A common set of rules would encourage competition, enhance consumer choice, and provide greater predictability for employers. The solution is not to waive all requirements for particular groups, but to establish an appropriate and consistent framework for all participants to ensure that small employers have maximum options to meet their needs. This means that the federal and state governments need to work together to encourage "best practice" regulation. This process has begun with the development of draft legislation—known as the State Modernization and Regulatory Transparency (SMART) Act—that would promote uniformity in plan processes, particularly internal and external review of coverage disputes, speed-to-market and market conduct standards.
- Encourage prompt product approval and consistency in regulatory processes. Steps should be taken to ensure that states adopt a mechanism by which health insurance plans can bring innovative products to the market in a timely manner. Ideally, the federal government should encourage states to be forthcoming regarding their standards for policy rate and form filing requirements and to abandon unwritten "desk-drawer rules." This ultimately will create oversight mechanisms that allow companies to provide consumers with the products they need in a timely manner.
- Establish an independent advisory commission to evaluate the impact of mandates on health care costs and quality. Such a commission could advise policymakers on the safety and effectiveness of proposed and existing mandated

health benefits, and assess whether proposed mandates result in improved care and value. The commission's findings also could inform public program coverage and decision-making to ensure that evidence-based standards are applied consistently in Medicare, Medicaid, and other public programs.

Provide Funding for High–Risk Pools

AHIP's Board of Directors approved a statement in June 2004 indicating support for federal funding for state high-risk pools to cover individuals who have unusually high health care costs. This legislation fits within the parameters of what Congress is able to accomplish from a budgetary standpoint at this time. This initiative is one of the next steps Congress should take as part of a long-term strategy for strengthening our nation's health care safety net.

Expand Tax Credits to Encourage the Purchase of Health Care Coverage

To address the needs of working Americans who are uninsured and ineligible for public programs, Congress can help make health coverage more affordable by expanding tax credits for low-income persons. This approach will be particularly helpful to Americans who do not have access to employer-sponsored coverage and to those who decline such coverage because of the high cost. Moreover, tax credits could prompt more small businesses to offer employee health benefits. The Employee Benefits Research Institute (EBRI)[10] has reported that among small employers that do not offer employee health benefits, 71 percent would be more likely to seriously consider offering health benefits if the government provided assistance with premiums.

VI. CONCLUSION

It is increasingly clear that the U.S. health care system faces significant quality challenges that are further heightened by rising medical costs. Taken together, these factors create an urgency for stakeholders to work collaboratively to improve the quality, safety and efficiency of the health care system. Programs that recognize and reward quality performance should be an important part of this effort.

We applaud the subcommittee for focusing on the value of payment arrangements that align reimbursement with quality performance.

Rewarding Quality Performance: Health Insurance Plan Examples

Aetna

Hartford, Connecticut

In January 2004, Aetna launched a network of specialist physicians developed based on quality and efficiency indicators. The new Aexcel SM network was created by identifying medical specialties associated with a large portion of health care spending and features specialists who demonstrate effectiveness against certain clinical measures such as hospital readmission rates over a 30-day period, and reduced rates of unexpected complications by hospitalized patients; volume of Aetna enrollees" cases; and efficient use of health care resources. Aexcel SM benefits consumers through lower copayments for seeking services from more efficient providers, and providers benefit through increasing the volume of patients to their practices.

Physicians in six medical specialties—cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics/gynecology, and orthopedics—who have met the established measures were designated to participate initially in the network option. Aetna also recently expanded its network to include additional six specialties (e.g., otolaryngology, neurology, neurosurgery, plastic surgery, vascular surgery, and urology). The Aexcel SM network is currently available in the nine markets of Atlanta, Houston, metropolitan Washington DC, Los Angeles, Connecticut, metropolitan New York/New Jersey, Dallas/Fort Worth, North Florida and Seattle/Western Washington. Additional geographic regions will be added over the next two years.

Blue Cross Blue Shield of Michigan and Blue Care Network

Detroit, Michigan

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network (BCN) have designed and implemented a number of provider incentive initiatives and are continuing to expand and evolve these efforts.

The BCBSM Hospital Incentive Program rewards hospitals that demonstrate achievement in three major categories: clinical quality, patient safety, and community health. Through this program, hospitals can earn up to an additional four per-

[10] Employee Benefit Research Institute, Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey, January 2003

cent on their inpatient payments. BCBSM's participating hospital agreements establish the incentive program; up to four percent is added to each Diagnosis Related Group (DRG) payment, based on each hospitalization or admission, if the standards are met. The actual amount a hospital earns is based on its individual performance. Hospital performance has improved each year the program has been in place. In 2004, performance in the program has earned participating hospitals an average incentive payment of over three percent, the average incentive, which is added to the DRG payment.

The BCBSM Cardiac Centers of Excellence program established in 1996 helps enrollees make informed decisions when selecting a hospital to meet their cardiac needs. Ten Michigan hospitals currently meet the quality criteria for this program. As a result of this initiative, BCBSM has observed lower mortality rates, fewer unplanned coronary artery bypass grafts, fewer heart attacks, and fewer cases of kidney failure requiring dialysis. These improvements are associated with approximately $8 million in annual savings.

The BCBSM Physician Group Incentive Program rewards physician groups for their ability to: create registries for patients with particular medical conditions; provide performance feedback to individual physicians; promote consistent delivery of care according to evidence-based guidelines; refer to care management programs; and demonstrate improvement in generic drug prescribing and cost-effective prescribing. A pay-for-performance pool is distributed quarterly to selected medical groups. The share of the incentive pool for each group is based on the numbers of enrollees served and in meeting performance expectations. Ten physician groups were selected to participate in 2004 and two more joined in 2005.

Blue Care Network Performance Recognition Program (PRP) and Blue Reward" programs reward primary care physicians and medical groups for surpassing quality and patient satisfaction benchmarks and for other focused short-term performance improvements. From 2001–2003, BCN has rewarded approximately 80 percent of nearly 3,000 eligible primary care physicians for performance improvements each year across the state of Michigan. The rates of breast cancer screening, cervical cancer screening, childhood immunization, smoking cessation, and patient satisfaction all increased through the PRP program. The innovative Blue Reward" program (short term, focused) has also recorded early successes with Prilosec OTC" and electronic referral initiatives.

CIGNA HealthCare

Hartford, Connecticut

CIGNA HealthCare of California participates in the Integrated Healthcare Association's (IHA) quality incentive program. CIGNA uses IHA's common measurement set to evaluate performance. CIGNA then rewards the top 50 percent of contracted physician groups for meeting each of the IHA clinical and member satisfaction metrics. Fifty-percent of the overall pool is being rewarded to providers for meeting HEDIS/clinical measures, such as breast cancer screening, cervical cancer screening, and appropriate medications for asthma; 40 percent for enrollee satisfaction; and ten percent for the adoption and implementation of health information technology. Top-performing groups in all components of the Rewards Program are eligible to receive a minimum of $1.60 per member per month. Payment is based upon the total annual member months of the group's population. In the first year of the program, the payout in California for IHA was $4 million.

CIGNA also uses other non-financial strategies to recognize their network providers. Participating physicians and hospitals that have met certain quality criteria are recognized in its online Provider Excellence Recognition Directory. Physicians are recognized for being certified by the National Committee for Quality Assurance for providing high quality diabetes or heart/stroke care. Hospitals are highlighted for meeting the Leapfrog Group's three patient safety standards (e.g., Computer Physician Order Entry systems, Intensive Care Unit Physician Staffing, and Evidence-based Hospital Referrals).

Harvard Pilgrim Health Care

Wellesley, Massachusetts

Harvard Pilgrim Health Care (HPHC) implements a multi-faceted Provider Network Quality Incentive Program that includes a Physician Group Honor Roll, a Quality Grant Program, and a Rewards for Excellence program. These activities are highlighted below.

HPHC participating physician groups are eligible for inclusion in the Harvard Pilgrim Physician Group Honor Roll by exceeding performance levels in clinical areas, such as breast cancer screening, appropriate diabetes care, and childhood immuniza-

tions. On an annual basis, HPHC publishes the names of all Primary Care Physicians affiliated with the physician groups that have achieved Honor Roll or Honorable Mention in print and online physician directories.

HPHC's Quality Grant Program provides support to local physician offices to implement quality improvement interventions that may face particular challenges in achieving high performance targets. These grants help practices to address important issues, such as geographic access to needed services, language or cultural barriers, and outreach and other services to disadvantaged populations. These practices, in turn, support Harvard Pilgrim Health Care's mission to improve the health of its members and the community at large. In 2003 and 2004, a total of 2.5 million dollars was granted for 34 grants.

Another component of the Provider Network Quality Incentive Program is Rewards for Excellence. This initiative recognizes and rewards the exemplary performance of local quality efforts. HPHC has identified a subset of areas of focus. These areas targeted include key Health Plan Employer Data and Information Set (HEDIS) performance measures where effective clinical interventions have been identified and/or where current levels of performance—nationally, regionally, and within Harvard Pilgrim—are less than clinically optimal. Current measures include such measures as eye exams and kidney screening for people with diabetes, appropriate anti-depressant medication management, asthma management, and chlamydia screening. HPHC offers its providers financial rewards for achieving excellent levels of performance in the defined target areas. In 2003, Harvard Pilgrim rewarded 55 out of 66 eligible practices.

HealthNet

Woodland Hills, California

HealthNet is an active participant in the Integrated Health Association initiative, a quality incentive program in California with six participating health insurance plans and 215 medical groups, representing 45,000 physicians. A common measurement set across all health insurance plans is used to evaluate provider performance. The measurement set includes quality indicators for both preventive and chronic care, such as breast cancer screening, and appropriate medications for asthma, patient satisfaction, and the investment and adoption of health information technology. Each health insurance plan then uses its own methodology and formula to calculate the physician group bonus. Collectively, health insurance plans paid approximately $50 million to physician groups in its first year.

HealthNet has seen the following results from this initiative: increasing numbers of contracted medical groups eligible for such rewards (70 groups in 2004 as compared to 30 groups in 2003); and HEDIS rate increases on average of two percent for all paying for performance program measures.

HealthPartners

Minneapolis, Minnesota

HealthPartners" Outcomes Recognition Program (ORP) offers annual bonuses to primary care clinics that achieve superior results in effectively promoting health and preventing disease. Eligible primary care groups are annually allocated a pool of bonus dollars that is awarded if a group reaches specific performance targets. Measures focus on important clinical issues, such as diabetes, coronary artery disease, tobacco cessation, generic prescribing, and consumer satisfaction. ORP bonus awards are an addition to the standard provider payment for primary care provider groups. In 2004, eligible clinics were able to earn financial rewards ranging from $90,000 to $290,000, depending on the size of their HealthPartners' enrolled populations and the number of measurable targets reached. In 2004, 19 of the 26 eligible primary care groups received a total of $656,250 in ORP bonus awards. Since 1997, ORP bonus awards have totaled over $3.95 million.

Highmark Blue Cross Blue Shield

Pittsburgh, Pennsylvania

Highmark Blue Cross Blue Shield's Quality Incentive Payment System (QIPS) rewards physicians in 20 counties in Western Pennsylvania for improvements in measures based, in part, on the Health Plan Employer Data and Information Set (HEDIS) for preventive screenings and treatment for chronic conditions. Additional quality and service performance measures include generic versus brand prescribing patterns, electronic submission of claims, and the use of Highmark's provider portal. Highmark's QIPS rewards are for Primary Care Physicians (PCPs) who participate in Highmark's HMO/POS product lines with panel sizes of at least 300 patients.

These physicians are eligible for a bonus in addition to capitation. Scoring is based on meeting or exceeding the Highmark network average for each indicator.

In the tenth year of the program (2003), primary care physicians were reimbursed $12.3 million for 12.6 million member months or approximately $0.98 per member per month. Over time, ninety-eight percent of the participating PCPs have met or exceeded some of the clinical indicators being evaluated and fifty percent of the eligible physicians meet the benchmarks for each quarter for all clinical indicators. Later this year, Highmark plans to expand this program to its PPO product line and to central Pennsylvania.

Since 2001, Highmark has also worked with its hospitals within its network to improve quality. Individual hospitals work with Highmark in its QualityBlue SM program to develop projects that focus on medication safety, patient safety, and infection control and meet their individual facility needs. Baseline improvement goals are established at the onset of the program to evaluate the hospital performance. A portion of the hospital's contracted reimbursement is placed at risk based on their performance. The participating hospitals represent over 50% of Highmark's total hospital claim payments.

Currently operating in 29 western Pennsylvania counties, participating hospitals in the QualityBlue SM program have achieved remarkable results in their indicators. Some of the achievements have been reducing or eliminating infections in targeted hospital units, preventing medication errors though implementation of technology, reducing readmissions for cardiac patients, and reducing or eliminating patient identification errors.

Independence Blue Cross (IBC)

Philadelphia, Pennsylvania

Independence Blue Cross (IBC) offers a quality of care incentive payments system (QIPS) to both PCPs and hospitals. The PCP QIPS program, for HMO capitated primary care practices, promotes both quality of care, including member satisfaction, and quality of service goals of the Plan. The program began in 1992, and was redesigned in 2002 to include clinical quality measures of effectiveness of care, such as screening rates for women's health issues, care of patients with diabetes, members with asthma, and selected cardiac conditions, and service measures of extended office hours, appropriate use of generic drugs, electronic connectivity, and the use of that connectivity for referrals and encounters. PCPs in approximately 1,350 locations caring for about 870,000 members are eligible for quality of care payments; 85% received payments as high as $2.30 Per Member Per Month over and above their regular capitation rate.

A hospital quality incentive payment system was designed in 2002 that currently includes one system with six hospitals. Hospitals agree to base a significant part of their annual rate increase on performance against agreed-upon quality indicators. Indicators are based on third party measures broadly accepted as good barometers of quality from organizations such as the Pennsylvania Health Care Cost Containment Council, the Joint Commission on Accreditation of Healthcare Organizations, the Leapfrog Group, the Agency for Healthcare Research and Quality, and others. Since 2002, a number of hospitals in the system have improved on several measures.

Independent Health

Buffalo, New York

The goal of Independent Health's Practice Excellence program has been to improve enrollee health through improved access/timeliness of care, preventive screening, and adherence to evidence-based guidelines for the treatment of chronic conditions.

A physician advisory group has helped to develop key program elements and has helped establish "performance targets" in areas such as patient satisfaction, emergency room utilization, access/office visits, breast and colorectal screening, immunizations, and treatment for diabetes and asthma.

Physicians earn an award based on their level of performance: high, average and below average. Unique to the Independent Health model, the diabetes and asthma adherence to guideline components are awarded based upon participation and active engagement in the program only (not performance-based). The overall award amount is based upon an additional per member per month reimbursement for the level of performance and participation achieved. Primary care physicians can earn up to $2 PMPM for high-level performance in all five areas.

Independent Health's Practice Excellence program has a continued record of success, with significant improvements in preventive health services and double-digit

improvement in over twenty performance metrics associated with diabetes and asthma.

Oxford Health Plans

Trumbull, Connecticut

Oxford Health Plans created the Best Practices Program (BPP) for diabetes to recognize and reward quality performance among physicians. Oxford's BPP initiative is designed to reach those individuals who are not engaging in the appropriate activities (e.g., diet, exercise and regular visits to specialists) to manage their conditions. Oxford works collaboratively with providers within their network to motivate members to: 1) become actively engaged in the care they receive; 2) modify behaviors to appropriately manage their health conditions; and 3) be accountable for personal health outcomes.

Currently, more than 380 high-risk members with diabetes have been referred to endocrinologists in Oxford's BPP initiative for diabetes. Of those members with confirmed visits to specialists, Oxford has seen an average decrease in A1C levels of about 8%. In addition, over 60% of members enrolled in the program improved their A1C results by the second physician visit.

In the initial phase of this program, Oxford selected high-quality endocrinologists or endocrinology groups across seven counties in New York to participate. These endocrinologists have achieved or have agreed to apply for the Diabetes Physician Recognition Program co-sponsored by the American Diabetes Association and the National Committee for Quality Assurance that measures the physician's ability to meet certain measures of diabetes care. A cross-functional team was developed to provide outreach calls to program participants to arrange appointments with a participating endocrinologist.

PacifiCare Health Systems

Cypress, California

PacifiCare Health Systems has adopted a comprehensive and integrated strategy to improve quality and affordability through Quality Index" profiles, value networks, a quality incentive program, health and disease management programs, and consumer rewards. Since 1998, PacifiCare's semi-annual Quality Index" profile of Medical Groups has used clinical, service, and data indicators to rank medical groups. The measures are sorted into five categories: Staying Healthy (e.g., includes cervical and breast cancer screening, chlamydia screening and childhood immunizations); Appropriate Care (e.g., appropriate care for diabetes care and coronary artery disease); Patient Safety (appropriate use of antibiotics and cholesterol-lowering drugs); Service & Satisfaction (e.g., satisfaction with medical groups or primary care physicians, and Primary Care Physician communication); and Affordability. PacifiCare profiles the medical groups and then posts the results as "report cards" on its Web site and includes a summary in its provider directory to members.

In addition, in 2003, PacifiCare began publishing an annual Quality Index" of Hospitals which serves as a report card on the relative performance of contracted hospitals on 56 measures of risk-adjusted complication rates and mortality rates, patient safety measures, utilization and patient satisfaction related to common medical, surgical, obstetrical, orthopedic and pediatric conditions. The profiles are available on PacifiCare's public website.

Enrollees who select physicians from PacifiCare's "value network" of higher quality, lower cost providers, also may pay $10 per visit for their primary care physician and $20 per visit for a specialist, whereas co-payments for office visits using physicians and specialists in the "standard network" may double those amounts. Furthermore, PacifiCare's Quality Incentive Program (pay for performance) incorporates a subset of the Quality Index(r) profile and has demonstrated an average improvement of 25 percent in 17 of 20 measures, with rewards exceeding $15 million in the past three years to better-performing providers.

Regence BlueShield

Seattle, Washington

Regence BlueShield's Clinical Performance Recognition Program acknowledges primary care providers who exhibit strong performance in both clinical quality "adherence to evidence-based guidelines and cost-efficiency "reducing condition-specific cost variation over the course of patient care. To be recognized, providers receive aggregate quality and efficiency scores, with each area given equal weight, and then each clinician's percentile rank is averaged. Only clinical specialties with at least 20 participating physicians are eligible for recognition. Clinicians within the top ten percent of the composite metric are acknowledged for their performance. To intro-

duce their program, Regence awarded $5,000 to 200 primary care physicians who met these performance criteria.

In addition, Regence and The Boeing Company have implemented a Hospital Safety Incentive program. The program is intended to encourage members of Boeing's largest unions to use hospitals that meet the Leapfrog Group patient safety standards. Patients requiring any of six procedures, such as Coronary Artery Bypass Graft and Abdominal Aortic Aneurysm repair must use a network hospital that meets the Leapfrog Group's Evidence–Based Hospital Referral volume standard in order to receive the incentive. For all other hospital services, patients must use a hospital that meets the Leapfrog Group's standards for Computerized Physician Order Entry as well as the Intensive Care Unit staffing requirements. Patients seeking care from hospitals that meet the required standards receive 100 percent coverage after their deductible (compared to 95 percent if they receive care from hospitals that have not met these standards).

Rocky Mountain Health Plans and Mesa County Physicians IPA

Grand Junction, Colorado

Rocky Mountain Health Plans (RMHP) and the Mesa County Physicians IPA jointly developed a three-year pilot project in late 2002-early 2003 to reward primary care physicians for performance in the management of chronic illnesses. The project uses a three-part strategy to recognize quality performance through strong outcome measures and support of quality improvement efforts of physicians. First, the project creates an opportunity for providers to share in the benefits of improving chronic illness outcomes through timely performance payments from the IPA. Second, practices can opt to access guidance and assistance, without charge from RMHP, in implementing a system for improved outcomes ("chronic care model"). Third, RMHP provides ongoing support for offices implementing the model through monthly collaborative educational lunches and a quarterly case management fee payment.

A physician committee established the clinical outcome measures used based on peer-to-peer comparisons. Initially, all measures are being equally weighted. Eligibility for physician rewards is based on levels of participation in the program:

- If no data is submitted, physicians are not eligible for performance payments.
- If data is submitted on an approved flow sheet or report, physicians are eligible for performance payments.
- If data is submitted on an approved flow sheet or report and criteria has been met for a chronic care office meeting, physicians are eligible for performance payments and quarterly case management fees per diseased member.

Within the first twelve months of the project, 100 percent of the primary care physicians in Mesa County who have RMHP members with diabetes were submitting data quarterly on nearly 1800 members. Approximately 50 percent of the primary care physicians are using an improved process for delivering care to their entire population with diabetes or asthma.

Significant improvement is being seen in diabetes clinical outcomes in all lines of business. There is also early evidence of the anticipated cost saving trend in the commercial line of business. Documented first year savings in the commercial line of business is about $41,500.

WellPoint Inc.

Indianapolis, Indiana

WellPoint's quality programs provide increased reimbursement to hospitals and physicians based, in part, on achieving improved quality measures. Below are several examples of proven quality programs at WellPoint:

Approximately 15,000 physicians in Anthem Blue Cross and Blue Shield networks receive a portion of their reimbursement through bonuses for improving care to health plan members. For example, hospitals selected for Anthem Blue Cross and Blue Shield's Coronary Services Centers program in Indiana, Kentucky, and Ohio must meet stringent clinical quality standards for patient care and outcomes for certain cardiac procedures. Examples of quality standards used for evaluation include: Cesarean-section rates, the percentage of patients who were prescribed beta-blockers after discharge, the number of discharged heart failure patients prescribed ACE inhibitors, and adoption of patient safety as a strategic goal. Since the program's inception in Ohio more than 10 years ago, participating hospitals in the state have seen a 38-percent decrease in mortality rates, and improved rates for beta blocker use after heart attacks.

Anthem Blue Cross and Blue Shield of Virginia's Quality-in–Sights Hospital Incentive Program (QHIP) rewards hospitals for improvements in patient safety, pa-

tient health, and patient satisfaction. The 16 hospitals that participated in the first year of QHIP in 2004 are receiving a total of $6 million for actively working to implement nationally recognized care and safety practices that can save lives. Hospitals are measured on such indicators as the adoption of JCAHO patient safety goals, implementation of computerized physician order entry systems, administration of beta blockers after heart attack, pneumococcal vaccination, and rates of serious complication following diagnostic cardiac catheterization. Hospitals can earn up to an additional one percent from Anthem, with the reward added to reimbursements going forward. In 2005, 45 Virginia hospitals are participating in QHIP.

Blue Cross of California (BCC) is implementing comprehensive physician pay-for-performance programs. In 2003, BCC paid $57 million in bonus payments to 134 medical groups based on quality criteria. The quality indicators evaluated within the HMO program include member satisfaction, compliance with preventive screenings, such as mammograms, appropriate treatment of asthma, and smoking cessation. BCC is also a member of a coalition of six health insurance plans that awarded $50 million in bonus payments to 215 physician groups in 2004 based on clinical benchmarks.

In October 2002, Blue Cross of California also expanded these programs to include a PPO Physician Quality and Incentive Program (PQIP). The payment rewards are currently limited to six counties in the San Francisco area. Over 4,000 physicians located in six counties in the San Francisco area are eligible to participate in the Physician Recognition Program and receive a financial bonus for superior performance on clinical quality (e.g., breast cancer screening, childhood immunizations, and eye exams and Hemoglobin A1C testing for diabetes), service quality (e.g., enrollee complaints) and pharmacy measures (e.g., generic substitutions). Nearly $3 million in bonuses were distributed to close to 2,000 physicians in Spring, 2004 based on first year PQIP performance. Going forward, PPO physicians could be eligible for a fee schedule increase up to 14 percent above the plan's standard PPO fee schedules.

Chairman JOHNSON. Dr. Galvin, you are welcome to begin.

STATEMENT OF DR. ROBERT GALVIN, DIRECTOR OF CORPORATE HEALTH CARE AND MEDICAL PROGRAMS, GENERAL ELECTRIC, FAIRFIELD, CT, ON BEHALF OF THE HUMAN RESOURCES POLICY ASSOCIATION

Dr. GALVIN. Good. Thank you, Chairman Johnson, Congressman Andrews and other distinguished members of the subcommittee. Thank you for asking me to testify on the challenging issue of employer-sponsored health benefits.

My name is Robert Galvin, and I am the Chief Physician of Global Health Care for General Electric. I am appearing today on behalf of the H.R. Policy Association, where I am serving as director of Health Care Value initiatives.

In my position at GE, I am responsible for the design and operation of GE health benefits. To cover over 350,000 U.S. employees and retirees costs the company $2 billion annually, growing at a rate that is three or four times faster than the CPI. Like most large companies, GE believes healthy employees and families contributes to our success as a company. We remain committed to helping our employees staying healthy and providing them access to highest-quality treatment when they are ill.

However, I cannot overestimate or stress enough the level of concern both to GE management and to GE employees about the relentless increase in health costs. H.R. Policy Association, a group representing chief human resource officers from more than 25 large employers, and the Business Roundtable, an organization representing CEOs of large employers, have declared that health costs are the biggest issue facing senior leadership. This shows how this has reached the radar of top leadership of American corporations.

In 2003, the H.R. Policy Association Board of Directors created the health care Policy Roundtable to use the collective buying power of the 20 million workers employed by HRPA companies to leverage health care reforms within existing policies. Two private-sector initiatives by the Roundtable that are relevant to the discussion today are explored in greater detail in my written statement, called the National Health Access and the Regional Health Care Quality Reform initiatives.

The most important trend, I think, going on among employers today is that, in response to both the unpopularity of managed care in the last decade and the new research, which Ms. Ignagni mentioned, showing the serious gaps in quality and the variation, employers have moved from a focus purely on cost to one based on value. What we mean by value is the highest quality and quality first at the best price.

To be able to buy value, employers believed two fundamental changes are needed and that without these fundamental changes it won't be possible to move forward. First, comprehensive information about the performance of doctors and hospitals needs to be publicly available as quickly as possible. Second, existing financial incentives which currently drive the wrong behaviors need to be changed.

Let me give you a real-world example of how our current system plays out for employees and patients.

Last month I got a call from a very concerned employee seeking advice about whether the place that a primary care doctor had recommended she get treated was really the best place for her to go for a diagnosis of cancer.

Despite searching every data base I could find, I was unable to answer this person's question. I called a colleague who collects this kind of data, and I asked him if he could help. He replied that he would like to help but that the doctors and hospitals that agreed to send him data only if he refused to reveal their individual performance. I asked if he were willing to help the patient and me by doing the following.

As I mentioned possible treatment sites, would he cough once as I mentioned the best one and would he cough twice when I mentioned the second best. I quickly named the facilities and hearing first a single cough, then two coughs, I realized what he was telling me. I then had a long discussion with the employee and her family to help them make the decision.

In this case, it turned out that she went to an alternative center from where she was going because they had much more experience in treating her kind of cancer. So as strange as it my be to hear that true story in our information rich country in the year 2005, it is also true and equally strange that the best facility and the worst facility get paid exactly the same.

Employees also do not have incentives around their choices. Our data at GE shows that in every metropolitan area where we are, which is most of them in the country, among the hospitals with the highest quality costs differ by 30 percent. Yet in almost every benefit design that employers have created—and employers pay the same whether they choose the most expensive option or the one with the best value—a recent analysis we just did of GE data

shows that our employers are going to the highest quality doctors and hospitals best judged by available measures only 30 percent of the time. If those employees were to go to the best providers all the time, GE would save at least $100 million annually, and our employers would get improved quality.

In a recent survey, 80 percent of our employees told us that they would change doctors and hospitals if they had the data they trusted, just like the employee I mentioned a minute ago. A majority of doctors with whom we have spoke have told us that getting rewarded for quality not only seems fair but would help them save to have more money to invest in important improvements like having computer-based medical records.

Programs like Leapfrog and Bridges to Excellence, which you will hear about in a couple of minutes, are examples of what health care can do. Our employees in Louisville, Kentucky, where we make refrigerators, now know that there are 40 doctors recognized to have superior performance in treating diabetes, when they had no such knowledge a couple of years ago, all due to this program Bridges to Excellence.

The question now is how to increase the momentum. Since all significant change in health care creates controversy, it is important that public and private sectors work together. The most important steps that the Federal Government would take would be, one, to support the recommendations of the March, 2005, MedPath report to immediately integrate performance-based payment into Medicare; and, two, to become value-based purchasers yourself in your own programs, by which I mean the program you have for Federal employees and the one that the DOD provides through TRICARE for employees of the Department of Defense.

Partnership between private sector employers and the public sector would be a powerful message that I believe would not only begin to change our system to get better, but it will help us preserve an employer-based system.

Thank you for the time.

Chairman JOHNSON. Thank you, sir. We appreciate your testimony.

[The prepared statement of Dr. Galvin follows:]

Statement of Dr. Robert Galvin, Director of Corporate Health Care and Medical Programs, General Electric, Fairfield, CT, on behalf of the Human Resources Policy Association

Chairman Johnson, Congressman Andrews, and other distinguished members of the Subcommittee, I am Dr. Robert Galvin. I appreciate the opportunity to share the employer perspective on the topics of the day: pay-for-performance measures and other trends in employer-sponsored health care. This is an important issue and I applaud the Subcommittee for creating a forum for Members of Congress and the public to learn more. I am Director, Global Health, for General Electric. I also serve as Director, Health Care Value Initiatives for HR Policy Association's Health Care Policy Roundtable. In my position at GE I am responsible for the design, operations and financial performance of the health benefits GE offers its employees, family members, and retirees as well as for the overall health of this population. Our population totals about a million people with an annual expenditure exceeding two billion dollars.

HR Policy Association represents the chief human resource officers of more than 250 large employers. The Chairman of the Association is William J. Conaty, Senior Vice President of Corporate Human Resources for GE. The number one concern among HR Policy members is the unsustainable increases in health care costs and deficiencies in health care quality that threaten the viability of our nation's health

care system. In 2003, the HR Policy Association Board of Directors created the Health Care Policy Roundtable to take decisive action using the collective influence of America's largest private employers to address health care cost and quality issues that plague both private employers and government payers. The Roundtable is chaired by J. Randall MacDonald, Senior Vice President of Human Resources for IBM. Its strategies are premised on the recognition that companies, which employ more than 20 million employees worldwide, can use their collective buying power to leverage health care market reforms within existing public policies. In turn, these reforms may provide guidance to policymakers in addressing needed changes in U.S. health care policy.

Two private sector initiatives being undertaken by HR Policy's Roundtable are relevant to the discussion today—the National Health Access program and the Regional Health Care Quality Reform Initiatives. National Health Access is a program created by a coalition of 60 companies within the Association to create improved health insurance options for workers without access to employer provided coverage, and simultaneously drive two key market principles: transparency, meaning the public release of measures of performance about doctors and hospitals, and pay-for-performance. The program has the potential to affect 3 million individuals and will launch with the first round of employers this fall. The efforts of the Roundtable's Regional Health Care Quality Reform Initiatives, which are chaired by John D. Butler, Executive Vice President, Administration and Chief HR Officer of Textron, Inc., are a critical component of the Roundtable's reform agenda and are directly in line with the focus of today's hearing. The Roundtable has worked with a number of companies and organizations in specific regions to accelerate the measurement, reporting, and dissemination of health care provider quality and efficiency data. I will describe the early efforts of one of these initiatives in Phoenix in more detail later.

The Problem

Many of us are too familiar with the problems that plague our health care system. Purchasers, providers, and patients of health care services can no longer accept the status quo. The U.S. spends significantly more on health care, both in terms of dollars per capita and as a percentage of Gross Domestic Product, than any of our trading partners, yet it is difficult to make the case that sufficient value is being derived to justify the enormous cost. At the same time it is large employers, the private sector, who bear a significant portion of the financial burden for this difference with our trading partners, and for that we suffer the competitive consequences. Health care purchasers face double digit increases each year with no sign of a decline in costs or more manageable inflation in the foreseeable future. As such, health care is crippling America competitively and draining our federal budget.

Of equal concern is the fact that the huge resources we plow into our health care system do not provide access and high quality care for all. It is estimated that 45 million Americans are without health insurance coverage. Simply layering our existing, opaque, health care system across 45 million uninsured Americans is not the solution. This would increase overall cost without addressing the systemic flaws in our health care system. In addition to a coverage gap, there is a serious quality gap. A recent study by the RAND Corporation found that adults received recommended care only about 55 percent of the time. Clearly meaningful reform is needed. Fundamental components of the solution to these quality deficiencies lies in greater transparency and disclosure about cost and quality throughout the system, engaging consumers who have a stake in the financial as well as clinical outcome, and basing payment to doctors and hospitals on performance.

Focus of Testimony

I am fortunate to share the panel with two individuals who are very knowledgeable about pay-for-performance measures. In particular, Jeff Hanson of Verizon is an expert on the topic and as President of Bridges to Excellence, he is heading a successful practical application of a pay-for-performance model. As a result, I will focus my testimony on other efforts that employers are collectively and individually undertaking to create incentives for doctors and hospitals to improve patient care and patient outcomes. Specifically, I'll describe three emerging trends among employers: 1) purchasing aimed at finding providers that provide the best clinical outcomes at the best value; 2) efforts to inject greater transparency about the clinical effectiveness and efficiency of providers into the health care system accompanied by a payment that rewards performance; and 3) increasing involvement of business leaders at the corporate executive level in health care purchasing. I'll also provide some examples of these trends.

Employers Are Shifting to Value Based Purchasing in Health Care

Employers recognize that the purchase of health care is unique and personal for a company's workforce. There has to be a sense of trust between those making decisions on benefits and those for whom the use of the benefits is critically important. Therefore, there cannot be a perfect comparison between purchasing health care and selecting a supplier for other services. However, the basic premise of demanding high standards and holding suppliers (health care providers in this instance) accountable is transferable to health care purchasing.

It was not too long ago that the dominant employer model for purchasing health care focused on finding the lowest unit cost of care. This short-sighted approach may have resulted in short-term savings for a limited time, but did nothing to improve the overall health of our workforce. In addition, as demonstrated by the double-digit increases in health care premiums that employers have faced over the last several years, it is clear this approach failed to lower health care inflation for any appreciable time. Employer purchasing of health care is no longer simply a matter of finding the cheapest deal. This would be a disservice to employees and do nothing to address deficiencies in the system.

Employers are moving from purchasing based on cost to purchasing based on value, meaning health care that delivers optimal clinical outcomes in the most efficient manner. Experts have continuously demonstrated that there are significant differences between doctors and hospitals in how well and how efficiently they deliver medical care. At GE, our analysis shows that in every major market that we have employees the same level of quality is available at prices that differ by 30–40 percent. Our data shows that less than 35 percent of our hospital admissions occur at hospitals that score highest on both cost and efficiency. Large employers are beginning to demand more and hold providers and health plans accountable for delivering high quality care. They are sending the message that it is no longer tolerable to accept these deficiencies.

Transparency is the Foundation of Meaningful Efforts to Lower Costs and Improve Quality

GE, along with the members of HR Policy's Health Care Policy Roundtable, believe a fundamental component of the solution to quality deficiencies lies in greater transparency and disclosure about cost and quality throughout the system, and engaging consumers who have a stake in the financial as well as clinical outcome. True market reforms can't occur when purchasers and consumers have no idea what the true cost of certain health care services and products are. Employers and employees must be exposed to the real net cost of the product or service. At a minimum, health care purchasers and consumers want to lift the veil to find out who the best health care suppliers are—including hospitals and physicians—for specific procedures. This information can then be used to provide incentives to consumers to use high performing providers and the best treatment alternatives and to pay providers differentially based on their performance.

A major positive advance over the past decade has been the development of metrics that can measure quality at the level of doctors and hospitals. While it is true that these measures are still being perfected, most private sector employers and employer organizations like the Health Care Policy Roundtable, as well as many physicians, believe that they are accurate enough for public release. Recent efforts to develop a standardized set of these measures have been successful, including the Ambulatory Quality Alliance, a collection of professional trade organizations which recently agreed on a starter set of measures acceptable to organized medicine and health insurance companies, and the HR Policy Association which developed a more complete core set of measures. Although there is little scientific data to cite, it is common sense in the business world that what is measured is managed, and that making public the performance of doctors and hospitals will spur improvement.

Injecting greater transparency into the system is even more important as more employers and employees shift to designs that give consumers more control over their health care decisions. Health savings accounts and high deductible health plans are based on the premise that patients as consumers will be more sensitive to costs when using these products, and therefore more engaged in demanding value for their health care. At GE, when we ask our employees, over 80 percent say they want the kind of information that can be provided through available metrics and will use it to make decisions about who to see and where to go for treatment. Without transparency, consumers are denied the ability to make informed choices about the care they receive. Needed reform must have the support of both government and private payers. The business community is pleased that some government leaders, such as Mark McClellan who heads the Centers for Medicare and Medicaid Services, are embracing these concepts.

Health Care Has Gained the Attention of Corporate Executives

The experiences of the Roundtable's various Regional Health Care Quality Initiatives is an eye-opener as to what it takes to address some of the problems of our health care system. The effort has evolved to recognize that deficiencies will not be addressed unless the payers force a solution, which can only be done if they work together and exercise their leverage to achieve improvements. Health care has been the number one concern of chief human resource officers for the past several years and is likely to remain a priority concern for several years to come. However, until now, the prevailing model has been for senior executives to delegate involvement in collaborative efforts to those at a lower level within the company. Those individuals are critical to the success of such efforts. They are skilled and knowledgeable about the specifics of benefit design and employee communications. However, without the involvement of key strategic decision-makers, there are limits to what they can accomplish.

The kind of collaboration and long range planning that is needed is unlikely to occur if left exclusively to corporate benefit managers whose primary focus is meeting the company's benefits needs in the year at hand and putting something workable in place for the following year. They often lack the decision-making authority to institute strategic change at their companies. It is essential, therefore, that chief human resource officers and other senior executives become much more involved in setting benchmarks for the purchase and delivery of health care on a broad collaborative basis, ensuring that those standards are followed, evaluating and ensuring the proper execution of market reform strategies, and creating a climate of accountability to focus all players on the objectives of lowering costs and improving the quality of care purchased for employees. The ultimate solutions for fixing the health care system will involve setting a vision for the purchasing community, reaching consensus on objectives, and executing a collaborative strategy. This can only be achieved by the direct involvement of those at the highest levels among purchasers. Just as the overall direction of the company is set by those at its highest level, the company's role in the future direction of health care must also be shaped at that level as well. The ultimate goal is to drive the health care system toward the "Six Sigma" standards that GE and many employers have embraced within their own organizations.

Though the Roundtable's Regional Health Care Quality Reform Initiatives has focused its efforts at the regional level, where an immediate impact is most feasible, coalition members understand that it is important to not lose sight of the importance of maintaining a national perspective as well. The reality is that, while change is often a great deal more achievable at the local level, the broad structure of our health care system—currently an employment-based model—will still likely be a national paradigm, enormously influenced by how federal dollars are collected and spent. For this reason, members of the Roundtable believe it is equally important that senior human resource executives play a role at that level as well. These senior executives plan for their involvement not to be simply reactive, but to entail the shaping of a vision of the ideal future role of employers in the health care system with the formulation and promotion of federal policies that achieve that ideal.

Examples of Existing and Emerging Successes in Health Care Purchasing

Individual company and collaborative efforts that incorporate the three trends described above are emerging. Some hold the promise of producing needed reform, and others that have already demonstrated considerable success. At GE, while we have not found a "silver bullet," we are proud of our progress in addressing deficiencies in the health care system through our internal purchasing system. We have learned that a combination of flawless execution of purchasing basics plus a willingness to be innovative, using purchasing clout to address fundamental problems in our health care system, yields optimal results.

The Leapfrog Group. Employers have learned that through united efforts they can successfully catalyze change. The progress achieved by private and public sector purchasers through The Leapfrog Group is an example. The Leapfrog Group is a coalition of more than 165 Fortune 500 companies and other large private and public sector purchasers of health benefits. Its members work to trigger "leaps" in the safety, quality and affordability of healthcare by supporting informed health care decisions and promoting high-value health care through incentives and rewards. Leapfrog has identified and refined four hospital quality and safety practices: computer physician order entry; evidence-based hospital referral; intensive care unit (ICU) staffing by physicians experienced in critical care medicine; and quality index of measures of safe practices.

Leapfrog members work to trigger "leaps" in the safety, quality and affordability of healthcare by supporting informed health care decisions and promoting high-

value health care through incentives and rewards. Leapfrog's strategy is for each of its members to insist on transparency and pay-for-performance in its contracts with health plans. Leapfrog recently launched its Hospital Rewards program, which is essentially a private sector version of the highly successful CMS Premier Hospital Incentive Program. If enough purchasers include the Leapfrog language in their contracts and insist that plans participate in the Hospital Rewards Program, health plans will then change their contracts with doctors and hospitals, insisting on data release and paying for performance.

Phoenix Project. One of the Regional Health Care Quality Reform Initiatives being undertaken by the Health Care Policy Roundtable in Phoenix, Arizona is just getting off the ground, but holds great promise. Several HR Policy Association member companies with a significant number of employees and/or retirees in the Phoenix region, such as GE, IBM, and Honeywell, have teamed up with health plans and health care improvement organizations to enhance the depth of information about provider quality and efficiency available to employers and consumers. Major partners in the endeavor include CIGNA, The Leapfrog Group and Bridges to Excellence. CIGNA's decision to publicly release information on a core set of performance measures, moving away from a proprietary model for measuring quality, is a groundbreaking approach that will advance transparency greatly. Recently, St. Luke's Health Care Initiatives, an Arizona-based nonprofit dedicated to improving community health, and other national health carriers in the region have expressed interest in joining the effort.

Working together, the organizations will broaden access to standardized quality and efficiency measurements and to make that information publicly available to patients and purchasers. Phoenix partners have agreed to take the project on two paths. First, they will pursue a short-term goal of promoting pay-for-performance through existing programs such as Bridges to Excellence and The Leapfrog Group. At the same time, the stakeholders involved will work toward a more ambitious longer-term goal of aggregating data across health plans and employers on provider efficiency and quality, and making that information publicly available.

All comers are welcomed to this initiative, including additional health plans, regional coalitions and employers of all sizes. The more companies and organizations that are on board, the better our chances are for success. The Phoenix project creates a powerful and comprehensive approach to regional quality reform for care that can be emulated in other markets across the country. Though the Phoenix project will begin as a local endeavor, it can serve as a model for the sharing of data and information among employers, consumers and other health plans.

Conclusion

Consistent and dedicated efforts by employers can achieve significant improvements to our health care system despite the formidable challenges that we face. GE and the Health Care Policy Roundtable are examples of the business community's dedication to ensure that our nation's workforce receives the highest quality health care, and that health care purchasers and consumers have access to important quality information about doctors and hospitals upon which to make important decisions. Only then can purchasers begin to pay providers differentially based on the quality of care delivered. We are encouraged that the federal government, particularly through innovations in quality improvement and an examination of moving toward pay-for-performance in the Medicare program, is taking a lead on these important issues. We welcome efforts to partner with the government to move our nation's health care in the right direction.

Chairman JOHNSON. Dr. Rosenthal, you have got quite a varied experience. Please begin.

STATEMENT OF DR. MEREDITH B. ROSENTHAL, ASSISTANT PROFESSOR OF HEALTH ECONOMICS AND POLICY, HARVARD SCHOOL OF PUBLIC HEALTH, BOSTON, MA

Ms. ROSENTHAL. Thank you.

Thank you, Chairman Johnson, Congressman Andrews, members of the subcommittee. Thank you for inviting me here to discuss pay for performance and health care.

The most recent estimates suggest that there are more than 100 new pay-for-performance programs in the U.S. health care sector.

Variously, these programs reward physicians, medical groups and hospitals for health care quality goals. Typically, providers are evaluated and rewarded based on a set of quality measures which usually capture problems of underuse.

For example, physicians may be rewarded based on providing cholesterol screening to their patients with coronary artery disease. Hospitals are also sometimes rewarded based on outcomes measures, including complication rates and in-hospital mortality rates.

Pay for performance has significant positive potential in the health care sector, where reimbursement has traditionally been based only on the utilization of services and patients are often not in any position to distinguish high-quality providers from low-quality providers. Financial incentives for quality are new, however, and payers face a number of challenges in implementing these programs.

My review will highlight three key issues for policy. First, there is insufficient evidence to inform the design of pay-for-performance programs; second, there is a need for coordination across payers; and, third in its current form pay for performance is not positioned to deliver relief from the spending trend facing health benefit purchasers.

Let me describe briefly each point.

First, despite concurring enthusiasm for pay for performance, there is remarkably little evidence in the literature for purchasers of health plans to reference when they set out their pay-for-performance programs. Moreover, an existing analysis of pay-for-performance programs indicates that there are opportunities to improve the cost-effectiveness of these programs and to increase the likely gains in quality for all consumers.

For example, with few exceptions, pay-for-performance programs reward the best performers, either by reference to a fixed benchmark or by comparison to one another by ranking providers. Economic theory, however, would suggest that rewarding all providers for improvement would generate more improvement for a given fund.

In addition, there may also be concerns that if rewards only go to the top providers based on, again, the level of performance, there will be a downward spiral among the lower quality providers who may be serving vulnerable populations, populations who already have poor access to health care. There is simply no evidence as to the practical importance, the magnitude of these potential negative consequences.

Going forward, purchasers in health plans need timely evaluations of a broad range of programs, including assessments of negative, unintended consequences, as well as targeted decision support to help them sort through research findings and make appropriate tradeoffs. Congress could facilitate progress toward this end by enhancing the capacity of the agency for health care research and quality, which has played a critical role in this area.

My second point concerns the need for coordination among payers on the clinical domains and specific quality measures to target. As you have heard earlier, the issue is that if only a few of the many payers that a provider contracts with are paying for perform-

ance, or if they are all paying based on difference sets of measures, the effects will be deluded.

Some private sector employers—two on either side of me—have already begun aligning their efforts through coalitions such as the Leapfrog group Bridges to Excellence and a number of others, which sets standards for measurement and reporting, among other activities.

CMS's leadership role in this area will also go a long way toward this goal as private payers have historically emulated the CMS in terms of their payment reforms, including the respective payment system. CMS could also support pay-for-performance programs by further contributing deidentified—sorry, provider identified, deidentified data to these pooled efforts to profile providers using all pair data.

The third and final issue is that, despite the hopes of some benefits purchasers, the current generation of pay for performance is not designed to reap cost savings. This is in large part due to the fact that the greatest performance measurement has so far been on measures of underuse. Therefore, if we improve quality in that way, we will lead to increased use.

There is some indication, however, that pay for performance is being reoriented toward cost efficiency metrics. Along these same lines, payers could greatly benefit from a public investment in the development of quality measures that capture the negative consequences of overuse.

To summarize, there several ways in which Federal policymakers could enhance private sector pay-for-performance efforts.

First, increase the capacity of the agency for health care research and quality to support evaluation and dissemination of research on pay for performance, including research on the unintended strategies of particular strategies. Second, encourage the CMS to continue to take a leadership role in quality measurement and pay for performance. Third, facilitate the sharing by CMS of patient-deidentified provider-identified data to an all-patient base data set. Fourth, through AQHR or CMS, support efforts to approve the measurement of cost efficiency and overuse.

Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you. We appreciate your testimony.

[The prepared statement of Ms. Rosenthal follows:]

Statement of Dr. Meredith B. Rosenthal, Assistant Professor of Health Economics and Policy, Harvard School of Public Health, Boston, MA

Chairman Johnson, distinguished Committee members, thank you for inviting me to discuss pay-for-performance in health care. In my remarks, I will describe recent efforts by health plans and employers to reward physicians and hospitals for providing high value health care and discuss the economic incentives inherent in the design of these programs. My comments derive from my research in this area over the past several years, which has been funded by the Agency for Healthcare Research and Quality, the Commonwealth Fund, and the Robert Wood Johnson Foundation's Health Care Financing and Organization initiative. The views expressed in my testimony are, of course, my own and should not be attributed to any of these funding agencies.

Pay-for-performance has significant positive potential in the health care sector, where reimbursement has traditionally been based only on utilization of services and patients are often not in a position to discern high quality from low. In this environment, incentives to deliver high value health care are often absent or even negative (e.g., preventing a hospital admission will generally reduce the net reve-

nues of a health system that includes a hospital). Pay-for-performance is still new to health care, however, and payers face a number of challenges in implementing these programs.

First, there is little guidance in the literature for purchasers and health plans to reference when they set out to design their pay-for-performance programs. An analysis of the features of the first generation of programs indicates that there are opportunities to improve the cost-effectiveness of pay-for-performance and increase the likely gains in quality and value. To help them design more effective pay-for-performance programs, purchasers and health plans need timely evaluations of a broad range of programs and targeted decision support. Congress could facilitate progress towards this end by enhancing the capacity of the Agency for Healthcare Research and Quality (AHRQ), which has played a critical role in this area.

Second, coordination among payers on the clinical domains and specific quality measures to target is desirable. If only a few of the many payers that a provider contracts with are paying-for-performance or if each payer focuses on a different measure set, the effects of pay-for-performance may be diluted. Some private sector employers have already begun aligning their efforts through health care quality improvement coalitions such as the Leapfrog Group, Bridges to Excellence, and others, which offer standardized programs of performance measurement, reporting, and reward. CMS" leadership role in this area may go a long way towards this goal as private payers have historically emulated many of Medicare's more significant payment reforms, such as the Prospective Payment System. CMS could also support pay-for-performance efforts further by contributing de-identified data to an all-payer data set from which more reliable performance evaluation could be conducted (because of larger denominators).

Finally, despite the hopes of some benefit purchasers, the current generation of pay-for-performance is not designed to reap cost savings, particularly since most of the quality measures it targets are measures of under use. In my view, it would be desirable to enlist pay-for-performance in the service of enlightened cost control in order to preserve the availability of private insurance coverage. There is some indication that pay-for-performance is being reoriented towards cost savings with the incorporation of increasingly robust cost-efficiency metrics, which are being refined by a number of researchers. Along these lines, payers could also greatly benefit from a public investment in the development of quality measures that capture the negative consequences of over use.

Pay-for-performance should be viewed as one element of the set of strategies that employers, health plans, and government programs are undertaking to improve the value of health care spending and make insurance coverage more affordable. Other promising tools that are taking hold alongside pay-for-performance include public reporting of quality and cost information, tiered benefit designs that give consumers incentives to choose higher quality and lower cost providers and treatments, shared risk payment models such as the one being evaluated under the Centers for Medicare and Medicaid Services Provider Group Practice demonstration, and disease management. All of these approaches to cost control and quality improvement are evolving and come with their own set of advantages and disadvantages. Because there is very little evidence base that can be drawn upon to inform the design and implementation of these efforts, it is critical that the natural experiments being undertaken by both public and private insurers be evaluated and the results disseminated effectively to key decision makers.

Payers Increasingly Align Financial Incentives with Quality Goals

During the past three years, numerous employers, purchasing coalitions, and health plans in the U.S. have announced new efforts to pay providers for performance on quality and cost-efficiency measures. The most recent estimates suggest that there are more than 100 individual pay-for-performance efforts underway in the U.S. health care sector. These programs vary along a number of dimensions including (among others) the type of sponsor, the size of the bonus, the formula for determining the bonus allocation, and the clinical areas targeted. I describe several examples to illustrate the diversity of approaches and then highlight the most prevalent program features and their economic and policy implications.

In California, seven health plans are coordinating pay-for-performance programs under the auspices of the Integrated HealthCare Association (IHA), a multi-stakeholder coalition. The seven plans, which constitute more than 60% of the commercial market for physician services in the state, are awarding bonuses to large, multispecialty physician groups based on clinical process measures such as rates of childhood immunizations and cholesterol screening, patient satisfaction, and investments made in technology and infrastructure. While the performance measures are common across the seven IHA health plans, the structure of the bonus varies. Most

plans have opted to reward the top performers only (e.g., the top deciles or quartiles) using a bonus that is proportional to the number of the plan's patients cared for by the group.

Similarly, Anthem's New Hampshire Blue Cross/Blue Shield plan pays bonuses to physicians who screen patients for breast, cervical, and prostate cancer and high cholesterol, help patients manage diabetes, and provide other recommended preventive health care. Anthem's performance bonus was $20 per patient for the top quartile of physicians and about half of that for physicians ranked between the 50th and 75th percentile. Physicians were also eligible for an additional payment of $20 per patient for participating in the plan's disease management program.

Another noteworthy physician reward program is Bridges to Excellence, a growing collaborative effort started by several large employers including General Electric and Verizon Communications. The program offers $100 per diabetic patient to physicians who become certified by National Committee for Quality Assurance/American Diabetes Association's provider recognition program. A similar program for cardiac care has also been launched. Finally, doctors can receive $55 per patient for establishing clinical information systems in their offices that aid in regular follow up in the care of chronically ill patients, and implementing patient education programs. Many of the measures within each of the areas targeted by Bridges to Excellence are structural in nature (i.e., they catalogue the existence of specific elements of infrastructure or capacity such as an electronic medical record), although both process and outcome measures are also featured in the scorecards associated with each area of focus.

Finally, as you may know, the Centers for Medicare and Medicaid Services (CMS) have been actively developing their own pay-for-performance programs. In July 2003, CMS and Premier, Inc., a nationwide organization of not-for-profit hospitals, announced a demonstration project to provide quality bonuses for hospitals based on performance related to treatment in five clinical areas that are particularly critical for Medicare's elderly population: heart attack, heart failure, pneumonia, coronary artery bypass surgery, and hip and knee replacements. Performance measures include both process and outcome measures. For example, the set of measures for coronary artery bypass surgery includes rates of aspirin prescribed at discharge, inpatient mortality, and post-operative hemorrhage or hematoma. Hospitals are scored and ranked on the measures condition by condition and any hospital in the top 10% for a given condition will receive a 2% bonus on their Medicare payments; hospitals in the next 10% will receive a bonus of 1 percent. In the third and final year of the demonstration, the hospitals with the worst performance (those that fall below a predetermined threshold) will be financially penalized. Early results disseminated by CMS suggest that substantial improvement has occurred among the participating Premier hospitals in the targeted clinical domains.(See http://www.cms.hhs.gov/media/press/release.asp?Counter=1441) In addition to the Premier demonstration, the CMS has incorporated pay-for-performance features into its Provider Group Practice and Health Support demonstrations. For example, in the Health Support program, disease management contractors have guaranteed savings to CMS and will also be made financially accountable for a variety of performance measures including patient satisfaction.

Common Themes among Pay-for–Performance Programs

The majority of pay-for-performance arrangements target both measures of clinical quality and patient experience. Particularly for physicians, clinical quality measures are typically rates of preventive care and other "process measures" that can be easily extracted from administrative data. Nearly all of these process measures address problems of under use—they measure the rate of use of recommended care for specific population groups. The focus on process measures reflects the state of quality measurement (particularly our ability to account for underlying patient differences across physicians and hospitals) rather than priorities for quality improvement. Thus, in the current context, paying-for-performance almost always means rewarding physicians and hospitals for delivering more services, for which they may also be able to bill (depending upon the reimbursement system). Perhaps in recognition of the cost implications of correcting under use through pay-for-performance, as pay-for-performance programs have evolved payers are also increasingly providing incentives for performance on cost-efficiency metrics. (Baker and Carter, 2004)

Almost without exception current pay-for-performance programs reward the best providers—all those either above a specific threshold or percentile ranking. Quality improvement is not explicitly required for the receipt of a bonus so that in practice the incentives to improve will vary with baseline performance. Particularly with an absolute performance threshold (e.g., an 80% childhood immunization rate), physi-

cians or hospitals that already meet the standard need only to maintain the status quo to receive payment. Similarly, for bonuses that are tied to the use of information technology or other "structural" measures of quality (such as having a patient registry) payments will go not only to those providers that improve their infrastructure, but also to every provider that already conforms to the standards. Most payers understand this very clearly and believe that it is important to reward providers that deliver the best quality care even if the rewards do not provide incentives for change.

It is also noteworthy that among pay-for-performance programs in the U.S., few payers put at risk more than 5% of payments. Moreover, because of the small market shares of some pay-for-performance program sponsors, the percent of a physician's overall revenue that is at stake can be much less than 5 percent. From an economic standpoint, the gain from quality improvement must counterbalance the cost, so if the quality improvement goals we set for providers are costly to achieve the current levels of payment may be insufficient to generate the desired response.

What is Known About the Effectiveness of Pay-for–Performance?

Two recent reviews document the scarcity of evidence to support the effectiveness of pay-for-performance in health care (Rosenthal and Frank In Press; Dudley et al. 2004). These reviews identify only seven evaluations in the health care literature that are pertinent (Amundson 2003, Fairbrother et al. 1999; Geron 1991; Hillman et al. 1998; Hillman et al. 1999, Kouides et al; 1998; Roski et al. 2003), one of which offered no interpretable results (Geron 1991). Among the other six studies, three (among which were those with the strongest research designs) yielded null results (Hillman et al. 1998; Hillman et al. 1999; Fairbrother et al. 1999). Two other controlled studies found modest improvements with pay-for-performance (Kouides et al. 1998; Roski et al. 2003) while the sixth study demonstrated substantial performance improvement but no evidence with regard to how much of this was due to the program rather than secular trends. (Amundson et al. 2003) Five of these six studies involved interventions targeting only a single dimension of care such as childhood immunizations (Fairbrother et al. 1999; Geron 1991; Hillman et al. 1998; Hillman et al. 1999, Kouides et al; 1998; Roski et al. 2003) and most of these provided only small rewards. In one of the two studies with positive findings linked to pay-for-performance, it was found that most of the gain in performance was achieved through better documentation of immunizations provided outside the physician's practice rather than improvements in immunization rates per se. While improved documentation may be valuable, it was certainly not the main goal of the program.

Outside of the health care sector, there are a variety of studies of similar incentive programs, the results of which are relevant to health care (Rosenthal and Frank, In Press.) Pay-for-performance programs have been used in schools and several recent experiments have documented improvements in test scores and other outcomes under these programs (Lavy 2002; Clotfelter and Ladd 1996; Hanushek and Jorgenson 1996.) One of these studies, by Lavy (2002), also demonstrated that pay-for-performance was more cost-effective (produced a larger impact for the same expenditure) than direct subsidies for new programs and additional staff time. Pay-for-performance has also been incorporated into Federal contracts for job training programs. Studies examining these programs found that pay-for-performance had a positive impact on the rate of job placement and average earnings, even after accounting for gaming on the part of contractors.

Empirical evidence regarding the existence of unintended consequences of pay-for-performance both inside and outside of health care is relatively well-established. Gaming has been shown to occur with pay-for-performance systems among return-to-work programs and schools, largely in the form of selecting trainees and students with the highest ex ante probability of success. In health care, both physicians and hospitals have been found to attempt to select healthier patients under prospective payment to maximize net revenues. Other possible negative effects of targeted incentives including reductions in quality of care in areas not targeted for financial rewards, which may be a particular concern in primary care because of the broad scope of practice, have simply not been evaluated empirically.

Key Policy Issues

Through the lens of economic theory and empirical evidence, my review of current pay-for-performance programs yields three key policy issues. First, there is little guidance in the literature for purchasers and health plans to reference when they set out to design their pay-for-performance programs. An analysis of the features of the first generation of programs indicates that there are opportunities to improve the cost-effectiveness of pay-for-performance and increase the likely gains in quality of care. To help them design more effective pay-for-performance programs, pur-

chasers and health plans need timely evaluations of a broad range of programs and targeted decision support. Congress could facilitate progress towards this end by enhancing the funding capacity of the Agency for Healthcare Research and Quality, which has played a critical role in this area.

Second, coordination among payers on the clinical domains and specific quality measures to target is desirable. If only a few of the many payers that a provider contracts with are paying-for-performance or if each payer focuses on a different measure set, the effects of pay-for-performance may be diluted. Some private sector employers have already begun aligning their efforts through health care quality improvement coalitions such as the Leapfrog Group, Bridges to Excellence, and others, which offer standardized programs of performance measurement, reporting, and reward. CMS" leadership role in this area may go a long way towards this goal as private payers have historically emulated many of Medicare's more significant payment reforms, such as the Prospective Payment System. CMS could also support pay-for-performance efforts further by contributing de-identified data to an all-payer data set from which more reliable performance evaluation could be conducted (because of larger denominators).

Finally, despite the hopes of some benefit purchasers, the current generation of pay-for-performance is not designed to reap cost savings, particularly since most of the quality measures it targets are measures of under use. In my view, it would be desirable to enlist pay-for-performance in the service of enlightened cost control in order to preserve the availability of private insurance coverage. There is some indication that pay-for-performance is being reoriented towards cost savings with the incorporation of increasingly robust cost-efficiency metrics, which are being refined by a number of researchers. Along these lines, payers could also greatly benefit from a public investment in the development of quality measures that capture the negative consequences of over use.

Pay-for-performance should be viewed as one element of the set of strategies that employers, health plans, and government programs are undertaking to improve the value of health care spending and make insurance coverage more affordable. Other promising tools that are taking hold alongside pay-for-performance include public reporting of quality and cost information, tiered benefit designs that give consumers incentives to choose higher quality and lower cost providers and treatments, shared risk payment models such as the one being evaluated under the Centers for Medicare and Medicaid Services Provider Group Practice demonstration, and disease management. All of these approaches to cost control and quality improvement are evolving and come with their own set of advantages and disadvantages. Because there is very little evidence base that can be drawn upon to inform the design and implementation of these efforts, it is critical that the natural experiments being undertaken by both public and private insurers be evaluated and the results disseminated effectively to key decision makers.

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Chairman JOHNSON. Mr. Hanson, you may begin.

STATEMENT OF JEFFREY R. HANSON, REGIONAL HEALTH CARE MANAGER, VERIZON COMMUNICATIONS, PRESIDENT, BRIDGES TO EXCELLENCE, PORTLAND, ME

Mr. HANSON. Mr. Chairman, Congressman Andrews and members of the subcommittee, my name is Jeffrey Hanson; and I am the regional health care manager for Verizon Communications and President of the Bridges to Excellence initiative. I want to thank you for giving me the opportunity to testify on what private companies such as Verizon are doing in the area of pay for performance.

Verizon provides health care coverage to nearly 800,000 employees, retirees and their family members at an annual cost to the company of more than $3.2 billion. The quality of health care received by our employees, retirees and covered family members is of paramount importance to Verizon. One of the cornerstones to obtaining real transformation of our health care system is provider quality differentiation, quality data transparency and realignment of the provider payment system based on quality performance.

The number of pay-for-performance programs has increased rapidly over the past few years, numbering now over 100 programs across the country. Verizon participates either directly or indirectly in many of these programs. We are a founding player in two of the more prominent initiatives, Bridges to Excellence and the Leapfrog hospital incentives and rewards program. Bridges to Excellence is a physician-based program, and the Leapfrog program is a hospital-based pay-for-performance program.

These two initiatives found their genesis in two very high-profile reports generated by the Institute of Medicine, Crossing the Quality Chasm and To Err is Human. These reports grabbed the attention of senior executives in corporations coast to coast. It was literally a call to action.

Bridges to Excellence is a not-for-profit organization organized to create significant advances in the quality of health care by developing reimbursement models that encourage the recognition of health care providers who have implemented changes in their delivery of health care to achieve better patient outcomes.

There are three components of this program. The Physician Office Link component enables physician office sites to qualify for bonuses based on their implementation of specific processes to reduce

errors and increase quality. They can earn up to $50 per year for each patient covered by a participating employer or health plan.

In addition, a report card for each physician office describes its performance on the program measures and is made available to the public.

The Diabetes Care Link portion of the program enables physicians to achieve 1-year or 3-year recognition for high performance in diabetes care. Qualifying physicians receive up to $80 for each diabetic patient covered by a participating employer or plan. In addition, the program offers tools to help diabetic patients get engaged in their own personal care, achieve better outcomes and identify local physicians that meet the high-performance measurements.

Finally, the Cardiac Care Link portion of the program enables physicians to achieve 3-year recognition of high performance in cardiac care. Qualifying physicians are eligible to receive up to $160 for each cardiac patient covered by a participating employer or plan.

Bridges to Excellence programs are currently in progress in four markets, Cincinnati, Louisville, Boston and Albany, New York. In addition, we are looking to implement Bridges to Excellence in several new markets in the coming months, including Houston, Phoenix and Omaha, to name only three.

To date, the results of our program have been very encouraging. We have 282 recognized physicians in our pilot markets who qualify for the Diabetes Care Link program and 571 physicians who qualify for our Physician Office Link program. We have distributed over $1.5 million in physician rewards to these physicians. Early program analysis shows that physicians rewarded through our diabetes care program are approximately 10 to 15 percent more efficient than the nonrecognized diabetes physicians. In the Physician Office Link program, rewarded physicians are approximately 10 percent more efficient than those not recognized.

The Leapfrog group, formed in 1998 by Verizon, along with other employees, was brought about to focus on hospital patient safety. Leapfrog now has over 160 member companies and organizations, both private and public. Together, we spend over $64 billion annually on health care and cover over 34 million individuals in all 50 States.

Leapfrog is now augmenting its patient safety measurement function with a new initiative, the Leapfrog hospital incentive and rewards program. This program measures hospitals on both quality and efficiency and creates incentives and rewards for performance improvement. This program is currently being launched in Albany, New York, in partnership with the Bridges to Excellence program.

As described above, the private sector has begun to use its leverage as a purchaser to provide incentives to physicians and hospitals to install quality improvements in their operations, much as we have in our daily business activities.

The government, with its power as a purchaser for Medicare and to some extent Medicaid services, should work with the private sector on these initiatives to securitize efforts to reward the same quality improvement objectives.

In an age of rapidly rising health care costs, combined with little or no system accountability for outcomes, there is a greater risk than ever for purchasers, providers and especially patients to find their interests at odds. This is unacceptable. Peoples lives are at risk. We need to work to solve these systemic problems.

Verizon has recognized this and is involved. We hope you will join this effort. Taking steps now to encourage better performance and reduce inefficiencies will pave the way for a better system of care, one that provides better outcomes for patients as well as meets the goals of purchasers and providers.

I want to thank you, Mr. Chairman, Mr. Andrews and members of the subcommittee, for the opportunity to discuss these important initiatives and would be pleased to answer any questions. Thank you.

Chairman JOHNSON. Thank you.

[The prepared statement of Mr. Hanson follows:]

Statement of Jeffrey R. Hanson, Regional Healthcare Manager, Verizon Communications, President, Bridges to Excellence, Portland, ME

Mr. Chairman and members of the Committee, my name is Jeffrey Hanson, and I am the Regional Healthcare Manager for Verizon Communications, as well as the President of the Bridges to Excellence initiative. I want to thank you for giving me the opportunity to testify on what private companies are doing in the area of Pay-for–Performance.

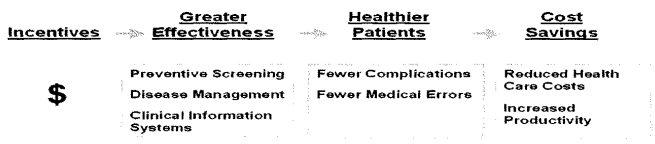
Verizon provides health care coverage to nearly 800,000 employees, retirees, and their family members, at an annual cost to the company of more than $3.2 billion. The company subsidizes approximately 80 percent of the health plan costs for management employees and 99 percent for associates. The rising cost of care challenges a company's bottom line.

Verizon works aggressively to preserve quality health care while trying to curtail costs. However health care spending is increasing at a rate faster than company revenues. Cost shifting from medical providers, health care disparities, untapped technology options and rising health care industry prices contribute to the problem.

The quality of healthcare received by our employees, retirees and covered family members is of paramount importance to Verizon.

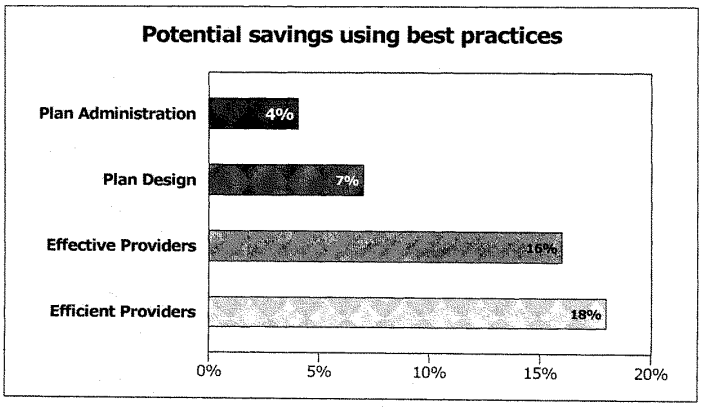
- Inadequate quality of care from medical providers requires corporations to pay twice: once for the expensive but less-than-optimal care, and then again for decreased productivity, i.e., time not worked and increased costs for sick pay and disability pay.
- Inappropriate treatments force patients to suffer longer. In 2003, the Rand Corporation found that 45% of the time, on average, patients did not receive the recommended care required for their condition.
- Studies by the Institute of Medicine and others estimate the nationwide annual costs of inappropriate care is in the $300–$500 billion range, or one third of national expenditures on health care. To a large degree "the system is broken."

Verizon Perspective:
Improved Effectiveness Leads to Cost Savings



As one of the largest employers in the country, Verizon is committed to ensuring that the people we cover, and all Americans, have access to quality, innovative and affordable health care options. Therefore, Verizon has taken a leadership role to advance a proactive public policy agenda for health care reform. Pay-for-performance is an important cornerstone in our efforts to advance the quality improvement imperative. And it is an important part of a long-term cost reduction strategy for employer health benefits. Plan design and administrative changes produce only short-

term, temporary savings. The identification and rewarding of higher quality, more efficient healthcare will produce long-term value for employers and employees alike.



The Business Roundtable and William M. Mercer, 2002

Pay-for-Performance

One of the cornerstones to obtaining real transformation of our healthcare system is provider quality differentiation, quality data transparency, and realignment of the provider payment system based on quality performance. Quality measures encompass several areas including process systems, clinical systems and outcomes. The number of pay-for-performance programs has increased rapidly over the past two years, now numbering over 100 programs across the country. Verizon participates either directly or indirectly with many of these programs.

Verizon advocates for the agenda set for by the National Health Information Infrastructure, including:

- Deliver high quality, safer care through rewards around common sets of metrics for use of interoperable Electronic Health Records and data standards through NHII and outcomes from their implementation with a view to accelerate the transformation of care processes and increased accountability.
- Reform reimbursement to incent appropriate use of health IT including care coordination, disease/care management, data sharing, publishing/subscribing performance accountability and quality.
- Equitable payments by all payers for the ongoing use of and improved outcomes from HIT.

We are a founding player in two of the more prominent national initiatives, Bridges To Excellence and the Leapfrog Incentives & Rewards Program, both of which provide incentives to the provider community based on nationally recognized quality metrics. Bridges To Excellence is a physician-based program and the Leapfrog program is a hospital-based program.

These two initiatives found their genesis in two very high-profile reports generated by the Institute of Medicine, To Err is Human and Crossing the Quality Chasm. These reports grabbed the attention of senior executives in corporations coast-to-coast. It was literally a "call-to-action."

Bridges To Excellence

In the 2001 report, "Crossing the Quality Chasm", the IOM identified six key attributes around which the health care system should be redesigned. They said the system needs to be more: Safe, Timely, Effective, Efficient, Equitable, and Patient-centered (STEEEP).

Redesigning the healthcare system around these attributes will not be easy. In fact, it will require changes at every level, including:

- Environments such as insurers, purchasers and regulators;
- Organizations such as hospitals and medical groups;
- Micro-environments such as office practices and hospital units;
- Individual clinicians;
- And at the center, the patient.

In one major recommendation, the IOM said payments for care should be redesigned to encourage providers to make positive changes to their care processes.

Ideally, this shift will begin with purchasers and insurers, and filter down through the delivery system to help encourage improvements at all levels.

In response to this challenge, a group of employers, physicians, health plans and patients have come together to create Bridges to Excellence. Bridges to Excellence is a not-for-profit organization with a Board composed of representatives from employers, providers and plans. The Corporation is not formed for pecuniary profit or financial gain. The Corporation is organized to create significant advances in the quality of health care by:

- Providing tools, information and support to consumers of health care services,
- Conducting research with respect to existing health care provider reimbursement models,
- Developing reimbursement models that encourage the recognition of health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable and patient-centered care which is based on adherence to quality guidelines and outcomes achievement.

Guided by three principles, its purpose is to create programs that will realign everyone's incentives around higher quality:

- Reengineering care processes to reduce mistakes will require investments, for which purchasers should create incentives;
- Significant reductions in defects (misuse, underuse, overuse) will reduce the waste and inefficiencies in the health care system today;
- Increased accountability and quality improvements will be encouraged by the release of comparative provider performance data, delivered to consumers in a compelling way.

Three programs guided by these principles are already underway: Physician Office Link, Diabetes Care Link and Cardiac Care Link.

Physician Office Link enables physician office sites to qualify for bonuses based on their implementation of specific processes to reduce errors and increase quality. They can earn up to $50 per year for each patient covered by a participating employer or plan. In addition, a report card for each physician office describes its performance on the program measures and is made available to the public.

Diabetes Care Link enables physicians to achieve one-year or three-year recognition for high performance in diabetes care. Qualifying physicians receive up to $80 for each diabetic patient covered by a participating employer and plan. In addition, the program offers a suite of products and tools to help diabetic patients get engaged in their care, achieve better outcomes, and identify local physicians that meet the high performance measures. The cost to employers is no more than $175 per diabetic patient per year with savings of $350 per patient per year. Cardiac Care Link enables physicians to achieve three-year recognition for high performance in cardiac care. Qualifying physicians are eligible to receive up to $160 for each cardiac patient covered by a participating employer and plan. In addition, the program offers a suite of products and tools to help cardiac patients get engaged in their care, achieve better outcomes, and identify local physicians who meet the high performance measures. The cost to employers is no more than $200 per cardiac patient per year with savings up to $390 per patient per year.

BTE Program Structure

Physician Office Link:

- Physician Rewards of up to $50 pmpy
- Consumer Activation from report card and patient experience survey

Clinical Information Systems	Patient Education and Support	Care Management
Use of Patient Registries	Educational Resources (languages)	Care of Chronic Conditions (disease management)
Electronic RX and Test ordering systems	Referrals for Risk Factors & Chronic Conditions	Preventable Admissions
Electronic Medical Records	Quality Measurement and Improvement	Care of High-Risk Medical Conditions (care management)

Diabetes Care Link (NCQA Diabetes Recognition Program):

- 12 measures developed with the American Diabetes Association
- Physician Rewards of up to $100 pd/py
- Consumer Activation from report card, care management tool and rewards for compliance

Cardiac Care Link (NCQA Heart Stroke Recognition Program):

- 6 measures developed with the American Heart Association
- Physician Rewards of up to $160 pcp/py
- Consumer Activation from report card, care management tool and rewards for compliance

Bridges To Excellence programs are currently underway in four markets, Cincinnati, Louisville, Boston and Albany. These programs are all employer-driven and reward monies being paid to the physicians are paid by the employer participants. Recently health plans have expressed interest in the program and we are working with them to launch BTE in several new markets including, Phoenix, Houston, and Omaha, to name only three. In addition, BTE is coordinating efforts with CMS as they implement the MCMP (Medicare Care Management Project) in four markets around the country. We are working collectively to align our provider quality measures to promote all stakeholders working to transform the healthcare system do so using mutually-developed standards.

BTE is live in four markets

	Cincinnati, OH / Louisville, KY	Boston, MA	Albany / Schenectady, NY
Launch Date	June 2003	February 2004	May 2004
Program(s)	DCL	DCL, POL	POL, DCL, CCL
# of Employers	7: GE, Ford, UPS, P&G, Humana, CCHMC, City of Cinci	3 (6): GE, Raytheon, Verizon, (IBM, AZ)	4: GE, Hannaford Bros, Verizon, Golub
# of Plans	6: Humana, Aetna, UHC, Anthem, BCBS (OH, AL)	3: Harv[illegible], Harvard, UHC, BCBS(MA, AL)	3: MVP, CDPHP, UHC
# of Covered Lives	200,000 (7,000 Diabetes)	85,000 (3,500 Diabetes)	45,000 (2,000 Diabetes; 1,000 Cardiac)

BTE Results to Date

- 282 DPRP recognized and 571 PPC recognized physicians in pilot markets
- Distributed over $1.5M in physician rewards

- DPRP physicians are approximately 10–15% more efficient that non–DPRP physicians
- PPC recognized physicians are approximately 10% more efficient than non–PPC recognized physicians

Leapfrog Incentive & Rewards Program

In 1998 a group of large employers, including Verizon, came together to discuss how they could work together to use the way they purchased health care to have an influence on it's quality and affordability. They recognized that there was a dysfunction in the health care market place. Employers were spending billions of dollars on health care for their employees with no way of assessing its quality or comparing health care providers.

Leapfrog now has over 160 member companies and organizations, both private and public. Together they spend over $64 billion annually on healthcare, covering over 34 million individuals in all 50 states.

A 1999 report by the Institute of Medicine, To Err is Human, gave the Leapfrog founders an initial focus—reducing preventable medical mistakes. The report found that up to 98,000 Americans die every year from preventable medical errors made in hospitals alone. In fact, there are more deaths in hospitals each year from preventable medical mistakes than there are from vehicle accidents, breast cancer, and AIDS. The report actually recommended that large employers provide more market reinforcement for the quality and safety of health care. The founders realized that they could take "leaps" forward with their employees, retirees and families by rewarding hospitals that implement significant improvements in quality and safety.

The Leapfrog Group and its members work to initiate breakthrough improvements in the safety, quality and affordability of health care for Americans. Research has shown that patients receive recommended health care only 55% of the time, and 30% of health care costs are due to poor care. Poor quality also means up to 98,000 deaths per year due to medical mistakes.

The Leapfrog Incentive and Rewards Program:

- Inspired by the current CMS–Premier demonstration program
- Measure both effectiveness (quality) and efficiency (cost)
- The primary goal is to create incentives for performance improvement, both on quality and cost
- Purchasers and plans can make this work in their current environments
- Hospitals can participate with very minimal additional reporting
- All aspects of the program were reviewed by experts and vetted by stakeholders

This program is being launched currently in Albany, NY in partnership with the Bridges To Excellence program, already underway in that market. In it another example of bringing together stakeholders from across the healthcare system in a concerted effort to drive quality reform using common sets of standards and measures.

Recommendation

As described above, the private sector has begun to use its leverage as a purchaser to provide incentives to physicians and hospitals to install quality improvements in their operations, much as we have in our daily business activities. The federal government with its power as a purchaser for Medicare and to some extent Medicaid services should work with the private sector on these initiatives to synchronize efforts to reward the same quality improvement objectives.

Summary

In an age of rapidly rising health care costs, combined with little or no system accountability, there is a greater risk than ever for purchasers, patients and providers to find their interests at odds. This can lead to intractable gridlock and the creation of few, if any, solutions to systemic problems.

Taking the steps now to encourage better performance and reduce inefficiencies will erase this gridlock and pave the way for a better system of care—one that meets the goals of purchasers, providers and patients alike. Implementing systems to support physicians is a great place to start. We hope you will join us in this effort.

I thank the Committee for the opportunity to discuss these important initiatives and would be pleased to answer any questions.

Chairman JOHNSON. Let me ask you one. Just because it is more efficient, does that make it better?

Mr. HANSON. It is a step to making it better. Efficiency——

Chairman JOHNSON. What do you mean by efficiency? I mean, you know, does that require more nurses or better or what?

Mr. HANSON. No, I think the statement was made well earlier that efficiency really is the best value, is value. It is the best care at the best price.

Chairman JOHNSON. So if you go in for heart surgery, for example, if they roll you right into the operating room, they are more efficient, does that make it better?

Mr. HANSON. No, that is not our definition of efficiency.

Chairman JOHNSON. OK, tell me what it is.

Mr. HANSON. No, our definition of efficient is that you deliver the best-quality care at the best price.

Chairman JOHNSON. How do you measure that? I guess it falls back to CMS—and all of you are welcome to answer this question. How many of you think they are doing the right job and can we do better through them? Because, really, they are the ones that have contacts with all the hospitals and doctors in the country.

Go ahead.

Mr. HANSON. I think currently——

Chairman JOHNSON. How many do you think are doing a good job? Let me ask you that question.

Mr. HANSON. Do you think they are doing a good job?

Chairman JOHNSON. No. I asked you that question. Are they?

Mr. HANSON. I think we are all trying to do a better job, and that is why we are sitting here at the table.

Chairman JOHNSON. Karen—you don't mind me calling you that?

Ms. IGNAGNI. No, sir, please.

Chairman JOHNSON. I think I remember that.

Ms. IGNAGNI. I was going to give you an allergy example on your efficiency question.

But on CMS I think they are. They have set out specific goals. They have met each one of the goals. They have put quality on the table. They have put the whole effectiveness and value issue on the table. So I think they deserve to be commended, and they are bringing stakeholders in to participate in a strategy, in designing a strategy to get it right.

In terms of the answer to the efficiency point that I think Mr. Hanson made very well—and bringing it back to an allergy example, a simple concept. For me, an asthma patient, for example, what is not an efficient expression of health care utilization is for me to end up in the hospital emergency room. So as part of a disease management program to understand my medicines, to understand when I should take them and to have someone, my physician, looking over the shoulder to advise on the appropriate combination, that is a good example of efficiency.

Dr. GALVIN. I think CMS is doing a good job, and I think most people in the private sector feel that way, I think for many of the reasons Karen mentioned. They have reached out to do partnership. They are really leaders in this idea of they are using all in their power to be a purchaser, not just a regulator. That has really resounded. I think they are doing a fabulous job.

Chairman JOHNSON. Go ahead.

Ms. ROSENTHAL. I have to agree that the main thing that CMS has done that has been really important is improving the trans-

parency of performance across their providers, which is pretty much all of the providers in the United States, but through the hospital quality alliance, other public reporting interventions that they have done.

On the payment side, that is mostly in the demonstration stage. But there are, through the provider group, practice demonstrations, for example, working with trying to reorganize the reimbursement system to reward efficiency in the sense of—again, getting to a certain outcome at the least cost, including all kinds of costs that might be in the future, for example, getting to the least cost through the reimbursement system. They are well targeting performance improvements on the quality of care side, including patient experience, patient satisfaction. So I think they are moving in the right direction.

Chairman JOHNSON. Do you all see any resistance from doctors?

Ms. ROSENTHAL. I suspect there will be significant resistance from physicians. Because, again, this is all about measurement and transparency. No one necessarily wants to have their grades posted on the Web.

Chairman JOHNSON. You are getting it from patients, too, because they don't want to put their stuff on a computer, you know.

Dr. GALVIN. To the question about physicians, what I have learned is there is no one physician response. So I think organized medicine has a lot of hesitations and are really concerned about this.

We have found tens of thousands and collectively more than that of physicians who really get it, who think that being measured makes them better.

There is a great example in this Bridges to Excellence program. A doctor in Louisville actually treats inner city—it is not a doctor that treats GE patients—agreed to join the program. His comment was, you know, I thought I was doing a 100 percent great job. I got my actual measures back, and it turns out I was only doing the right thing about 60 or 65 percent of the time. His attitude was, that is great. Now how do I get better? So I feel there is variation among doctors about this.

Chairman JOHNSON. That is good, and don't try to rank us up here.

Yes, ma'am.

Ms. IGNAGNI. Mr. Chairman, a great example of the doctors coming to the table. Washington is full of examples of strange bedfellows. Our organization has been working for 9 months with the College of Physicians, the family physicians, and now the AMA is involved, to get a number of employers and consumers to try to wrestle with this idea of how do you create uniformity in measurement. CMS has been involved. ARC has been involved. It has been a great example of physicians leading the conversation—and with their colleagues—about what is the right thing to measure under what circumstances. It is a great example of partnerships between public and private entities.

Chairman JOHNSON. Thank you.

Mr. Andrews.

Mr. ANDREWS. Thank you.

I want to thank you for your testimony, and I wanted to ask Mr. Hanson about the Bridges to Excellence program. My understanding is you are coming up on 2 years of experience in Cincinnati or Louisville.

Mr. HANSON. That is correct.

Mr. ANDREWS. There are about 200,000 lives in the program?

Mr. HANSON. Across all four markets, yes.

Mr. ANDREWS. It says that 7,000 are in the diabetes section. Explain to me how that works. If I understand it correctly—or study a certain set of materials. Then if that physician does, then he or she is identified in the program as sort of a diabetes person, or get some kind of Good Housekeeping Seal of Approval.

Mr. HANSON. We work collaboratively. One you are specifically talking about is a diabetes recognition program, which was collaborative with the American Diabetes Association, which is producing outcomes or the right kind of thing.

Mr. ANDREWS. Presumably that educates that physician with how to deal with diabetes. They get paid for it? They get a certain amount per patient per year?

Mr. HANSON. Correct.

Mr. ANDREWS. I know it is early, but what kind of incidence are there on reduced strokes or heart attacks or bad outcomes for those diabetes patients?

Mr. HANSON. The level of that data we are just getting to. I have a feeling, when I talked about there is more efficiency in the system, 10 to 15 percent, we think a lot of that is part of the reduction and the ER visits that you mentioned. I think that is a level of the data that we are just now beginning to analyze.

Mr. ANDREWS. I would assume the way we would approach this study is to say, all right, among these 7,000 people, if they behave like their cohorts, given their age and demographic profile, we could expect X numbers of strokes, Y number of attacks, Z number of emergency room visits and other problems in a 2-year period. Are you then going to measure how these 7,000 people did against those expected norms?

Mr. HANSON. Right. We use a data base that includes people that are not taking part in the controlled program.

Mr. ANDREWS. Is there, in fact, going to be such a systematic evaluation? If so, who will do it?

Mr. HANSON. We currently work with a number of companies who specialize in this kind of thing to work with the right data and get the right data base.

Mr. ANDREWS. When will they get their assessment?

Mr. HANSON. They are in the process of doing the initial assessments now.

As I say, we are 2 years into the program. We are going to do assessments every year. We will actually look at trending. You know, how do these people trend from year to year? Is the same amount of savings from there? Is it exponential every year? If we see X amounts of savings this year if we continue to see a certified doctor, is that savings?

Mr. ANDREWS. Will those data be publicly available on the script of their proprietary or personal criteria? With specific reference to the diabetes study in the Cincinnati-Louisville markets, what per-

centage of physicians have become diabetes certified, to use my term? Do you know?

Mr. HANSON. Well, I think it is probably a very low percentage, the reason being that physicians that get rewarded are those physicians or employees and family members of the companies that are participating in the program.

Mr. ANDREWS. That is a lot, 200,000 people. I think there aren't many physicians that don't see the employees of those companies.

Mr. HANSON. Well, but you are talking over four different markets.

Mr. ANDREWS. Two hundred thousand out of 4 million people or something.

Mr. HANSON. Yes.

Mr. ANDREWS. I see. Will there be an effort to recruit more employers into the BTE program?

Mr. HANSON. There is an effort. We had a couple of new employers join recently in the Boston program. We are already a year in. It is a 3-year program. My point is, in Cincinnati and Louisville, we are starting up on the third year. We wouldn't look to recruit a new employer at this point in time. We are looking to evaluate——

Mr. ANDREWS. The question I have for any of the panel—you can supplement your answer in writing, because it is a longer issue. Do you see any embedments in the ERISA law that would retard progress in this field?

Let us assume that the study that is done by BTE comes back the way we hope it does. It says that there are significant quality improvements in the outcomes, we have fewer strokes, fewer ER visits, fewer heart attacks, a lot of healthier people and that this worked—and that more companies then, more employers want to join a program like this, and they voluntarily do so for good, sound business reasons.

I am not aware of any, but are there any problems or limitations in the ERISA statute that would retard against that progress? Or, conversely, are there changes in the ERISA statute you would make that you would think would enhance and facilitate that kind of access?

Again, anybody could answer it, but I would be interested in the written comments that any of you would make on that.

Dr. GALVIN. I would be happy to take a swing at it, if you like.

Mr. ANDREWS. Sure???????

Dr. GALVIN. Just to get back to a prior question about more employers joining, Mr. Hanson was right. Part of the strategy was also to go to health plans and to have them license. We actually developed the licensing for this product.

So over the past about 8 months, we have had some leading health plans—United Health Care with about over 20 million covered lives. They have Humana with about 8 million or 10 million covered lives. We have CareFirst in Maryland. So we have about 30 or 35 million covered lives under these health insurers who cover multiple employers who have the capacity now to do Bridges to Excellence. So the expansion strategy is both other employers individually, and I think it is a much better multiplier to go to health plans who have millions of covered lives.

In terms of the ERISA, we didn't get a formal assessment, but our own counsel looked this over, and ERISA itself did not seem to either be an impediment or really affected positively or negatively, so we didn't see the ERISA statute either way.

Mr. ANDREWS. That would be my assumption as well. But I want to be sure in the subcommittee's jurisdiction that we think about that issue and the terms of that statute.

Ms. IGNAGNI. Mr. Andrews, we haven't looked at that specifically. We will now and get back to you. My sense now is the same as Dr. Galvin's, but I want to make sure that I am right about that.

Mr. ANDREWS. Thank you. Thanks very much.

Chairman JOHNSON. Thank you, Mr. Andrews.

Mr. Boustany, do you care to question?

Mr. BOUSTANY. Thank you, Mr. Chairman. I have a few questions.

Let me start by saying that pay for performance is an important step in health care. I am a physician, a cardiac surgeon. I had one of the busiest practices in Louisiana. I led the effort to bring in a national data base on cardiac surgery in all hospitals where I work.

I took a lot of criticism from my colleagues, but we did it nonetheless. As a cardiac surgeon and a physician, I make decisions for my family on health care issues based on anecdote. That is a side indictment of our system.

I am on the board of the hospital and sit on some of the numerous committees at the other hospitals. Again, my decisions are based on anecdote. I have sat down and shared my data with two of the largest insurers in our State and asked to see their data and compared notes. The quality of their data was deplorable. It was again an indictment of our system. We have got serious problems, but I think we are on the right track with that this.

A few questions. One, is this a potential tool to just enhance profits without providing education to physician groups? Certainly we do need to make sure that we provide proper transparency. Because I am convinced in health care, if we are going to create competition, to bring down costs and enhance quality, we have got to provide information with transparency to the consumer, ultimately. We need to provide choices to the consumer, and we need accountability.

So I want to make sure that there is going to be a proper dialog in all of this with physician groups, hospitals and so forth, so that we are all measuring the right things and going about this properly.

Ms. IGNAGNI. I think that you have made a very important point about the issue of transparency, and it starts before we get to consumer transparency. You need to have transparency with respect to clinicians. They need to be involved in the development of the standard. They need to be not only involved in the development of the standard, they need to be confident that it is the right proxy, the right measure. Otherwise, we are not going to move to a quality-based system.

This is why, in our view, it is key for physicians to lead this conversation, to help point us in the right direction, to have a consensus about uniformity of measure, so that when the standards are developed then the physicians have confidence in them. They

will be very strong advocates for their colleagues to follow those standards, and we will quickly shrink the kind of variation and practice patterns that now exist across the country.

We have provided some evidence of that in our testimony. There have been legions of articles about it.

So we couldn't agree with you more about the importance of transparency. It starts with the clinicians. It starts with the partnership between insurer, health plan and physician to then move out to get the kind of measurement and trust that consumers can rely upon. But, most importantly, the clinicians can trust and feel that they are, in fact, in charge of creating a system that best represents their talent.

We go out and talk to physicians. This is what we—in talking with the chairman and Mr. Andrews, this is what we found in our partnership with the key physician groups, that they feel very, very excited about the possibility to get this right and to move in a direction that finally rewards the best physicians and the best care, which I think is a testimony to the point that I think you have made very compellingly.

Dr. GALVIN. On the comments you made, I just wanted to add a couple of things. I think that—let us assume that we can get the right measures that are agreed upon by everyone. You have raised another point, which is, is there an education point? Some of the things we have heard in the Bridges to Excellence program were two things that weren't in our original planning.

First, all the physicians wanted a chance to win. In other words, they didn't want the bar so far from where they were, or they didn't want to be demoralized from the beginning.

Second, particularly individual doctors in individual practices asked if we could help think through some way to help them improve. Because let us say when this doctor I mentioned in Louisville got his numbers back, he was only scoring 60 or 65 percent when he thought it was 100. What he then looked for, is there someone to help me figure out how I can improve? Do I need to change the system? What do I need to do?

So I think those two, everyone having an opportunity to win, second, thinking through how to support physicians if we get the measures right, which I think we will, I think are important issues also.

Mr. BOUSTANY. The other issue will be dealing with the information technology gap that we have in health care. It is a real critical problem. Payers have somewhat of a gap. It is clearly evident on the side of the providers, both hospitals and physician practices. So somehow we are going to have to bridge that gap.

Then the other issue would be the dynamic state of outcomes analysis right now. Because it is not static. With new technology rapidly coming upon us, new drug therapies, measuring outcomes and keeping up with it and coming up with some sanity to the whole process is going to be quite challenging.

I applaud what you are doing. I know you are all experts in the field. I have read some of your work. I thank you for your testimony.

Chairman JOHNSON. Mr. Kildee, do you care to question?

Mr. KILDEE. Thank you, Mr. Chairman.

First of all, Dr. Rosenthal, my son attended the Harvard School of Public Health and got his Master's Degree in health care finance, so he advises me regularly. He knows far more about it than I do, however.

Ms. ROSENTHAL. Excellent. Well, I would expect a graduate of our program to know quite a bit.

Mr. KILDEE. Certainly more than any of us here. So thank you for being here today.

I have a question of Dr. Galvin. What should we do in the Congress or the government to improve on the coughing method of determining quality of performance? What—really, what type of legislation might help discover really and reveal to people where quality can be found?

Dr. GALVIN. I would answer there are two things. The first wouldn't be legislation. I think the first would be something that I mentioned in my final couple of sentences, which is you, as purchasers through the Federal employees and their families, that is 9 million covered lives; through TRICARE and the Department of Defense, it is another 9 million covered lives. Eighteen million covered lives. That is about 18 times the size of what GE covers.

Yet really none of these programs have any of these fundamentals we are talking about. There is no insistence that the health insurers with whom they can track can show this information about doctors and hospitals. There is no requirement in their contracts that they start paying based on performance. So they are really neutral. So that is not statutory. It is just a practice. But that is 18 million covered lives in our system, is a very big deal.

In terms of the statutory, I think the immediate opportunity is what is going on in physician payment. I think kind of the dilemma that you are facing with the SGR and what to do about physician payments and Medicare is an opportunity to do something. Because what I am told by CMS is they don't think they have authority, existing authority, to really move pay for performance or performance-based payments out of demonstration into the core of fee-for-service Medicare. Trying to integrate that pay for performance into whatever update you do with physicians I think is an opportunity that will take immediate statutory change.

Mr. KILDEE. Can we possibly anticipate civil action when certain medical providers are not listed among the quality providers?

Dr. GALVIN. I think that is an excellent question. We have not faced that yet. I would have to think that through. It is something we worry about.

We did that with Leapfrog, where basically we listed the hospitals that met these safety leaps, meaning the ones that we thought were the most likely to do the best job. We did not have any civil action. But I would think it is something you would have to think about. If you were a provider and you were not listed and you lost businesses as a result of it, I would think that would be an issue you would have to think about.

Mr. KILDEE. It would seem to me to be a fundamental consideration.

Ms. IGNAGNI. I think this is a very important question you are probing. I know that the specialty borders, as they reevaluate and recredential essentially specialty physicians and primary-care phy-

sicians, are now beginning to move in the direction of baseline standards with respect to quality performance. I think that is a very important start as well.

So I think were there someone here from the specialty boards it would be to compellingly talk about the shift that is going on—which is a very important shift—and this is post the Institute of Medicine report directly aimed toward those improvement aims that were enumerated in that report.

Mr. KILDEE. Thank you very much.

Mr. Chairman, thank you for assembling a such great panel. It has been very, very good. Thank you very much.

Chairman JOHNSON. Thank you, Mr. Kildee.

Mr. Kline, do you care to question?

Mr. KLINE. Thank you, Mr. Chairman.

I thank all the panelists for being here, a really, really great panel. We often get great panels here, but this is perhaps extra special.

I am a little bit intrigued by the one-cough, two-cough method. I thought that was a great example. We didn't determine if there was any head turning involved.

It seems to me that I am looking at a couple of projects in my district that are moving forward very rapidly and well, I think, with electronic medical records. There is an opportunity there to prevent an awful lot of mistakes and lower costs, provide better care, at least in my judgment.

When you are looking at places to go, either in the BTE or from your roundtable or something, if you are—if you could put in your list those clinics and hospitals that have such a system, that would be a way of sort of stepping out toward paying for performance, if you will, in the sense of the hospital and clinic and not be an individual evaluation. Is that something you are already in the mix?

Dr. GALVIN. I can comment that the Leapfrog group that Mr. Hanson mentioned, it was called that because it came up with three initial leaps to make quality much better. The first of those leaps was to have those kinds of computerized systems in hospitals, particularly focused on drug ordering.

So this was—we found the most avoidable errors that were occurring in hospitals had to do with drugs. Either the physician's writing was illegible, or physicians can't remember 100,000 facts, and so they might have prescribed a dose that wasn't right for the patient on that day. So that was actually the No. 1 that we put out.

Now what is interesting is that, although all the urban hospitals in the country—we asked if they would fill it out—only 1,000 out of the 3,000 or so non-rural hospitals agreed to fill it out. So one of the challenges we have is that, as long as it is voluntarily, and completely voluntary, it is difficult. Because now the 2,000 that didn't fill it out—many of them were in the same town where some did and some didn't—we didn't know the quality of their value. So I think it is a challenge.

Mr. KLINE. Let me just follow up on that. It seems to me we are looking for a way—and we would ask the question a number of different ways up here if it is something we can do in legislation or policy. But if you have clinics or hospitals that have the electronic medical records—and we will just stick with that one example—it

would seem to me that the insurers and perhaps the different programs that we are talking about here would reward that, right, because they are on the list.

You have such an electronic medical record you are going to be rewarded because the patients are going to be referred there. That would be some incentive for them to move with even more alacrity to get that in place.

So I am a little confused. Why would it be in somebody's interest to not be forthcoming? So they will not be rewarded?

Dr. GALVIN. I agree. I think up till now there haven't been rewards. I think, in the absence of that, it isn't quite as compelling, the Leapfrog project hospital program that Mr. Hanson talked about that was just launched. In fact, we have a workshop on Friday with 150 employers to explain it to them. That will be actually the first time we start our rewarding based on having computerized systems. Now employers need health plans.

The partnership is particularly important. Because even as big as GE and Verizon are, we are not nearly as big as most of the health plans. So we will work very hard through our contracts and through our bidding process to try to move business to those health plans that also think this is a good idea, and we will begin to institute this.

Mr. HANSON. Can I——

Mr. KLINE. We will try to do both in the seconds.

Ms. Ignani.

Ms. IGNANI. Thank you, sir.

One of the things you will see in our testimony is we have given the examples of where a number of our health plans are incorporating incentives from the conversion from paper to electronic, both in the physician level as well as the hospital level. And I think you will see more of that.

The way we have approached it is to set—develop a consensus with the providers with respect to what is measured, what the outcomes are, and, as part of achieving those outcomes, then moving to an electronic-based system is often very desirable.

So rather than simply reward the technology in a silo with no connection to the outcome or the goal, establish the goal, recognizing that the technology is a part of that. And we would be glad to submit more information for the record if that would be useful to the committee.

Chairman JOHNSON. Thank you.

Mr. HANSON. I would just like to echo what Karen has said, and that is that it isn't so much just having the technology, but how you use it. There is evidence out there now that even hospitals who have computerized physician order entry, only 25 to 30 percent of the physicians at that hospital are using that technology.

So I think, to throw out a caution, is that while it is admirable that people are adopting technology, the benchmark really is, as Ms. Ignani has said, is how do you use that technology, and what kind of outcomes are you getting with it, and what are you looking for? So it is a bigger picture than just going out and purchasing your technology and having it in place in the long run.

Chairman JOHNSON. Thank you.

Ms. ROSENTHAL. Can I just contribute two quick points on that? First, on the issue of getting hospitals to actually report their capabilities and their quality measures, the CMS had a very successful initiative that you may be aware of. They had a voluntary hospital reporting system, and in the second year you could volunteer to give up half a percent of your revenues. And surprise, surprise, all the hospitals reported in the second year. So I do think having CMS can very much take strong action if they asked hospitals to do CPOE——

Mr. GALVIN. Statutory.

Ms. ROSENTHAL. Yes, statutory. But that is an example of how it could be done in any case. And the second thing is being on the Leapfrog Website in and of itself may not be a reward, because as much as we all think that consumers should be motivated to use this information, should choose hospitals on that basis, most of them don't. And even when the information is made available to them, to date they are a little reluctant to use quality information.

We need to think of better ways to get them to understand the information and why it is important to them and make decisions on that basis.

Mr. KLINE. Thank you.

Thank you, Mr. Chairman.

Chairman JOHNSON. Mr. Tierney, care to question.

Mr. TIERNEY. Yes, I would, Mr. Chairman, thank you. Thank the members of the panel for the questioning.

In Massachusetts there have been some concern among some at the Mass Medical Society. They are skeptical. They say they are skeptical of the current methods that are employed to gather the physician performance data. I am sure you have this before. Those that don't yet have an electronic medical recordkeeping system think that evaluating it on claims forms isn't fair to them.

Can you just discuss that a little bit if it is appropriate? Is it fair to them, and should we be doing that without the electronic recordkeeping data? How do we move more quickly through the electronic data?

I know there has been a few experiments, one in my district up in Newbury Port, up in other places around the country, as well as my State. Who pays for it? What is the incentive for somebody who is, say, in a small practice to undergo that risk and the cost?

Dr. GALVIN. I know a lot of licensed physicians still in Massachusetts, and I trained there, so I will take the answer first.

There is a lot of concern among physicians everywhere, in Massachusetts as well. I think there are two issues. I think the first is really the original kind of chicken and egg; in other words, I think from the purchaser of health care point of view, we are wondering when we will be able to start publishing this data. When will we give this woman I talked about actual information about where she should go to get her cancer treated? So some of it is the physicians rightfully say, wait a minute, be careful, the claims forms aren't perfect, we don't have it. We say we have been talking to you for about 30 years. When will the time be right?

So I think we have moved ahead with some trepidation, because we don't want to alienate the physicians, but we feel we had to get things started.

I do agree with you that the answer, or part of the answer, is to get this information technology much more established in offices. A couple of many issues, one is kind of the coding, but the other one is who pays for it.

One of the Bridges to Excellence's modules actually has extra payment if you have a computer in your office, and you show that you have better outcomes for it. That is one way we have tried to build it into the rewards is to help pay for the technology.

Mr. TIERNEY. Can I ask you something? Is that working?

Dr. GALVIN. So far it is working. I think 600 doctors have signed up.

Mr. TIERNEY. They are willing to take the risk if they know down the line they will get something back?

Dr. GALVIN. Mainly in Boston, if I am right.

Mr. HANSON. Mainly in Boston. Boston market is the biggest market for the program. Just to echo, too, I think the way Bridges to Excellence is structured is that the first year you will get 100 percent if you qualify to be recognized in the program. You are going to get 100 percent. And you may have an Excel spreadsheet that happens to be the disease registry for your office.

Our hope is that the incentive reward that you get that first year, then you will capitalize on that, invest in the technology, because the second and third years we are going to be looking at how has your office improved to actually reach the top benchmarks. So there is some built-in, which I think is a critical issue—built-in improvement steps for offices to take.

Mr. TIERNEY. I am pleased to hear that. I am just surprised, because the physicians that have been visiting my office all seem very reluctant to make the outlay themselves. They were looking at some of the different directions. Some of the smaller practitioners thought that that was just too large. Some told me it was a few thousand dollars. Others said it was 10- to 15- to 20,000, depending on what the size of your practice was.

Mr. HANSON. In Bridges to Excellence, actually, we cap the amount an individual physician can earn in rewards, and that is $20,000, because that seems to be about what it might take to capitalize, to invest and bring your office up to the infrastructure and process infrastructure that it would take. So it reimburses them for all that investment almost 100 percent.

Ms. IGNANI. Mr. Tierney, Dr. David Brailer has launched a whole conversation at the Department about connectivity with respect to health care, and they are having very productive discussions, and, in our, view a very solid approach to moving forward.

We hope that one of the things—that as this work comes through, not only will we be talking about the standards, how do we create uniformity with respect to the exchange, and how do we create uniformity across the country, but also at the same time how do we deal with the financing question.

We think that there can be things done very productively in the reimbursement system, but with employers appropriately telegraphing that there is a great deal of stress, there is a competitiveness issue, then that is a serious issue, and it is—we think that that could be joined, the issue of—in the conversation about connectivity, could be joined with financing to maybe begin think-

ing about tax credits, in terms of R&D, there is a productivity enhancement here.

And we think you can draw a direct line in the research between a tax credit for this kind of purchase, and it could be done over time, and the productivity that would result.

And the Chairman started talking about the conversation—you framed the conversation in terms of productivity. So we think that there is some opportunity here to bring all of these things together, not in one-stop shopping or one size fits all, but various components that could be looked at together.

Mr. TIERNEY. They already get a tax break. That is a business expense. It is a business expense. They are already getting a sizable tax break.

Ms. IGNANI. There could be other things that have been done in the past in certain R&D areas that could encourage the purchase and do it more swiftly.

Mr. TIERNEY. Do we run a risk of having a lot of people implement this electronic recordkeeping before you have the standards for connectivity, either statewide or nationwide?

Ms. IGNANI. We think the standards are absolutely essential. They need to be on a fast track. They need to be laid down so that physicians from the standpoint do not make a purchase that is not useful to them, No. 1——

Mr. TIERNEY. Is it already too late, though?

Ms. IGNANI. No. It is not too late at all.

And you asked the question about is the Department doing a good job? This is an area in which they are launching a series of activities to get to the question of standards, to talk about how they get developed and how they get developed quickly and uniformly. And we think that is just the right conversation.

Chairman JOHNSON. Mr. Holt, do you care to question? I think your time has expired.

Did someone have an answer that wanted to answer out there?

Dr. GALVIN. Just one other comment, if I may, and that is when you go back to your physicians in Massachusetts, I just want to make sure that if you represent what I said that—you know, I don't get a phone call—but I do think the standards are a big deal. It reminds me very much of those of us who remember VHS or Betamax, and if you chose wrong, it was a big deal. We are still in that era. So it really is an the issue, and Karen is right that we need to expedite that.

And the second is Bridges to Excellence isn't enough. The funding in many of the creative ways she talked about from the Federal side also needs to be a big part of the solution, so——

Chairman JOHNSON. Go ahead.

Mr. HANSON. In answer to the same thing, I know the Commission on Systemic Interoperability which has been set up, and Ivan Seidenberg, CEO of Verizon, is sitting on that, is dealing with this very issue of connectivity, interoperability, funding sources. And I know that report is due out in October. As Ms. Ignani says, it can't come soon enough.

There are several trains moving down the track, and right now we are pretty much in sync, but we are looking forward to that report.

Mr. TIERNEY. Thank you all.

Thank you, Mr. Chairman.

Chairman JOHNSON. Mr. Holt, you are recognized.

Mr. HOLT. Thank you, Mr. Chairman, and I thank the witnesses. I apologize if I go over some ground that has already been covered here, but I guess I need to pursue a little bit this issue of kind of the faith in the market to straighten things out here.

First of all, the rewards that would be provided for good performance, is this new money, or is this taken out of the system? And then, I guess, a fundamental question is by rewarding the good performers—and we could have some questions, and maybe there will be time for that, to talk about how the benchmarks are actually set to determine who is a good performer—don't we end up, if we carry this to its extreme, with a small number of good performers in the system and everybody else out of business? Have we found some way to improve the performance of the bad performers rather than just threatening or punishing them, you know, and the floggings will continue until morale improves?

So let me throw out those two questions, and if there is time, I have a few others.

Ms. ROSENTHAL. May I? Just to start out, as an economist I have to—even though I know you print money around here, I think there is no such thing as new money. And even, with all due respect to everyone, if the employers and health plans say that this is new money, it will eventually come out of the old money.

There are no places where that is just—you know, as it is we are spending $1.7 trillion on health care, as you know. Do we need to spend more to get the right quality care?

And so, I think fundamentally it is going to be a redistribution, and that does raise the question if we are redistributing moneys from some providers to others, is that desirable? And, of course, the whole point is to redistribute money to the best providers, so some of that must be desirable. But there are ways probably of doing that to improve the quality more across the board. Cost savings have to come out of somewhere. If we are not going to be driving some providers out, it must mean that we have to find cost savings. And I suggested in my remarks that they are not built into these pay-for-performance programs yet. They could be.

I do think there are lots of ways to try to provide technical assistance to poorly performing providers. And like Bridges to Excellence provides steps so that even providers who are starting at a relatively low level, they have some opportunity to make small improvements and get some of the resources to make larger improvements. And I think it is very important to consider that.

Chairman JOHNSON. Let me add that the dollars are not being cut. You know, there is a steady increase out of Medicare, and that is where those dollars are coming from. All they are saying is they are going to reward the guys that do a better job. And docs aren't going to get out of business. They can improve. That is what she is talking about, I believe.

And by looking at the docs that are doing a good job, maybe they can change their techniques or their performance to improve. And I will give you some more time. Go ahead.

Mr. HANSON. I would just like to build on the statements just made, and that is that clearly one of the efforts in the Bridges to Excellence program is not from a punitive standpoint. I can't imagine that if we have 100 docs in the Boston market who qualify for the program, that we are going to be able to shift an enormous amount of capacity to those doctors. Our goal is to build in these step processes so that even doctors who think they may not qualify have some level of entry into the program, and at which step it becomes a step process.

And I think that is going to be true with the Leapfrog incentives and rewards program, that although a hospital may not meet all the standards when they come out of the chute and apply initially for the program, there is some effort to reward those that have some minimal qualification to the program and show some signs that over time they have a plan to get there.

We have to raise the benchmark for the entire system. We can't, as you say, have a lot of docs go out of business, and I don't think that is the intent of any of these pay-for-performance programs.

Mr. HOLT. In the short time that is remaining, let me ask one more question then. Will doctors and hospitals avoid taking on high-risk patients? Will the good performers be the ones who have been smart enough to choose good patients?

Dr. GALVIN. I think that is a major concern. I think you are really kind of accurately hitting some of the big challenges, because no change is without these challenges. I think you are accurately hitting them, and either—certainly through surveys and anecdotal kind of experience, the idea that that will happen, and I think built into the system has to be some audit of that, or some kind of guarding against that. In other words, I think we would be naive and be going down the wrong road if we just assumed that that wouldn't happen. So I think the tendency will be to game it, and that would be one of the ways.

And I just think we have to be smart enough to anticipate it. And I think it is really an audit kind of technique we are going to have to build in to guard against that.

Ms. IGNANI. One of the things that I think that stands out here in our conversation this afternoon, politics is local. But if health care is local, you get into trouble. And we are now moving from a system that has been based primarily on the way it has always been done to one that is moving to a more objective, scientific, evidence-based system. But we are not going to leap there overnight. And so what we have tried to do through our health plans is we go across the country and work with physicians to reorient the incentives, is to start with the positive.

You asked the question, positive versus negative, and in deference to the very important point that Dr. Rosenthal made, if you incent physicians and reward them for best practices, according to the science, and if they are confident in the data that are chosen, and they have participated in that choice, then we are going to begin to move the system in a way that is productive for all.

So, to the extent that—and that also gives us an opportunity to evaluate the issues that you probe quite correctly, how do you deal with risk adjustment? How do you deal with not intentionally—the unintentional consequences of having a particular physician who is

isn't appropriately recognized for complications that he or she may treat?

So as you move in a critical path fashion, systematically as opposed to trying to do everything overnight, that allows for the kind of collaboration that is necessary to make this tectonic shift, if you will, but at the same time will allow us to get the kinds of results that I think all of you expect and that employers, the purchasers and ultimately the consumers expect as well. So in our view, that is how systematically we are approaching it.

Mr. HOLT. Thank you, ladies and gentlemen.

Thank you, Mr. Chairman.

Chairman JOHNSON. You bet.

Mr. Payne, you are recognized. Do you care to question?

Mr. PAYNE. Yes. Thank you very much.

I came in, I was a little bit taken aback by the terminology "pay for performance." In New Jersey there is a pay to play. So I didn't know whether this was in New Jersey or whatnot, we New Jersey people. So that is—they get it; you all don't.

But let me just say, I am sorry that I missed your testimony. I have been quickly looking through the material, but I do have a question that, when looking at pay for performance, and any of you respond, has anyone looked at a system problem? For example, in rewarding good performance, what I mean by that is, for example, one standard imposed on many hospitals is what they call the 4-hour rule, where a patient should receive antibiotics for pneumonia, for example, within 4 hours of walking into an emergency department.

Now, oftentimes in urban areas, where emergency rooms are, you know, used as a physician's office because of the lack of accessibility to health care, oftentimes the emergency department is overcrowded, and therefore it actually prevents a patient from being seen and diagnosed by a provider for more than 6 hours, which is sometimes common.

So my question is, you know, so this is the example that is the hospital penalized due to a more widespread health care system problem to access to care, and how can you kind of break that down?

Ms. ROSENTHAL. May I? That goes somewhat to Mr. Holt's question as well. I do think the issue is that one size does not fit all, and there will be some providers, particularly safety net providers, who are already stretched thin, have very few resources, and we don't want to drag those providers into a worse situation by reallocating resources away from them. And I think that we need to be very conscientious of those problems as private payers thinking about developing these programs, and making sure that technical assistance, again, or, perhaps some kind of different program, is tailored for providers such as the one that you have described.

I do think it is a real problem, and we don't know the extent to which these pay-for-performance programs are going to exacerbate existing strains on the system. And it is something that needs to be monitored.

Mr. PAYNE. Thank you.

I just have a general question. I know the whole question is trying to contain the escalating cost of health care, but I wonder is

this pay for performance, do you see it actually being the method to control health care costs, increases or to limit it, or do you think that it might just slow the increase down? Will it provide better health care? Will it make, therefore, funds available for all of those shut-out people? That is a whole different subject. What would you like to see achieved, if you could, say, maybe in a couple of sentences?

Ms. IGNANI. I think, Mr. Payne, one of the most compelling pieces of data now in the health care arena suggests that only 55 percent of what is done is best practice. So clearly we have a long way to go. And the incentive through the reimbursement system has been to pay pretty much the same for good practice, bad practice, mediocre practice. We haven't differentiated.

With this movement toward setting goals and objectives, rewarding clinicians who meet those objectives, that can be a powerful incentive to improving the value that we are all getting out of the health care system.

The conversation has been very relatively simple with respect to health care costs. It has been about the trajectory of the cost curve. That is serious enough. But when we look at the amount of money going into the system, and we match it with the data that suggests that only 55 percent of what is done is best practice, then it indicates there is a great deal of room to reorient and refocus health care resources and do a much better job.

So I think as the committee has opened up this conversation, we appreciate very much the thoughtfulness and the breadth of the conversation because it really does go to that issue of value: Are we getting value for our health care investment?

Mr. HANSON. Just to add to that, it is a complex issue. I don't think it is the silver bullet, but I think it is part of what the health care system needs to transform itself into.

There is a whole lot of consumer behavior involved with mitigating the costs of health care. I see this as only one part. It is an important part, but it is only one part of an enormous, complex transformation.

Mr. PAYNE. Thank you very much.

Earlier this morning we had a hearing on education, and two Governors, one from Iowa and one from Massachusetts, said the same thing, that we have to somehow differentiate pay for poor teachers that get the same pay as good teachers. I think that is sort of what you put your finger on. So thank you very much.

Chairman JOHNSON. Ms. McCollum, do you care to question.

Ms. MCCOLLUM. Thank you, Mr. Chair.

I am from Minnesota where we have done a few things a little differently. We have not-for-profits and all kinds of things, and now we are ranking our hospitals. And from what I am starting to see kind of get shifted out on that is the health insurance companies, when faced with some tough questions about is this really comparing apples to apples, is comparing a teaching hospital, a teaching hospital that also does indigent care, a hospital that handles pediatrics primarily, are we really—are we really ranking all this pay for performance accurately? And after all the names were published pretty much, in ranking, in the local papers, you started sifting through the next year or two, and there were a few like little

whoops. So I think we need to be careful when moving forward with this, and I think there is a lot of things that have to be taken in account.

In reading through here, one of the things is diabetic care. I couldn't agree more that there should be, you know, a standard for performance for diabetic care. But how does this work for a physician who maybe has multiple insurers, and one group of insurers is going to pay for test strips and everything; oh, and we will pay for your how to live with diabetes class, and we will make sure it is offered at a time that is flexible for you to take off of work, versus a doctor who has another patient who has bare-bones insurance that doesn't really cover too much of anything, to be supportive of that diabetic? So I am confused as to how this is going to work for doctors with multiple insurance.

And then when we start looking at protocol, protocol still isn't really shifted out based on gender and the way drugs interact with women. There is even still challenges for the pediatrics. I believe—and I served on a the State Medical board for a while. I believe there are physicians and nurse practitioners and a whole lot of people who can do a whole lot better. I also believe that there is a lot of people out there working really hard with a lot of different systems in place.

And so when you start putting all these things together, if there isn't one standard protocol for diabetes that is going to be nationwide, and then we start judging the physician, how they are doing on that, not even taking into account the patient responsibility on the end of it, I am wondering how do we really get there in a way that is just, and a way that is fair to the physician; to blow the whistle on someone who is not doing a good job, but not to penalize somebody because either their patient isn't cooperative, or they have 12 different insurance plans with all different kinds of menus with how to handle, and I will use diabetes as the example.

Ms. IGNANI. You have asked a 20-minute question, but I am going to give you a succinct answer. But I would like to follow up, if that would be appropriate, because I don't want to give the short shrift.

First, you should be, and I know you are, proud of what is going on in Minnesota. All of our health plans in partnership with the medical society and the hospital association have done some things that haven't been replicated in other States. So it is a great laboratory for best practice.

What we have learned in Minnesota, and also other places, and that—and this is one of the reasons that we have placed so much emphasis on the question of uniformity of protocols and selection of measures, is that it is very important that a physician who may be treating a subset of the community not be disadvantaged because they may have the individuals who are the least healthy, they have the most chronic conditions, comorbidities, et cetera.

So one of the things we have been working hard to do is to get consensus about what is measured, but also that is only part one; deal with the issue that you raised quite rightly, which is how do you put these data together so we can get a sense of—across all of the patients that the physician is treating of how they perform, as opposed to necessarily the patients that are just hooked to a

particular insurer. That would give equity inherently in the system for physicians, and we have been working with a number of physician groups we talk about in our testimony, and I would like to provide more data on that.

We have gone a long way on the measures, step 2. We are moving forward; we are moving forward rapidly. We are not completely there yet. But it is going to be very important not only to put the private sector data, but the public sector data so we can look together at the entire population that the physicians and the hospitals are treating.

So I think you have opened up a very important series of compelling questions that, Mr. Chairman, I would like to provide more detail on, because it really deserves a more thoughtful answer than I think in the time we have today. But this is very important.

The bottom line is I think we can feel hopeful that because of the way this is being rolled out, that we are doing positive incentives as a first step to try to elicit all of the issues, get them on the table, and see what needs to be done to do this right. It is a much more responsible way to proceed than go the other way.

Ms. MCCOLLUM. Mr. Chair, I appreciate that, but—and I look forward to seeing what you have to say. One thing that comes into this argument that I don't know, I didn't see it being discussed in the testimony, and I didn't hear every word of the testimony, is you are getting to patients' right to privacy. And we have been struggling with that at the legislative State level when your medical records start becoming part of a group medical record, starting to become part of analysis issues, having your medical records, your right to privacy and who is looking at what.

So that is, if we are going farther on this, Mr. Chair, I would suggest to tackle that in a hearing earlier on so that you are not confronted with it on the floor of the House, because it is a very sticky wicket, to use a colloquial term.

Chairman JOHNSON. You had another, Doctor, did you want to make.

Dr. GALVIN. If I could, I wanted to just respond to your initial concern about kind of where was the patient in the process, and were they engaged. And I think that is an awfully important question.

When Leapfrog and Bridges to Excellence were formed, employers did it because we couldn't get any health insurance plans to do it. But we could not get the system moving a number of years ago. It is good to see that a few of them are starting to move in that direction.

And one of the things we learned from managed care in the last decade was that who got excluded were the two most important players in the system, which were the doctors and the patients. And so when we started out to create these, it was we are going to have them at the table, and we are going to kind of only develop a plan if it meets their needs.

And just in terms of the consumer, a very interesting thing happened in Bridges to Excellence, which is we were moving down trying to figure out what a reward was, what the measures were, and at one point the physician said, you know what? We are not going to participate unless you also build in incentives for our patients,

because I can do the best thing, I can draw my blood sugars, I can do everything right, and if the patient then goes out and goes to McDonald's or doesn't follow what I, you know, have prescribed, I don't want to be disadvantaged for that.

And so there are pretty significant consumer incentives for basically living a healthy lifestyle. I just want to make it clear that I do think it is awfully important that consumers get engaged.

Chairman JOHNSON. Thank you.

In regard to your idea of sending us some more information based on your own opinions, we would appreciate that, and we would dutifully accept anything that you send to us and have it put in the record, and I thank you for the offer to elaborate.

I would carry on with that idea of how do we necessarily protect, you know, the docs and hospitals and the privacy issue that she is talking about personally.

You know, I know we have wrestled with that in other committees. I happen to be on the Medicare committee, too, and I think that with today's, he and I were talking about eye scan. We use that in the airports now to get through. There isn't any reason why you can't use something like that to identify patients. But her question, more to the point, was how do you prevent people using them for analysis publicly? Have you got protections figured out? Anybody think about that?

Ms IGNANI. Mr. Chairman, we have thought a great deal about this, and one of the ways to begin to get to—from a physician standpoint—and we have spent a lot of time talking about this this afternoon, it is very important to have not simply a snapshot of the patients that he or she is treating associated with a particular health plan, but to have their entire practice looked at from the standpoint of equity, to make sure that we are dealing with the high risk, low risk, medium risk, et cetera. In doing that, as you aggregate data, it is less important to know who I am personally. It is much more important to know what was done given my condition to ensure that certain objectives are met.

So in statistics we talk about deidentify data. It is a great deal of you just—it means you don't have to have the patient associated with that particular analysis.

And there has been a great deal of work done in the context of disease management and a number of other strategies with respect to care coordination that are going on that we think can inform this very productively. But clearly, this is new territory. It needs to be proceeded with caution. There needs to be a cautious path followed.

But we think that there are ways to address the issues of equity, but at the same time protect the patients. But where you put the balance point is an important thing to talk about prospectively as opposed to in retrospect, or retrospectively.

Chairman JOHNSON. Thank you. I appreciate it.

Yes, sir.

Dr. GALVIN. I agree it is an awfully important issue, and I think we, again, as large employers, address it early on because we all have a policy that we don't want to know any specific information about any of our employees. So it is something that we delegate to our health plans to do.

That all being said, we don't make any step in this pay for performance without having a council of our own employees and have our privacy committee at the company look at it, because I think these are delicate issues.

I think, as Karen said, we are kind of plowing new ground, and so I think that having it built into the structure from the beginning with the right people at the table is our best way to address it moving forward.

Chairman JOHNSON. Thank you.

Mr. Andrews.

Mr. ANDREWS. I again want to express my pleasure to the members of the panel for a very edifying, interesting testimony today. And I share Mr. Johnson's desire that you supplement the record with further thoughts. I think that is an excellent idea.

Mr. Kildee and I were talking during the testimony that—this discussion is reminiscent of a discussion that was held in this room and others over the last couple years over the No Child Left Behind Act. We started out with a concept that we wanted to articulate meaningful and high standards for every public school and every student, and we went about the business of trying to build measurements that would animate those goals. The jury is very much out on whether the standards that we—or the tools that we created successfully do that or not.

One of the other issues that is reminiscent of No Child Left Behind is something Mr. Payne brought up, and that is about the need for remedial investment when an institution is failing to meet a standard not because it doesn't know how to or won't, but can't because of resource limitations. And I would urge in your written comments to think about this problem.

I have several hospitals in my district, one in particular that is in an urban area, where probably 85, 86 percent of the revenue stream is either Medicare, Medicaid, what we call Uncompensated Care in New Jersey, which is a State fund for the uninsured. And probably this hospital is not following practices in certain areas that would be generated out of a study like this not because they are not aware of them, not because they are resistant to the change, because they don't have the resources. And we do want to be careful that, in identifying practices and areas that are not meeting the standard, that we discriminate or distinguish between institutions that can meet the standard but won't, and institutions that would meet the standard but can't because of resource allocation problems.

And whether we address that through graduate medical education, reimbursement for teaching hospitals, whether we address it through some kind of supplemental Medicare payment or what have you, it is a very serious consideration, because it is true that the driving concept here is to take dollars you are already spending, as Dr. Rosenthal said, and allocate them more wisely. But in some cases, even wise reallocation of those dollars won't cover what needs to be done because of gunshot wounds, and HIV problems in huge numbers, and low-birth-weight babies, and kids with lead poisoning, and lots of other things that these kind of hospitals deal with.

So I don't know the answer to that question, but it is a question that I would like you to take into account when you think this through.

Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you. He is right; all hospitals aren't the same. So we need to think about that.

I want to thank you all for your valuable time and your testimony. You are a very good panel. And I want to thank the members for their participation as well.

I would encourage you to tell your cancer patient M.D.

Anderson is a good place.

Dr. GALVIN. That is a one-cough hospital.

Chairman JOHNSON. That is it. And I think you will make your plane, Dr. Rosenthal.

Thank you all for being here. If there is no further business, this committee stands adjourned.

[Whereupon, at 3:43 p.m., the subcommittee was adjourned.]