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IMPROVING HEALTH CARE QUALITY: AN INTEGRAL STEP TOWARD HEALTH REFORM

HEARING

BEFORE THE

COMMITTEE ON FINANCE UNITED STATES SENATE

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SECOND SESSION

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IMPROVING HEALTH CARE QUALITY: AN INTEGRAL STEP TOWARD HEALTH REFORM

TUESDAY, SEPTEMBER 9, 2008

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

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Lincoln, Wyden, Salazar, Grassley, Snowe, Bunning, and Crapo.

Also present: Democratic Staff: Bill Dauster, Deputy Staff Director and General Counsel; Elizabeth Fowler, Senior Counsel to the Chairman and Chief Health Counsel; Billy Wynne, Health Counsel; and Neleen Eisinger, Professional Staff. Republican Staff: Mark Hayes, Health Policy Director and Chief Health Counsel; Michael Park, Health Policy Counsel; Susan Walden, Health Policy Counsel; Kristin Bass, Health Policy Advisor; and Lyndsey Arnold, Intern.

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

The CHAIRMAN. The committee will come to order.

Aldous Huxley once cynically wrote, "The quality of moral behavior varies in inverse ratio to the number of human beings involved." Today we focus on the quality of health care, and, even though a lot of human beings are involved, we will look for ways to improve its quality.

As we have been exploring ways to improve the health care system, we have been hearing about a 3-pronged approach: controlling health care costs, expanding access to care, and improving quality.

Over the last few months, the Finance Committee has held a series of hearings on health reform. Previous hearings have explored ways to control health care costs and ways to expand access to care. Before the end of the month, we will hold two more health reform hearings.

Today we will look at quality. Today, our health care system does a poor job of encouraging and rewarding quality. Medicare awards health care providers based on the volume of services that they provide. The more patients they see, the more revenue they bring in. That is regardless of the quality of care.

Most policy experts and health care providers recognize that we need to shift our focus onto quality. We need to encourage better patient outcomes. This effort would improve the health and lon-

gevity of patients, and improving patient outcomes should also help to reduce costs and reign in health care spending. Health care spending has been growing at roughly 7 percent a year, the overall economy has been growing at less than 5 percent a year, and general inflation has been rising at less than 2.5 percent a year.

With health care costs growing this quickly, we simply cannot afford to continue paying for inappropriate or inadequate medical care. We need to encourage high-quality and high-value care, and we need to reward health care providers who deliver it.

We have made some progress. Over the last few years, Medicare has encouraged hospitals to track and report on a variety of clinical activities that have been shown to improve quality and outcomes. For example, do heart attack patients consistently receive aspirin when they arrive at the hospital? Medicare pays hospitals more if they measure and report these activities.

We have also tried some other approaches. For example, the Medicare Hospital Quality Incentive demonstration program goes beyond just paying for reporting. This program links Medicare payments to hospitals' actual performance on a variety of clinical and quality measures.

This nationwide demonstration program has involved more than 250 hospitals. The program has shown that focusing on quality results in marked improvements for patients suffering from heart attack, heart failure, or pneumonia, and for those undergoing hip or knee replacements.

Similar efforts are also under way to encourage doctors to track and report quality and clinical improvement activities. For Medicare, we have worked to establish the Physician Quality Reporting Initiatives, or PQRI. This program asks doctors to report back to Medicare on their compliance with a standard set of quality measures. Doctors who participate in this program get a 2-percent bonus payment from Medicare. This program has focused its quality improvement efforts on improving treatment for high-cost chronic conditions.

The private sector has also worked on quality improvement, and employers as purchasers of health care have begun working on health plans and health care providers to encourage higher quality for their health care dollar.

We have made some progress, but we need to do more, much more, to encourage and reward quality health care services. Today we will hear from a private health plan, a purchaser, a hospital, a physician, and a policy expert. Each of the witnesses has been on the cutting edge of quality improvement efforts.

We will get their perspectives on how we can transform our health care system into one that encourages and rewards high-value and high-quality health care. Improving health care quality is an integral part of health reform, and I look forward to hearing from each of our witnesses on this important topic.

Speaking about our Constitution, Benjamin Franklin once optimistically wrote: "Wisdom is the specific quality of the legislator, grows out of a member of the body, and is made up of the portions of sense and knowledge which each member brings to it."

So I hope that the Congress can bring some wisdom to the health care debate, and I hope that each member will bring large portions

of sense and knowledge. I hope that, through this effort, we can help improve the quality of health care and, thereby, the quality of people's lives.

Senator Grassley?

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Thank you, Senator Baucus. To our panel, thank you for coming. I know a lot of you have come a long way. Thank you very much for sharing your expertise with the Congress on this very important subject of examination of health care quality, which is the third of the themes that we have been discussing this year in this committee on reforming health care.

In the report, "Crossing the Quality Chasm," the Institute of Medicine said that, "Between the health care we have now and the care we should have lies not just a gap, but a chasm."

Now, I know that there are dedicated providers who work hard day in and day out to provide high-quality care, but not all providers are at this level. There is a recent Dartmouth University study that shows that. There are wide geographic variations in the quality of care. So the challenge is, how do we work to make sure that all providers give the right care, and at the right time?

A fundamental building block to meeting this challenge is performance measurement. After all, how can we improve quality if we cannot measure what that quality is in the first place?

I am pleased to see the dedication that many are giving to current efforts to measure quality performance. This is, of course, a substantial undertaking. But the end result will enable us to draw an apples-to-apples comparison between providers based upon quality. In Medicare, we have added financial incentives for a number of providers to participate in these performance measurements. Hospitals, home health agencies, and physicians currently receive some form of payment incentive for reporting quality measures.

But, of course, this is just a first step. If we are able to figure out who is or is not passing muster, we have to devise a system to encourage everyone to become high-quality performers. The way Medicare currently pays for health care certainly does not provide these incentives to improved quality. Today, poor-quality providers get paid the same as high-quality providers, and in some instances the poor-quality provider gets paid even more.

In fact, the current system encourages a high volume of services instead of quality. It is just, of course, disgraceful that Medicare rewards poor quality care in many cases, and, because many private health plans follow Medicare's lead in how they pay providers, these flaws in the Medicare system spread throughout the entire system, and that further compounds that problem.

Congress then needs to make changing the way Medicare pays for high-quality care a priority, and then insurers need to change their incentives as well. We need incentives for quality instead of quantity. Value-based purchasing would provide the right incentives. High-quality providers should be financially rewarded, while poor-quality providers are encouraged to do better. Payment systems that reward quality have been tested both in Medicare and in the commercial market and they have shown promising results.

Senator Baucus and I convened a roundtable discussion earlier this year on Medicare hospital value-based purchasing. There was overall support for such a concept, and I will look forward to working with my chairman and other committee members, and, of course, stakeholders to make this a reality.

Today we are very fortunate to have many of the major health system stakeholders here to talk about how to improve quality of care that hospitals and doctors provide. I will look forward to hearing their perspectives. I am even more interested in learning how we can all work together to improve quality because, if there is one message we heard loud and clear at the roundtable, a roundtable on value-based purchasing, it is that we all must work together to improve quality in our health care system.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

I would now like to welcome our witnesses. First we hear from Mr. Peter Lee, who is the executive director of national health policy for Pacific Business Group on Health. Second, Dr. Samuel Nussbaum, executive vice president of clinical policy and the chief medical officer of WellPoint. Third is Dr. Gregory Schoen, the regional medical director of Fairview Northland Health Services in Minnesota. Our fourth witness is Dr. Kevin Weiss, who is president and CEO of the American Board of Medical Specialties. Finally, we will hear from Dr. William Roper—good to see you again, Bill—dean of the University of North Carolina School of Medicine, and vice chancellor for medical affairs and CEO of the University of North Carolina Health Care System.

A reminder to all of you, your written statements will all be included in the record, and we ask each of you to limit your oral remarks, please, to 5 minutes.

Mr. Lee, why don't you proceed?

STATEMENT OF PETER LEE, J.D., EXECUTIVE DIRECTOR OF NATIONAL HEALTH POLICY, PACIFIC BUSINESS GROUP ON HEALTH, SAN FRANCISCO, CA

Mr. LEE. Thank you very much. Good morning, Chairman Baucus, Senator Grassley, and members of the committee. It is a pleasure to be here. I am Peter Lee, the executive director of national health policy for the Pacific Business Group on Health, and I appreciate the chance to talk with you today about how the Federal Government, and Medicare in particular, can join with leading employers, labor groups, consumer organizations, and providers to measure and reward quality and cost efficiency to foster improvement in a very troubled health care system.

As the debate on how best to reform our broken health care system continues, virtually all agree that we have a current system that covers too few, costs too much, and does not deliver consistently high quality. Without ensuring quality, access to care may be meaningless. Without addressing costs, care will remain inaccessible to many Americans.

For employers that PBGH represents and for many consumers, we face premiums that have increased over 125 percent in the last 8 years alone. What that means for many small businesses is they are being driven out of the health insurance market entirely. For

large businesses, they're becoming less competitive internationally. What that means, as they are facing foreign competition, is it adds impetus to, in essence, the last thing we want to be exporting, which is American jobs.

The good news is, and it is reflected by this hearing today, that there is agreement across the political spectrum and the range of stakeholders that we have to have a reform that addresses not just coverage, but also improving quality and cost effectiveness. The good news, as you will hear from the panelists here today, is that there are real solutions we can work with.

I do need to note though, as we look at quality, we do need to remember when we seek to expand coverage, that we do that in a way that does not just shift costs. Too often we look at coverage as an issue that just gets individuals into public programs that then result in cost shift to the private sector, so the fewer employers and individuals that have private coverage are picking up more of the bill for the public sector, and that is something I want to keep in front of the committee and in front of Congress.

The problem with cost shifting, though, underscores why we must improve coverage and go beyond that to, first, measure performance; second, use that information so consumers/patients can make better choices; third, change payments to providers and provide incentives to consumers to reward quality; and finally, promote reengineering in care. The starting point for that reform has to be in understanding what works and who's doing the job right.

I am going to make a number of specific recommendations relative to Medicare and the Federal Government. My written testimony goes into more detail. But, first, I note that Medicare needs to make routinely available Medicare claims data to qualified quality reporting organizations such that employer-sponsored and individually sponsored health benefits plans can lower premiums by using aggregated claims data across multiple beneficiaries.

Second, we need a national initiative to measure and compare the effectiveness of drugs, devices, and procedures that includes formal economic analysis and that is trusted by all stakeholders, is rigorous and transparent, and we need to improve the quality and value of care by making sure those results are used by public and private plans in benefit design, payment, and patient decision support.

The second major area after we measure performance is, we need to get that information into the consumers'/patients' hands. The Federal role here needs to be, in particular, to make sure that valid information is available to be used by a whole range of stakeholders, whether that be consumer organizations, health plans, or private groups.

Next, we need to align payments to providers and provide incentives for patients to foster better care. There are, as we have heard, literally hundreds of payment reform pilots going on around the country, but, if we do not have Medicare join with private payers, this will not make a difference. We need to design payment systems that reward providers, building on many of the good efforts that we have heard discussed by Senators Baucus and Grassley that have been launched in Medicare to build on the efforts to reward quality on both the clinician and facility fronts.

Part of that effort, though, needs to be rebalancing the payment equation to better compensate providers that engage in preventive care and primary care. I would specifically encourage this committee to look at MedPAC's recommendation to establish a budget-neutral payment adjustment that would shift support for preventive and primary care. This is the right thing to do, because we need to send the message to today's and tomorrow's physicians that we are going to reward primary care.

Also as part of that rebalancing, we need to have Congress relook at how CMS establishes the relative value assessment within Medicare. Currently, that is far too centered around the physician perspective. That rebalancing needs to be done from a patient perspective, anchored in patients' views and payers' views.

Finally, I would just note—and I look forward to hearing questions from the members of the committee—that the Federal Government needs to promote markets, both directly as a purchaser and by supporting information every American needs to make better choices.

As I have noted, Medicare and the Federal Government can take leadership by making comparative information available to all Americans, by rebalancing Medicare payments to reward primary care and to support reengineering, and by establishing a new payment review process that is physician-informed, but patient-centered. These three steps, along with many others, will move us toward a health care system that is patient-centered and sustainable. Thank you very much, and I look forward to your questions.

The CHAIRMAN. Thank you, Mr. Lee.

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

The CHAIRMAN. Dr. Nussbaum?

STATEMENT OF SAMUEL NUSSBAUM, M.D., EXECUTIVE VICE PRESIDENT FOR CLINICAL HEALTH POLICY AND CHIEF MEDICAL OFFICER, WELLPOINT, INC., INDIANAPOLIS, IN

Dr. NUSSBAUM. Chairman Baucus, Senator Grassley, and distinguished members of the committee, I am Sam Nussbaum, executive vice president and chief medical officer of WellPoint. It is an honor and a privilege to appear before you to discuss how WellPoint is advancing health care quality and safety in the United States.

At a time of breathtaking advances in biology and medical science, the U.S. health care system has not kept pace. By most measures of public health and health care quality, the U.S. lags many European nations. And while the health benefits industry has been a lightening rod for concerns of rising health care costs and for access for affordable coverage, we know there is no single cause or cure for our Nation's health care challenge. What we do know is our reliance on increased spending to improve quality has failed us, and so we must fundamentally shift by investing to drive better outcomes to improve safety and to provide greater value.

The health insurance industry is undergoing a transformation, unnoticed by many, to drive quality outcomes, evidence-based medicine, and health improvement. With over 35 million members and another 60 million Americans touched by our subsidiary companies, WellPoint's capability and responsibility to positively impact health care are great.

I would like to focus my remarks today on five elements of our quality strategy: (1) determine what works in health care through comparative effectiveness and outcomes research; (2) promote quality through innovative payment models for physicians and hospitals; (3) enable informed decision-making through the use of health information technology; (4) improve the health of our members and communities; and (5) improve pharmaceutical and health care safety.

Imagine, if you will, a day when a health plan uses a vast amount of claims, pharmacy, and laboratory information to determine what works in health care. Today, WellPoint is conducting clinical outcomes and comparative effectiveness research to determine how drugs work outside of the clinical trial and in the real-world setting.

For example, our research found that 63 percent of our members with high cholesterol could be effectively treated with generic statins, and we found that, even in our insured population, racial and ethnic disparities exist, with insured African American women diagnosed at a later stage of breast cancer and less likely to receive state-of-the-art therapy.

Imagine a day, if you will, when the health plan provides you information to help you improve your health care and save money, suggestions that are tailored to your specific needs. Today we are providing our members, including Federal employees, with clear, actionable messages regarding health improvement and member cost-saving opportunities. We have seen a 10-percent improvement in care guideline compliance.

Imagine being diagnosed with a chronic illness and finding that your health plan has already developed a suite of specific programs for your condition based on the latest clinical evidence, with a nurse available 24 hours a day and a health plan that is helping your physician manage your care regarding sharing information directly.

We are using that health information strategy in Kettering Health System in Dayton, OH, working with General Motors to combine all of this clinical data in an integrated health record that is improving health care for 10,000 members. These results indicate a 7.4-percent reduction in medical trend and higher quality for individuals with chronic illness.

Imagine a day when physicians and hospitals are paid in part based on clinical quality. Today, WellPoint's pay-for-performance programs assess physicians and hospitals on quality indicators and reward them for better health outcomes, for better patient safety, and for member satisfaction.

Imagine a day when health plans work with Federal agencies and academic experts to improve drug safety. Our WellPoint Safety Sentinel System monitors a 35-million member database and identifies drug events in near real-time, and we are working with the FDA, the CDC, and academic experts to evaluate therapies after a drug is approved and is in clinical use.

To impact health, however, we must transform clinical evidence into clinical action. We can work together to improve health care quality and the performance of our health system. So I would like

to close by highlighting what we believe Congress can do to advance these goals.

(1) Support recommendations for establishment of a National Clinical Effectiveness Assessment Program. This is the theme reflected in the Comparative Effectiveness Research Act of 2008 sponsored by you, Senator Baucus, and Senator Conrad.

(2) Continue to create incentives for the adoption of e-prescribing and health information technology. We appreciate the incentives created last year for e-prescribing in Medicare, thanks to the leadership shown by many members of this committee.

(3) Deploy innovative payment methodologies in Federal programs that reward quality and improved outcomes.

(4) Partner with WellPoint and other health plans on national drug, vaccine, and health care safety initiatives.

I have shared a vision of a health care day that is already dawning. I commit to you that our company has the passion for health improvement, the vision, and the resolve to positively impact the health of our Nation.

Mr. Chairman, Senator Grassley, and distinguished members of the committee, thank you again for the opportunity to speak before you today. I welcome questions that you may have.

The CHAIRMAN. Thank you, Dr. Nussbaum, for that vision. We appreciate it very much.

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

The CHAIRMAN. Next is Dr. Gregory Schoen.

STATEMENT OF GREGORY SCHOEN, M.D., REGIONAL MEDICAL DIRECTOR, FAIRVIEW NORTHLAND HEALTH SERVICES, PRINCETON, MN

Dr. SCHOEN. Chairman Baucus, Ranking Member Grassley, and other members, on behalf of Fairview Northland Medical Center, my name is Greg Schoen. I am a practicing family physician. Our facility is about 50 miles north of the Minneapolis–St. Paul area, and we have a 54-bed hospital. As such, I am standing before you representing rural America and the challenges of health care today.

Fairview Northland is one of 250 participants in the Hospital Quality Incentive Demonstration Project which was launched in 2003 as a joint effort by Premier Health Care Alliance and CMS. The project provides incentives to hospitals that successfully use evidence-based, widely accepted clinical treatments with measurable outcomes in five specific areas: acute myocardial infarction, chronic heart failure, pneumonia, total hip and knee replacement, and coronary artery bypass grafting.

Our hospital chose to participate in the HQID project, knowing that improving quality is the right thing to do for our patients. We believe that a model where we can align financial incentives will be an effective way in pushing quality to a higher level, and have demonstrated that in this project. Pay-for-performance is an engine for improvement and can be a framework for fundamental transformation of health care.

The HQID project was a catalyst for our quality improvement in our hospital. For years we had been dabbling in quality improvement, but, once incentives became part of the picture, we found

that we went under a cultural transformation: the board, the administration, and the entire medical staff became actively engaged in moving quality to a higher level. It created a focus in our organization that had not existed previously.

It allowed us to stay ahead of the curve by participating in the project in the sense that we understood that ultimately quality would become part of payment through CMS, and other payers would soon follow. Comparing measurable outcomes is a strong motivator for hospitals and physicians to improve quality—not that we are comparing and keeping score, but learning from each other.

Finally, pay-for-performance does result in other measurable outcomes besides those that are being focused on for showing improvement, and as such we have found improvements in patient and employee satisfaction, as well as other clinical measures.

The pay-for-performance can, and does, work in small rural hospitals. Our facility is a good example of that. In year 1 of the program, we were in the bottom decile, or 10 percent, of the country in performance across the five measures in which we participate. However, by gathering our staff together and developing protocols and processes, we were able to improve in year 2 to the upper 20 percent for acute MI, heart failure, and pneumonia, and in year 3 we had moved into the top 30 percent in our performance in hip and knee surgeries. We have been able to sustain our gains in all of the other areas as well.

There are advantages to being a small hospital, in that small medical staffs and small hospital staffs are able to quickly get their arms around the issues at hand and create protocols and processes to improve outcomes. It also, within the HQID project, was demonstrated that that was not just our experience. The experience of other small hospitals participating was that they were able to achieve improvement at a greater pace than the non-rural hospitals.

We also face many challenges as a small hospital. The inpatient volumes are such that, in any subset of these populations, one outcome measure can seriously affect the outcomes of your performance in that particular measure. It also is the case that we have small, scarce resources in our facilities, that multiple tasks need to be performed by our staff, by our physicians, and that the attention to detail that is required for performance takes time and has to come from some other activities.

So, as we look forward to designing a pay-for-performance measure for how we reimburse for health care, we welcome the concept of being paid for quality. For far too long, we have been paid for simply just services rendered and not the outcomes and the quality in which those services are delivered.

However, we think there are some issues that need to have close attention as we move forward. There needs to be a minimum threshold of quality for outcomes for which there is a financial incentive. If we do not have a minimum threshold, the expectation of receiving care safely across the country does not exist. Hospitals performing below this minimum should not initially be penalized, but should be supported with tools from those hospitals that have success so that they can learn and gain knowledge through other ways rather than recreating that work from the ground up.

Special considerations need to be given to hospitals with small numbers so that those single items that fall out do not create a common-cause variation that denies them payments. Also, we would prefer the carrot approach of encouraging performance as the appropriate way to go, but we realize that penalties may be necessary.

We believe that there is a call to standardize the measures. As a small rural hospital, HQID and CMS provide measures, but we have multiple private payers who ask us to do their outcomes measures as well. We believe that gathering all those subsets together so that we can focus our attention on the same outcomes will get us to a better place more quickly.

Lastly, we recommend that the organizations who assure alignment between physician and hospital measures put these measures into pilot programs and testing before they become part of a public program.

In closing, the pay-for-performance system needs to be structured to incent quality improvement in every hospital in the country. Patients, regardless of where they are in America, should be assured that they will receive a consistent level of care.

Thank you. I look forward to questions.

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

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

The CHAIRMAN. Dr. Weiss?

STATEMENT OF KEVIN WEISS, M.D., PRESIDENT AND CEO, AMERICAN BOARD OF MEDICAL SPECIALTIES, EVANSTON, IL

Dr. WEISS. Thank you so much, Chairman Baucus, Senator Grassley, and members of the Senate Finance Committee, for the ability to testify on health care quality.

My name is Kevin Weiss. I am a physician, board certified in internal medicine. I actually had the privilege of being one of the members of the Institute of Medicine Chasm Report committee, and have sat on performance measurement committees that include NQF, AQA, PCPI, NCQA—pretty much the round of major quality organizations.

But I come to you here as president and CEO of the American Board of Medical Specialties, ABMS. ABMS is an independent nonprofit organization which, for 75 years, has been assisting 24 medical specialties in developing the standards used to certify physicians. ABMS's reach is broad and deep. There are over 700,000 U.S. physicians, both doctors of medicine and osteopathy, who hold a certificate by one or more of our boards. The standards that we set are used by almost all medical residency training programs and physician practices of just about every size and scope and every reach in the country.

The profession's investment in board certification is approximately $150 million a year, paid by physician fees, which represent about 85 percent of the physicians' workforce, who voluntarily go through a certification process as evidence of their support. We work in the public's interest in that we set standards to assure the patients and their families about the competency of physicians. A national survey suggested over 90 percent of the public uses board certification as a way to choose a physician.

Please note that earlier I said that we are supported by physician fees, not dues. We are not a member organization, nor do we accept support from the pharmaceutical or medical device industries in order to set our standards. We maintain our independence solely for setting standards and not physician payment.

In short, ABMS boards are private-sector oversight organizations that are very similar in mission to the National Committee on Quality Assurance and the Joint Commission.

We embrace a new definition of professional accountability that includes not only quality for patient care but also recognizes that physicians have a role in maintaining and reducing health care costs.

In my testimony today I hope to inform the committee on three issues: first, that we believe that no single strategy is sufficient to support our health care system; second, we believe that the best model of physician accountability rests both on physician performance measurement and other assessment processes; and third, that we have to align the public sector with the private sector initiatives more strongly to get the most change in our system.

Let me provide some brief details on each issue. First, we believe that multiple strategies are needed and that there are distinct and potential complementary rules for regulation of the market through pay-for-performance and through performance reporting and professional accountability.

Most physicians in practice are imbued with a deep sense of professional want and desire to provide the best care for their patients. Incentive-based programs tap into motivation that is extrinsic to the profession and thereby, while they ultimately will be successful, cannot do the whole job. The certification boards demonstrated that, with trustable, actionable data, physicians will voluntarily commit to improving their knowledge and their care delivery, thereby tapping into their intrinsic professional motivation, and it is these two that we have to bring together, extrinsic and intrinsic motivation, to accelerate change.

The second issue is, the best model for physician accountability will have to go beyond just performance measurement. Now, the tools that ABMS boards use to assess physicians are multifaceted, and I respect the fact that one of the cornerstones of them is performance measurement. Many aspects of clinical competency do not lend themselves to representation by performance measurement alone. For example, we have some excellent nationally endorsed performance measurement tools, looking at diabetes care, breast cancer screening, tobacco cessation. We have some great measures, and those measures will effect change. However, those are for common illnesses. Many of the illnesses that patients seek care for from doctors are not common: thyroid disease, viral meningitis, rheumatoid arthritis—important illnesses if you are a patient with these conditions, but the science of performance measurement cannot quite get to the level of those kind of quality questions.

So we need to have other measures and other assessment tools. The board has used things such as secure book exams, closed-book exams, to test medical knowledge and expertise. They look at clinical judgment through low- and high-fidelity simulation exercises, similar in context to that which pilots use in terms of maintaining

and demonstrating their skills. They require lifelong professional self-assessment and feedback, and expectations for practice-based, not just measurement, but improvement.

Our last issue is that the public and private sector need to align themselves better for physician accountability. Out of a desire to reduce wasteful and redundant data collection, ABMS boards have begun to align our assessment methods with those of the private health plans, hospitals, CMS, and other emerging forces such as NQF and the Health Care Quality Alliances.

ABMS boards are helping facilitate reporting clinical data through CMS as part of your PQRI process. ABMS boards are developing new kinds of partnerships, and we are beginning to launch a new activity this year with the National Quality Forum. We have been serving on the NQF's National Priorities Partnership, which my colleague, Dr. Bill Roper, will be discussing next in more detail.

In summary, professional accountability—and the public-facing values it embodies—offers proven mechanisms to connect to the heart of a doctor's professional obligation to engage in improving care. Then perhaps, by bringing to bear the professional obligation along with the market-based incentives Congress can offer through CMS and other governmental health care programs, along with private sector efforts at performance improvement incentives, we know that what we all would like to see is possible, and that is that our patients and public deserve the best possible, lowest price of care.

Thanks so much.

The CHAIRMAN. Thank you, Doctor, very much.

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

The CHAIRMAN. Now, our final witness is Dr. Bill Roper.

STATEMENT OF WILLIAM ROPER, M.D., MPH, DEAN, UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE; AND VICE CHANCELLOR FOR MEDICAL AFFAIRS AND CEO, UNIVERSITY OF NORTH CAROLINA HEALTH CARE SYSTEM, CHAPEL HILL, NC

Dr. ROPER. Thank you, sir. Thank you, Mr. Chairman, members of the committee. It is an honor to appear before you and to discuss this important matter of health care quality. I had the privilege some years ago of appearing often before this committee, and it is a delight to be back.

As health care reform efforts take shape, we have an important opportunity to advance the quality agenda as an integral part of addressing cost containment and coverage. As your committee hearings imply, these are three important things that are surely interrelated. I urge you and others to continue to consider them in that fashion.

Others have talked about the important notion of measuring and reporting results on health care quality. That is a powerful notion that has enormous potential for improving what we do in health care. It is important that it be done right, that we have quality information about quality. In short, quality does not happen in a vacuum and cannot be accomplished alone. To be truly successful, all parts of the system—providers, insurers, health plans, purchasers,

consumers, and government agencies—all must work together in this effort.

I am here today representing the National Quality Forum, which is working in partnership with CMS, the Quality Alliances, and others. NQF was founded in 1999. We now have more than 375 members representing virtually every part of the health care system, and we have a 3-part mission to improve the quality of American health care by: first, setting national priorities and goals for performance improvement; two, endorsing consensus standards for measuring and reporting results on performance; and three, promoting the attainment of national goals through education and outreach programs.

The health care measurement sets which we have today provide, I think, an adequate starting point from which to jump-start pay-for-performance and public reporting. But it is important for us to chart an evolutionary course out into the future for measures that will be used by both public and private purchasers and other stakeholders in the near future.

When an educated consumer buys a car, the decision is based not just on the cost of the vehicle, but on quality and value. In a similar way, we need to focus on the entire health care experience and say ahead of time what it is we are trying to achieve, and then measure results to decide whether we have, indeed, achieved what we set out to accomplish.

In particular, we need to focus on managing an illness over time and across settings. We need to do, as many others have said, align payment with quality so these are not viewed in isolation. We need to build high-performing health care organizations. We need new organizational models that integrate the delivery of health care services in a way that is good for patients and their families. I have had the privilege of working on this issue for more than 2 decades from Washington, and now at the local level.

Both national policy and local practice are important to this issue. As you have heard from others, we need a long-term, sustained commitment to improving health care quality. This is not something that is going to be done tomorrow, or next year, or really ever be finished. It is a permanent way of thinking about and working on what we do for our patients.

Again, as you have heard from others, we need a broad partnership that brings all parties at interest to the table and works on this in an integrated fashion. It is a privilege to be with you, and I look forward to answering your questions.

Thank you.

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

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

The CHAIRMAN. I would like to start with you, Dr. Schoen. Often we hear that rural hospitals are at a disadvantage compared with larger hospitals, basically because they do not have the infrastructure or the capital needed to address a new requirement, and whatnot.

As I understand it, you are basically saying that there are some advantages to being a smaller hospital, because you are able to work together better. But, as you worked on the efforts to improve quality, performing your HQID, just tell us again what worked for

a small hospital and what the problems are facing a small hospital, and what advice do you have for other hospitals generally, and maybe specifically for smaller hospitals?

Dr. SCHOEN. I think the first challenge we had was the notion of trying to create systems that worked for us, and where were we going to get the support and the staff from? Basically, you need a commitment to say, we have people whom we know their job is to do this or this, but we need to pull them off-line for a period of time to focus on making these changes. I think what you find when you do that is there are other operational inefficiencies that you learn how to improve in other areas so you can free up that time so that you can focus on the efforts that are important and appropriate.

So, during this course of time, there was a huge cost commitment in terms of human resources and development of protocols and processes and workflows that we put effort into. But on the back end of that, the improved results in patient quality have benefitted us greatly. I believe that it is a matter of resolve. Instead of saying we cannot because we are small and we do not have the resources, it is taking a look at, what other things really are not critical that we do not have——

The CHAIRMAN. So a lot of it was just a question of attitude.

Dr. SCHOEN. Very much.

The CHAIRMAN. That is, this is something we are going to do.

Dr. SCHOEN. On the other hand, there may be hospitals that are so small that they would greatly learn from collaboration with other hospitals so that they do not have to reinvent the wheel, so to speak.

The CHAIRMAN. And the staff at the hospital felt this was working, they joined in?

Dr. SCHOEN. Absolutely. It became a team effort across the entire organization. Once you get the board and the administration supporting it and the medical staff supporting it, it is easy to gather and get momentum.

The CHAIRMAN. Well then, why could other hospitals not do the same, basically?

Dr. SCHOEN. Again, I think it is a matter of resolve and commitment, to say this is a focus that we believe in and a direction we want to move in. It is transforming your organization from one that simply provides a service to one that wants to provide the highest quality of care.

The CHAIRMAN. And what could we do here in the Congress, what could CMS do, to help this effort?

Dr. SCHOEN. I think if we are looking at a program that rewards, we have to make sure that—for instance, in the project, we are looking at the top 2 deciles being rewarded. I think a minimum threshold of performance needs to be available. If all the country, through improved quality, crosses that threshold, the reimbursements should support all hospitals, not just those in a certain subset.

The CHAIRMAN. Could you discuss that threshold again, please? How you arrived at that number and why it is so important.

Dr. SCHOEN. Rather than specifically determining what the number is, I think, as you mentioned earlier in your opening state-

ments, a patient with acute heart attack should get an aspirin, should get a beta-blocker, should have ACE inhibitors, and all the appropriate levels of care that we know are evidence-based.

If those things are not happening, how do we help those hospitals in order to provide that level of care and have protocols and processes in place to ensure it happens for every patient across the country, regardless of time of day or who the doctor is on call at the time?

The CHAIRMAN. And your thoughts on the relative value of carrots and sticks that encourage hospitals to undertake these efforts?

Dr. SCHOEN. Physicians, by and large, and hospital systems are motivated by an incentive to pull them forward. I do think there is, as in everything in life, a subset of folks that kind of needs a little stick approach to move them forward.

The CHAIRMAN. Let me ask Dr. Weiss, how do we better align public and private incentives here? How do we go about doing this?

Dr. WEISS. There are probably several ways to begin the process. The first is a voluntary mechanism, sort of the encouragement side, the major initiatives now that are coming out of Congress through CMS and what is happening in the health plans and their physician accountability, and then at least at the physician level, what is happening through this voluntary process, this board certification process. We are all working hard, but relatively independently at this.

There is no great convening force to try to say, what should this implementation look like? Right now, the Quality Alliances help with that. NQF has been extremely helpful in setting common endorsed measures. But to create those incentives, we have to have a convening and an endorsement process, I think a signal from Congress to say that this is important in a way that means that there is a sustainable interest, to say we need to have a single set of measures and whatever we can do to help facilitate that. What we need to do is ask the question of not just measures, but what other things do we need to drill down on in terms of physician accountability.

The CHAIRMAN. Yes. But how do we make this happen, frankly?

Dr. WEISS. Step one. In terms of performance measurement, we need to find ways to have one set of performance measurements that are acceptable across CMS, the health plans, and the boards. We do not have that yet. In order to make that happen, we have to set the table right to get that.

The CHAIRMAN. My time has expired. I just think we have to figure out ways. We rely upon a lot of you, your advice, in how we make that alignment happen.

Senator Grassley?

Senator GRASSLEY. Dr. Schoen, your discussion that you had with Senator Baucus was something I wanted to discuss with you. You have gone over most of what I wanted to do. But since your hospital is similar to many of the hospitals that we have in my State of Iowa, I would ask you to zero in just a little bit on whether or not your experience from your point of view was typical of how you think a nationwide roll-out of value-based purchasing would occur, or did you get a lot of special outside help and resources from the demonstration?

Dr. SCHOEN. Although we are part of a larger health care system, and although Premier had services available to us, most of the work was simply done internally with folks rolling up their sleeves. We had gone through and done a lot of quality training. We had people in our facility who were quality experts, but we were not moving the dial in the fashion that we wanted.

So when there was an incentive in terms of reimbursement that came along, that became a much larger motivating factor for us to move forward. And again, then the administration and the board really put the focus on us improving from where we were. In year 1, we thought we were doing well. We did not do well at all. That completely changed the focus of the organization for the next year.

Senator GRASSLEY. And with good results ensuing?

Dr. SCHOEN. We have had very good results, and we have been able to sustain that, simply by changing our focus, our structure, and our commitment to quality.

Senator GRASSLEY. All right.

I am going to ask Mr. Lee and Dr. Nussbaum the next question. WellPoint's plan insures 35 million people. Dr. Lee, the Pacific Business Group on Health's members cover more than 3 million. You both note the importance of incentives to reward quality for both physicians and for hospitals. Can the private sector take the lead by itself in changing health care provider reimbursement to be based on quality and outcomes or must Medicare take a leading role?

Mr. LEE. Senator, I think it is absolutely clear and imperative that Medicare takes a lead in partnership with the private sector. As you noted in your opening remarks, the private payers very, very often follow Medicare. Medicare sets the standard that then ripples throughout the entire system. I think we need to have rapid-cycle payment demonstrations that do not have Medicare out there on its own, but have Medicare working with private sector initiatives so we do not have 120 different payment pilots scattered around the country, but we have issues where Medicare is working in conjunction with the private sector. But, if the private sector alone is trying to do this, it will not make the difference. Medicare has to lead, working with the private sector.

Senator GRASSLEY. And from your point of view, Dr. Nussbaum?

Dr. NUSSBAUM. Senator Grassley, I think our experience at WellPoint, which is the largest experience with pay-for-performance, shows that coming together, all of the health insurers, with Medicare, measuring the same quality performance measures and outcomes, can make a difference.

In California, where Peter is from, an organization called IHA has actually convened all the health plans to promote the same quality measurement and performance measurement for physician groups. And, while we may have variation in the incentives that we pay, WellPoint has paid over $60 million to those physicians, and we are showing improved quality of care.

So, we need to experiment, we need to see what works in care. It is not only about pay-for-performance, it is about advanced medical home and other innovative payment models. But working with Medicare, coming up with a common platform, we can drive even faster and greater improvement in quality.

Senator GRASSLEY. I do not have time for all of you to answer the last question. I was hoping I would have time. But let me ask you, some of you who feel confident answering this—a couple of you, maybe—are economic incentives the best way to improve quality, or does simply finding out that one's quality of care is substandard provide enough incentive to improve it? Go ahead.

Dr. WEISS. You know, I have to look back over the past week. A family member of mine was having some chest pain and was rapidly assessed and put in the hospital, and was given a cardiac catheterization. Thank goodness, everything was fine. But looking back on it, I asked my family member, what was that experience like, and what about your chest pain? They said, well, the doctor did the catheterization, walked in, walked out, and did not say a word. He said my heart was fine and left the room. I said, that is unacceptable.

Now, performance measurement is not going to get that, because technically the doctor did just fine. The profession should not accept that. That is the problem. So, financial incentives are not going to get to that level, so we have to work with some realignment of expectations of professional values here. That is what I was speaking to earlier about the intrinsic motivation. But, in order to do that, in response to Senator Baucus's earlier question, we have to force the alignment.

Right now, I would say, as one partner in that, and that is the boards, we have to try to find a way to have CMS listen to what we are trying to do so we can work with them. So far, we are having a hard time finding that pathway. We are beginning to find a pathway with the health plans, but if we do not have easy pathways and expectations set by Congress to say that these are not good enough professional expectations, the boards cannot come in and help.

Dr. ROPER. Senator, if I may, I agree with what Dr. Weiss said about the importance of the professional role in this agenda, but I would also say we very much need to have greater financial incentives to focus on quality. Otherwise, I believe—and this comes from experience—the rest of the system will simply not pay enough attention to this. Indeed, if I can be a bit more plain-spoken, I think my colleagues at CMS have not been sufficiently far-reaching, as far as the amount of money put at risk, for health care quality. We need to push that agenda farther, faster than we have in the past.

Dr. NUSSBAUM. Senator Grassley, we know that health care is 50 percent good, 50 percent high quality. It is not only pay-for-performance. That is a component. But I believe we have to provide doctors near real-time information on gaps in care, ways that they can achieve near-perfect care for chronic illness for their patients. That is an example of investment in health information technology and other strategies that will allow physicians to get to that promised land of near 100-percent high-quality care.

The CHAIRMAN. Thank you, Senator.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Gentlemen, whenever there is a discussion of quality in American health care there are loads of detailed debate about what qual-

ity means for doctors, for hospitals, for insurance companies, for employers, for just about everybody except the patient. The patient is pretty much an after-thought. That is why, in my view, we have this problem where it is easier for a consumer to get information about a microwave or a dishwasher than it is to get information about the quality of health care.

Now, in the Healthy Americans Act, the legislation that I and a number of colleagues on this committee have authored—we have eight Democrats, eight Republicans—we try to put the patient in charge in terms of this debate about quality. For example, we create a website where it would be possible for patients all across the country to get information about the quality of services in their area.

So what I would like to do, for purposes of starting this morning, is use an example and get your thoughts about how we could further involve the patient in driving this quality debate.

Dr. Jack Wennberg of Dartmouth, who is really renowned in this field, has talked at some length about the abuse of discretionary surgery. What could be done—and maybe I will start with you, Dr. Roper; it is always good to have you—to get information to patients in a user-friendly way that would allow them to drive a quality agenda where the country could deal with this problem of the abuse of discretionary surgery, which, I think all would agree, is certainly central to getting good quality?

Dr. ROPER. Thank you, sir. Of course, as you say, it is so very important that we design a health care system that is patient-centered, and it needs to include this notion of patients getting the information they need to make decisions about their care. As Dr. Wennberg himself has pioneered over the years, one of the techniques to that end is using educational videos and other ways of explaining to patients the different paths that they might choose, along with their physicians and others, for their care. He has done that most particularly around prostate surgery, and in other areas as well.

The challenge in all of this is, while patients need to be much better informed than they are, in the most critical moments of decision-making, many people—myself included, and I am sure my family included—will often say, doctor, just tell me what I should do.

So it is finding the balance between deeply informing patients, which we must do, and having physicians and other leaders in the health care system exercising the professional excellence that has already been talked about, and bringing that together to benefit patients. We can do a much better job than we have done. As you said, we have all sorts of information tools available to aid our decision-making in other parts of our lives, and we ought to have them in health care as well.

Senator WYDEN. Other thoughts? Doctor?

Dr. WEISS. I think, as Dr. Roper suggested, the performance measurements, again, will get you part of the way there. They are a necessary piece of this, to say, is a doctor doing much more surgery than you would expect him to do. But this really rests at the heart of the judgment, the clinical judgment of, did I talk to the patient, did I listen to what they were saying, am I making the

best decision that they would like, and trying to understand it from the patient's perspective? Dr. Wennberg and his colleagues have done a beautiful job of creating a science around that, as well as colleagues of his in Boston.

I think that that leads to a different type of an assessment. When I speak to my colleagues at the Board of Surgery, what they say is, we want to work on, how do we assess clinical judgment and the risk-taking behavior of physicians? Those are a set of different tools that need to be applied in looking at physician accountability. Simulation. What if you have a patient who is——

Senator WYDEN. But how do you get that to the patient and the consumer? That is my question. Even in this response, you are focusing on the providers. I want to hear about how that becomes friendly to the patient.

Dr. WEISS. What we are doing now in the boards is, for the first time in their 75-year history, we are looking at the CAHPS (Consumer Assessment of Healthcare Providers and Systems), this consumer assessment of health care. Next week, our board is going to be voting to implement a CAHPS program. Part of that is public reporting of the results of the communications. In your last visit, did your doctor treat you with respect? Did the doctor seem to understand what you were saying?

You have to not only assess it, but then make some of that available to the public in a way that the public can easily absorb. We have to build this into our assessment processes. It just has to happen. But in addition to that, we have to make sure that physicians have the skills to do it and expectations of what those thresholds should look like.

The CHAIRMAN. Thank you. Very briefly, because we are out of time.

Dr. NUSSBAUM. Senator Wyden, there is a 5-fold difference in the use of surgical procedures. This involves patient-informed decision-making. Patients need to be given the options. It needs to be presented to them in a way that they can understand the different outcomes for them. This can be done on the web, this can be done with care coaches and care guidance. It involves professionals and doctors, but most of all it means giving them the options of what the science shows and how to make the best choice for their individual needs.

The CHAIRMAN. Thank you, Senator.

Senator Bunning?

Senator BUNNING. Thank you, Mr. Chairman.

Dr. Schoen, it sounds like your hospital has embraced participating in CMS's demonstration and improving quality. You mentioned the fact—or maybe you did not, but someone else did—that maybe they are not paying enough.

Dr. SCHOEN. If we are simply to look at the dollars and cents applied during the 3 years of our involvement in the project, we have probably, in human resources, applied about $160,000 to the efforts. Our reimbursements to date have been more in the $40,000 range.

Now, we believe that——

Senator BUNNING. In other words, you believe that government's participation in finding out how to better serve the sick and those

who need your services is not equal to the amount that you are participating in?

Dr. SCHOEN. At this point, on a pure dollars and cents measure, the answer would be no. I think what we need to look at is functionality long-term, and what our outcomes do in terms of making patients healthy.

Senator BUNNING. Where are we in that respect? Where are we in outcomes and functionality? In other words, are you succeeding without the money or are you just giving it a half-way effort? What is it?

Dr. SCHOEN. No. I believe we are giving it a full effort, and I believe we have made a commitment. As such, when we look at budgetary crises—we are in that budget mode at this time of year—we have to make decisions on what services or what things we cannot provide and what things we have to continue to fund. We believe that funding quality, even though the reimbursement may not particularly match to that, is still critical. In fact, it may be unethical to withdraw services that we know are providing a higher level of care. So, we look for other areas with inefficiencies where there might be opportunities to improve them.

Senator BUNNING. Is there something other than dollars that we can do, that this committee can do? What?

Dr. SCHOEN. I think, again, if we can align the focus on quality so that we are not dealing with multiple private payers and CMS setting different structures for us to have to be accountable to, we can fine-tune our resources and make them more effective and efficient. I think there are some limited outcomes measures. As I mentioned before, the studies do show that, if you improve in these areas, other areas tend to follow suit because of the change in the culture of the organization.

Senator BUNNING. Dr. Roper, you said one option to reforming the health care system was to move from a fee-for-service system to one that pays doctors or hospitals a bundled payment for managing chronic conditions.

Dr. ROPER. Yes, sir.

Senator BUNNING. In your testimony, you mentioned one medical center. Is it Geisinger?

Dr. ROPER. Geisinger. Yes, sir.

Senator BUNNING. Geisinger Medical Center, that actually already does this. Do you know if health plans have been excited about this option and how it has worked for that medical center?

Dr. ROPER. Sure, Senator. A number of efforts in the past, and in the present, center around this notion of bringing payment together in a more bundled fashion to pay for integrated care. That is a powerful idea that has the potential to really transform the way we deliver health care services. Unfortunately, we continue in many parts of our system, especially in the Medicare program, to pay in separate amounts on a fee-for-service basis.

Senator BUNNING. You know what?

Dr. ROPER. Yes, sir?

Senator BUNNING. Talk to the doctors and hospitals about that, because they are pretty adamant about their money.

Dr. ROPER. Yes, I know. I am a physician myself, and I run a hospital, or several hospitals, and I do understand the point you

are making. It is where we must go if we are going to transform things.

May I add one other point, Senator?

Senator BUNNING. Certainly.

Dr. ROPER. As you were saying in your colloquy with Dr. Schoen, what he said is, we need to align everybody together and not have disparate, separate measures of quality. I would say that even more strongly. I think that is the single thing that is holding us back in the quality effort, because we are still, in many respects, in the Chairman Mao "Let a Thousand Flowers Bloom" phase of quality. Instead, we need to come up with a single integrated national strategy for quality improvement.

Senator BUNNING. We are having a heck of a time deciding how to do that. That is why we are asking you five people here how to do that.

Dr. ROPER. And, if I could betray my bias, I chair the board of the National Quality Forum, and we believe bringing folks together around a table, both public and private, consumer and purchaser, provider, everybody else to come up with a single strategy is what we must do.

Senator BUNNING. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman.

I think what is indeed troubling is the fact that there are so many standardized practices that have been proven to be effective, yet have not been translated into actual practice, at least not uniformly. For example, you mentioned aspirin and beta-blockers when someone has chest pain. These are not cutting-edge recommendations, these are ones that have been there for the better part of 20 years.

So what is the issue here? What is the problem in translating these standardized best practices into uniformity across the country? For example, Dr. Wilensky, when she was here in July, talked about developing a Center for Comparative Alternative Treatments. I think that is important. But we also should be evaluating these standards and why they are not translating into actual practice, which I think obviously the American consumer deserves.

Dr. Roper?

Dr. ROPER. Yes, ma'am. This is a point I made earlier, Senator. Of course this is a complicated matter, but I would urge us to focus on the simple powerful idea that you put forward. That is, we need to come to agreement on what works for patients and then put in place incentives to accomplish that. We are beginning to do that.

In my institution, the University of North Carolina Health Care System, we now have millions of dollars at risk in our payments based on whether or not we achieve those outcomes, like whether we have given the right medication to patients at the right time, and whether we have prevented infections as we should in cases, et cetera, et cetera, et cetera.

So what I do as dean of the medical school and CEO of the health care system is bring people together and say, folks, failure is just not an option. We have to hit these numbers. We have to produce these results. If it means hiring some more nurses and

some more doctors and whatever else, we have to do those things. That is a much different world than it was just a few years ago when "quality" was a committee that met on Tuesday afternoon. It was viewed as somebody else's problem. Now it is everybody's problem, including our board, who are putting pressure on me as CEO to get this done.

In stressing finance and the dollars, I do not want to overlook the professional role in this that Dr. Weiss, importantly, causes us to pay attention to. But dollars make it possible for us to do these things for patients, and if those dollars are at risk we will pay attention.

Senator SNOWE. Dr. Weiss?

Dr. WEISS. And I have to say, it is not just the professional role, it has to be the professional role with some teeth. I am reminded of the fact that, through PQRI, the average physician gets a few thousand dollars or more, and that is an incentive from Congress to say, focus on these measures. Then that same physician spends a few thousand dollars or more to pay us, the boards, to say, please make sure that I am at the quality that you want. Those are running independently to some degree right now, and we are trying to find alignment. If there is endorsement from you, encouragement from you in Congress to CMS that it is time for the boards and CMS to find a good common solution and to work hand-in-glove, we are willing to do that, and it costs you nothing.

The CHAIRMAN. But do all of you agree with that basic statement that Dr. Weiss just mentioned? Do you all agree?

Dr. NUSSBAUM. I do not disagree, Senator Baucus, but I think what is so vital is that, today, doctors know the answer to what works. Senator Snowe, they know the best treatments for asthma, the best treatments for heart disease, but they are not applying them. It is not only about payment. That is a piece of it. It is about professionalism.

But most importantly, it is at the point of care, making sure those gaps, those quality defects, are addressed. Payment is a piece of it. Quality measure is essential, but it has to go beyond that. I think, unless we can create an integrated care platform at that moment with information, with monitoring, with reward, to be sure, our American community is not going to get the best care that the best science can produce today.

The CHAIRMAN. All right. I am sorry, Senator. I took some of your time. Go ahead. Go ahead.

Senator SNOWE. No. Thank you, Mr. Chairman.

Then I guess the point is, can we set standards for best practices? I mean, I think that really is the issue as well. I mean, it seems to me that we ought to be able to do that.

Dr. ROPER. We surely can, Senator. That is being done right now.

Senator SNOWE. But on a uniform basis?

Dr. ROPER. Yes, ma'am. Again, the role of the National Quality Forum is to work with all the parties and interests, to get the physicians and others who are standard-setters to come together, and then through a consensus process, get agreement across the spectrum—payers, providers, consumers, government, and so on—on a single set of measures. It is the single set that is so very important.

Senator SNOWE. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Salazar?

Senator SALAZAR. Thank you very much, Chairman Baucus.

Over the August break, I had the opportunity of sponsoring some 31 health care hearings around the State of Colorado, and I did it, frankly, because of your leadership and your desire to focus on this issue. Everywhere that I went around Colorado, I found that everybody had the same conclusion, that we have a health care system that is very broken and that there is a lot of work that has to be done, that we cannot, at this point, measure outcomes, and consumers who are out purchasing health care or health care insurance really do not know what it is they are purchasing. It is a basketful of confusion out there among the 325 million Americans, the 5 million that I represent in my State.

So I think, Chairman Baucus, you taking the leadership role in trying to move us forward in dealing with health care reform as we anticipate the time after this election when we will be able to put our arms around it, I think, is tremendously foresightful and something that I very much look forward to working with you on.

I want to ask a question of the panelists. I want to just go down the row, the same question to each of you, and have each of you respond to it within 30 seconds, since that is about how much time I have.

It has to do with how we will measure the value and the quality and effectiveness of two aspects of health care. The first is prevention, where I think there is uniform agreement that we have to do a lot more. How do we standardize, by some way of our Federal legislation here, something that would help us bring about the kind of prevention in our population that we all, I think, agree needs to happen, whether it is cardiac conditions, diabetes, those sorts of things? So, the prevention side.

Second of all, quality of care in the end of lifetime, those last 2 years of life. I think we all know the statistics: 75, 80 percent of all health care dollars spent on any of us are spent in those last 2 years of life. How do we bring the quality of health care standards into play in those last 2 years of life to try to become better in terms of how we are treating people in those end-of-life times?

Mr. Lee, let me start with you and then we will come across the doctors. Each of you have about 30 seconds. Prevention and end of life.

Mr. LEE. The first thing I would note is, as Dr. Roper noted, the National Quality Forum is sponsoring an effort called the National Priority Partnership effort, which is a collaborative effort identifying eight areas of national priority, and you have pinpointed two of them, one being promoting prevention and wellness, the other addressing end of life. We are meeting later this week to have recommendations coming out in November on those areas, as well as six others, on what to measure and the actions to be taken.

Senator SALAZAR. So how soon will that be done, Mr. Lee?

Mr. LEE. The national report will be issued in November. We will be meeting again next week. But we are hopeful that that report for the National Priority Partnership will inform your deliberations. I would use my 30 seconds to plug that effort, because again, we go into a lot of detail with a collaborative——

Senator SALAZAR. Thank you very much. I am sure the members of the committee very much look forward to seeing that report and reviewing that report.

Dr. Nussbaum?

Dr. NUSSBAUM. We agree on preventive measures. There are many national organizations that have promulgated and looked at the value of those measures. They just have to be implemented. Health plans——

Senator SALAZAR. How do you do that?

Dr. NUSSBAUM [continuing]. Have covered preventive measures and need to make sure that everyone, particularly children, get those measures.

Regarding the end-of-life issues, we need to make sure, when we have the magnificent advances in biology that can make a difference in outcomes of care for cancer and other chronic illnesses, that we apply them. But when there is no hope in science and care, we have to bring all of the compassion and knowledge to again allow families and their loved ones to make thoughtful decisions that are compassionate about end of life.

Senator SALAZAR. All right.

Dr. Schoen?

Dr. SCHOEN. Thank you, Senator Salazar. I believe that physicians are not the owners of preventive care. I think they need to be the drivers of it, but studies have shown that, if you have 20 patients in a day to be seen, all of the preventive care items being addressed during the course of the day would consume the entire 8 hours and you would not deal with why the patient came in the first place. Use of electronic medical records has enabled us to set triggers in place for health maintenance alerts so that we have staff, whether it is rooming staff, scheduling staff, tell a patient, you are due for a mammogram, or you have not had this vaccine, and schedule it.

Senator SALAZAR. All right.

Dr. SCHOEN. We need to be allowed to off-load that from our work.

Senator SALAZAR. Dr. Weiss?

Dr. WEISS. I think you have heard a great amount on the preventive measure side. We are well on our way, and I think at this point we need to go from just developing the measures to setting the standards, and that requires a very healthy public discussion.

End of life is a different issue and it is extremely complex, as you all know. But coming back to Senator Wyden's version of thinking about this, so much of it is technology-driven and so little of it is listening to the patients and patients' needs at the end of life. We do not have a good set of tools, and performance measurements are not going to give us the tools of, let us say, how well do we listen? So we need to develop those assessment tools to see if the physician and others in the health care provider community are listening, and then make that available.

Senator SALAZAR. All right. Thank you.

Mr. Chairman, may I have 30 seconds for Dr. Roper?

The CHAIRMAN. Absolutely.

Dr. ROPER. Everything that they have said, I agree with. We simply have to move beyond platitudes and saying how much we

care about prevention and end-of-life care and make it real. I think the priorities project that Peter mentioned is altogether important. At the end of the day, if CMS and private payers put their money at risk to say these things are important to us, if you the Congress say these things are important to us, it will happen.

Senator SALAZAR. All right. Thank you very much.

The CHAIRMAN. Thank you.

Senator Lincoln?

Senator LINCOLN. Thanks, Mr. Chairman.

As has been demonstrated, there are so many questions and so little time, so we will throw them out at you.

Just quickly, Dr. Schoen, thanks for bringing to this conversation the experiences with the value-based purchasing and the Premier demonstration in Minnesota. I think you had some of that in your testimony. This may have already been covered by our chairman because he shares my desire to look out for our rural areas. I was extremely impressed. I toured one of the three demonstration projects in my State of Arkansas that was in the value-based pilot project, and it seemed like there were great results that were coming from that purchasing to date.

We know, however, that for some hospitals, especially in rural areas or in under-served areas, the concept can be a little harder on them than others. What do you recommend that we take from what we have learned from small hospitals like yours and ours to ensure that the hospitals in these areas have the resources and the will to be able to be successful under those types of programs? Is there anything you have learned that you want to share with us there?

Dr. SCHOEN. Yes. The Minnesota CIO comes out to each of the hospitals and facilities in the State and does a little performance evaluation. We had the good fortune of them coming to us and saying, you have done some really good things, what tools can we take from you to share with other hospitals who are not doing as well? So there already is an avenue there for us. We do not know where the hospitals are that are not doing well, but somebody does. Being able to share that information collaboratively, I think, makes sense. We need to collaborate more than we need to compete on quality and safety.

Senator LINCOLN. Well, hopefully that information will be there for us. I know, in visiting with my hospitals and seeing what they have gained, their excitement of being able to produce greater quality, greater services, reducing their costs and other things, are very important. But there are also smaller hospitals out there that are scared to death about whether or not they are going to have the resources to make those investments if they are asked to meet those qualifications in the same amount of time. So, hopefully we can gain from that information and really use it, because it does sound like a really good program, and it has certainly been beneficial to a lot.

Dr. Nussbaum, you mentioned your work done in health disparities and how that can help improve quality. Maybe you can share some more of your work in that area with us, also, the way that insurers are talking about health IT as the answer to health care. You have mentioned an awful lot of what more we can do there.

There is a great deal of discussion, though, even with CBO, about whether there will be economic savings from e-prescribing and health IT. I would just remind everybody that we still have tremendous difficulties getting CBO to show savings from things like health IT, chronic care coordination, which I am a huge advocate for.

These are areas where we are hoping that—Peter Orszag is supposed to produce a report this year that will help us with some options on how we use those things to be able to show the savings. I do not know. There is an Ohio pilot. What are some of the economic impacts that you have had there, if any, that would really help us prove that these are good directions to go and that there is proof of these types of efforts?

Dr. NUSSBAUM. Thank you, Senator Lincoln. Thank you for your advocacy of both health IT and quality improvement in addressing health disparities. On the e-prescribing front, let me give one specific example. We have found that we can increase generic use rate by several percent. That alone, for us, pays for e-prescribing, and that is why we make it available to doctors for free. We have had an opportunity to sit with Peter Orszag and his colleagues at CBO——

Senator LINCOLN. Good.

Dr. NUSSBAUM [continuing]. And show him those specific examples. In addition, that did not even get at the patient safety and the reduced hospitalizations.

Regarding health inequalities, as a Nation, first of all, this is not acceptable for us to continue to have racial and ethnic health disparities. I mentioned the studies that we have been involved in in terms of care for women with breast cancer, but it goes vastly beyond that.

For health plans, most of us do not have access to race and ethnicity data. We do certainly at our Medicaid and Medicare programs. But I think the first way to identify and deal with health disparities is to measure, to recognize, to bring about culturally sensitive programs that can address the needs of Latino or African American or Pacific Rim nations, because the very essence of how those populations respond to health care needs is very different. But we are not going to address health care quality, I agree with you, unless we can close this disparity. There are many, many programs that can be tailored, care and disease management, that can get us there.

Senator LINCOLN. Thank you.

The CHAIRMAN. Thank you, Senator.

I think there is general agreement that we have to move much more toward quality reporting, and there are a lot of problems. We talked a little bit about the public/private aspect. I remember you, Dr. Schoen, mentioned that it is a little bit confusing at your hospital; you have CMS and Medicare, and then you have the private requirements as well.

So my question is, what does it take for you, Dr. Roper and others who are working on this, to get together here to help force the issue? In your last statement, Dr. Roper, you said, well, if Congress wants it, or you implied, that the community needs some direction

from Congress. If that is true, what kind of congressional direction makes the most sense?

I am one who believes in benchmarks, standards, data, and dates, and all that kind of thing to measure progress and see how far we are moving along. You mentioned a little bit about the platitudes. I think there are platitudes, but I know people are wrestling with this and trying to figure out what is best, not moving too quickly, but the goal here is to move quickly enough.

So what can we in the Congress do generally to help move this along and get so there is more alignment, get the standards together better, and so forth? Dr. Roper?

Dr. ROPER. If I may begin, sir. Thanks for the question. It is the right one. My comment about platitudes is not meant to say that this is easy.

The CHAIRMAN. Right.

Dr. ROPER. It is just, we need some clarity and force behind it, though.

The CHAIRMAN. Correct.

Dr. ROPER. I would say what you can do, in part, you have already done. In recent time, the Congress has passed legislation authorizing CMS to make a sizeable grant to an organization that might well look a lot like the National Qualify Forum to fund efforts to set national priorities and goals and to underpin the effort to have unified measures and so on, so we thank you for that. That grant has yet to be awarded, and we look forward to working with CMS to that end.

A second thing you can do is encourage this secretary and this CMS administrator, and whoever will occupy those jobs in 2009 and beyond, to make this a priority and push us all aggressively. My day job is running a large integrated academic health care system, and we have to be pushed, otherwise we will find other things to occupy our time.

The CHAIRMAN. So how do we best push you?

Dr. ROPER. By saying that more than a percentage point or so of our payments are to be at risk for achieving the national priorities and goals. I would dramatically increase the amount of money at risk, and that is a signal that is powerful. I know in several of my comments I come back to the money, but I think that is the thing that will do it.

On information technology, Senator Lincoln and others talked about the value of health IT. It is surely a powerful, but largely unrealized, promise. What I would urge you to do is to push CMS and HHS to say, providers just have to have an electronic health care system and to establish a date certain for getting the job done. If a doctor or hospital cannot get it together by that time, they should not be allowed to participate in the Medicare program. I realize that by even saying those words, the people behind me are squirming in their seats. But without that kind of vigorous push by the folks who are here in Washington and leading the effort, it is not going to happen on anything like the time table it should.

The CHAIRMAN. I appreciate that.

Other comments? Yes, Mr. Lee?

Mr. LEE. Yes, if I could.

The CHAIRMAN. I will give each of you a chance to respond.

Mr. LEE. I would largely pile on to Dr. Roper. But the main thing is, measurement is critical, but money drives the system. We have a system that rewards quantity, not quality, that rewards error, not high performance. The steps that have been taken have been important steps, but we need to increase the percentage that is rewarding better quality and rewarding use of information.

I think the important thing you did with e-prescribing is, it is not just a matter of having it, but using it. When we think about and look at payment systems, you need to be, I respectfully suggest, pushing Medicare to change payments. We need to step back in a big way and say fee-for-service does not reward the right thing.

So changing the percentage, but also changing and paying for episodes, paying for medical homes. Those directions are the right things to be doing, but it needs to be speeded up with rapid-cycle testing so we are not looking at 15-year demonstrations that we learn about in 2040; rather, we are putting in place systems in 3 years that are changing payment.

The CHAIRMAN. All right.

Dr. Nussbaum?

Dr. NUSSBAUM. You have heard a lot of performance measurement, Chairman Baucus. We agree on performance measurement. Two of us sit with Dr. Roper on the National Quality Forum, so I think we have made great strides in that arena. I think the area that we need to look at is different payment models for Medicare.

Let me give a very specific example. Today, after you hospitalize a Medicare beneficiary, you have almost a 20 percent likelihood of being rehospitalized within 30 days. So think of the devastating health consequences and the cost of that rehospitalization. Studies at CMS show that almost half of those Medicare beneficiaries have had no care in that 30-day interval, no claims. That is an example where a payment for coordinated care for a chronic illness can make a difference.

Second, there are two areas in which science has led to accelerating health care costs. This is good cost. It is good cost to have new biological therapies that save lives or new advanced imaging techniques, such as PET scans, but they are not used wisely. We have actual measures that all would agree on on how to use those therapies. CMS needs to drive a better use and better management of those very expensive therapies.

Lastly, we can identify gaps in care where care is not of the standard that we all want to receive. Claims information, as well as clinical data, can be used to guide the patient, the Medicare beneficiary, to guide doctors to close that gap in care. An innovative payment model girds all of those, but there needs to be foundational changes in those other three areas to make a difference.

The CHAIRMAN. All right.

Dr. ROPER. Senator, let me rudely add one thing that I neglected to add that you can do, and I would urge you, please, to do. That is to appropriate adequate funding to the Federal agency that is responsible for this, the Agency for Health Care Research and Quality. Dr. Carolyn Clancy and her colleagues are doing great work, but it is way under-funded, and I urge you to do that.

The CHAIRMAN. All right.

Anyone else on what Congress can, and should, do to speed this along?

Dr. SCHOEN. One thing I would state is that there is no way that you can go from a low level of performance to a high one without some initial costs that are not going to be long-term. So the fundamental understanding that we have to fund that start-up cost to get over the hump to better quality, I think, is a piece of what has to be in the improvement process. That might be in paying people who have the knowledge or are the experts to go and teach those who are not.

The CHAIRMAN. All right.

Dr. Weiss?

Dr. WEISS. I just want to echo Dr. Roper's comment about AHCRQ as a vehicle within the government that is under-funded and needs to be helped. But I do not know that I have the wisdom to understand exactly how much more money is needed.

The CHAIRMAN. And not only money, but what can we do? What can Congress do to move this along aggressively?

Dr. WEISS. Exactly. So I do not know that more money is going to answer the quality problem. You have three major, and a number of smaller oversight bodies in the public sector. You have the Joint Commission, NCQA, and the boards that are not necessarily fully aligned with each other or with Congress. That does not cost money to create that alignment. It creates a will. To bring those to bear in a different and new way may be a nice, new opportunity.

The CHAIRMAN. But basically do you agree with Dr. Roper that more dollars have to be at risk here, both public and private, with respect to quality?

Dr. WEISS. I have to say that, from the board's perspective, we are not about changing quality for dollars, we are about quality for quality and professional accountability.

The CHAIRMAN. But you need dollars to make it happen.

Dr. WEISS. I am reminded of what my colleague and friend, Dr. Don Berwick says. The U.S. is the only system that has the most expensive health care, that is 5 times as expensive as the most expensive health care. I hope it is Dr. Berwick, and that I got it right there. We have a very expensive health care system. I do not know how much more money it is going to take to make it better. I actually think it takes professional accountability and more oversight that will help, in a positive way, to bring us forward in addition to the other things going on.

The CHAIRMAN. The theory is, it will bring down costs in other areas.

Dr. WEISS. It will, at minimum, help slow the costs and reduce the unnecessary work going on.

The CHAIRMAN. All right.

I have to leave here. I will turn the gavel over to Senator Lincoln. Senator Wyden is next, but Senator Lincoln, you are in charge here.

Senator LINCOLN. Thank you, Mr. Chairman. Be careful what you wish for. [Laughter.]

Senator WYDEN. Thank you to all my chairmen.

Dr. Nussbaum, I have come to the conclusion that the private insurance model as it is set up today does not do enough to promote

quality and value. Now, some people say, well, that is an argument for getting rid of private insurance. I do not buy that idea either. So, 16 of us in the Senate, with the Healthy Americans Act, have been looking at a very different private insurance model so that, in effect, companies would have to take all comers and that there would be a new focus on competition based on quality, price, and benefits.

But, for purposes of my question now, I want to get a sense about whether you agree with part of what concerns me. Today, if you are a private insurance company and you want to do a terrific job, for example, say, in treating chronic disease or diabetes, and you go out and market, for example, we want all those folks to come to us, what will happen is, you will get a whole lot of sick people. Even if you are very good at treating them, your costs will go up. The healthy people will get angry and they will say, gosh, we are not sticking around here, we are going to somebody else who is better at shedding risk and not doing so much of this good-quality stuff in terms of treating people who are sick.

Do you share some of that concern in terms of the way the model is set up today?

Dr. NUSSBAUM. Senator Wyden, you are asking such an important question. Let me respond to key elements of it. First of all, I applaud your bipartisan efforts to transform much of health care. Look where you have focused that is so positive: delivery system reform, disease management, preventive care, the medical home. Those are all elements that we can all embrace.

Where we have a foundational issue, is that 155 million Americans today have their health care through the insurance model, and I think that is a strong foundation. The issue that you speak to, though, is very real. In our own company, 1 percent of our members drives 28 percent of all costs; 5 percent drives 54 percent. So, health care costs are highly concentrated, and those individuals have significant medical needs and chronic illnesses.

We have a commitment to maintaining the health of the members, 50 percent of our members, of our insured, who use very few health care resources, so we are driven, we are motivated to promote preventive services. And, for the very same reasons of making people's outcomes of care better, we invest mightily in disease management programs. I had the privilege to be president of the Disease Management Association several years ago and believe deeply in those programs to both improve health outcomes and contain cost for those with chronic illness. An insurance company like ours is motivated to do both.

The risk, of course, that you speak about is, what do you do for people in the individual market? If you are in an employer-based system, we and our insurance peers take everyone. So, if you work for General Motors, whether you have complex illnesses or not, we take care of you and manage health needs.

But in the individual market, the issue that you are addressing is that of, how do you then cover someone who already has a preexisting condition? That is one that we need to figure out—how to bring those people into coverage, whether it is high-risk pools that certain States have, or actually insurance companies being rewarded for improving the outcomes and the cost of care that——

Senator WYDEN. The point, though, with respect to my question is, you are suggesting, gosh, if you are in an employer-based system, everything is pretty much all right. What we are seeing is, for example, most people in the employer-based system do not even have a choice. Most people are not like members of Congress; Senator Lincoln and I have loads of choices. So that is one of the things we do in the Healthy Americans Act, is we make sure that everybody has a whole array of private choices. They can choose WellPoint, they can choose Kaiser, whatever.

So I am going to want to have your thoughts further with respect to the model because, under our legislation, 250 million people are going to be getting coverage in the private sector, basically everybody other than those on Medicare or in the military. So this is an opportunity for the private sector to both do good and do well.

But I think there are going to have to be some changes in this model because, as I look at that model today, if you do gangbusters work—and I commend you, because you have taken on a variety of these quality initiatives—at some point the healthy people are going to get pretty unhappy because their costs are going to go up, and that is going to have to be dealt with.

Dr. NUSSBAUM. Senator Wyden, if I may add one comment—and I would be delighted to carry on this dialogue. But what is interesting is, we have worked with employer groups—and Peter Lee can speak to this even better—and we are finding that working on workplace wellness, health improvement activities, is really making a difference. I think that is a model for the new insurance vision, the new health benefits vision of the future. It is actually to be on-site as we are, with wellness and health programs that can take advantage of the employer model that we are speaking about.

Senator WYDEN. We think all of that is very valid, and that is one of the reasons why not only do we keep the current parts of tax law that reward employers for prevention and wellness, we actually expand on them because we say, for example, that the employees who enroll kids in anti-obesity programs, they would get rewarded. It still leaves us, however, with this question of a model that at some point, based under today's system, puts a lot more emphasis on shedding risk than it does on promoting quality.

I think, Dr. Weiss, I am going to see if you would like to add something.

Dr. WEISS. I am in agreement, in principle, with you. I have to say though, again, from the perspective of, how do we make a change to make it make sense, that we have to look for where there is excess use in the system, unnecessary misadventures within health care. So we have to look both at the financing mechanism, but also at the quality. There are dollars to be saved if we start to drill down on this accountability, this professional accountability agenda.

Senator WYDEN. No question about it.

Chair Lincoln, thank you.

Senator LINCOLN. Thank you.

Well, I have just a few more questions myself, so I hope you all will be patient. But we do appreciate both your professional view in terms of how we deal with the system, but also as clinicians—at least four of you, and certainly Mr. Lee from his background—

so we appreciate it and hope that we will be able to call on you in the future. We are all very proud that Chairman Baucus and Senator Grassley have made this a real priority for us, certainly in the first 18 months of the next session, to really focus in on how it is that we put our health care services and our health care delivery systems on the right track in this country.

So just to touch on a few things. Dr. Weiss, we have talked a little bit about paying for quality initiatives. I know Senator Snowe brought up process measures like aspirin and beta-blockers and what have you. I guess, when it comes to developing quality measures based on outcome, however, in an effort to reduce hospital readmissions, reduce hospital payment rates, not paying all when a patient is to return, things get a little bit trickier. I am married to a physician who has both been in research and academia, as well as a clinician.

I also know, myself, that when the physician says to me, maybe you ought to get a little more exercise or push away from the table, or whatever, some of the things that we get told, not just those common-sense type things, but you need to take this medicine 3 times a day, you need to get into a therapy program, you need to do a lot of other things. There are a lot of physicians who are alarmed about pay-for-performance initiatives when they factor in that patient compliance. So how do we take into account that many patients, especially in the Medicare population, with multiple chronic conditions, which we have talked about at one time—we may measure process or outcome for one condition in general, but how do we take into account all of those types of things?

Dr. WEISS. Well, I think that we have to move towards outcome measurement, and I think many of my colleagues, if not all of them at the table, would agree that that is the direction we have to rapidly go to. It is not going to be an easy journey for the chronic conditions where so much of it is a balance between medications and diagnostic and therapeutic ways that are imperfect, so you are not going to get the perfect outcome for every patient, and so how do you deal with that? I think that a good starting place that is understated is on the surgical side. My surgical colleagues and the surgical boards are very focused on saying we need to assess surgical outcomes and find ways to do that as part of board evaluation.

The difficulty is, we do not have the IT structure to help support that, so this is where working with any efforts that Congress can have to advance IT so that we can extract out what happens at the end of a surgical procedure and then carry that forward 30, 60 days and see what kind of complications, that is probably the easiest—and it is not an easy place, but probably the easiest—place to start to get a whole robust set of outcome measurements that have meaning to the public.

Senator LINCOLN. So I am assuming you are suggesting that, as opposed to what MedPAC put forward, which was reducing hospital reimbursement rates for hospital readmissions and some of the other more——

Dr. WEISS. From the board's perspective, it is not about the payment side, it is about the quality/safety side. So, it is about the outcomes. It is about what happens to a patient at 30, 60, 90 days,

6 months, a year into post-surgical care. It is about a 12-month cycle of——

Senator LINCOLN. Which goes back to what Dr. Nussbaum was saying, which is, we could get greater savings for minimal expenditures in terms of covering those patients after they leave the hospital, whether it is through home health, telecommuting-type monitoring, and other things like that where we get a bigger bang for our buck and probably save dollars in the long run, particularly with minimizing readmissions.

Dr. WEISS. Absolutely.

Senator LINCOLN. Dr. Roper, when it comes to quality measures and public reporting, we all know the devil is kind of out there in those details. The medical processes, procedures, administrations are extremely complex. I guess I know, having toured so many of my hospitals and talked to other medical providers, hopefully you can give us, maybe, some examples from your experience of some of the challenges or what we have learned not to do as we develop and reform quality measures and reporting initiatives? Is there any one specific example that comes to mind? Maybe you have already mentioned it and I missed it.

Dr. ROPER. Thank you, ma'am. The one thing I would say is, it is important that the measures begin with health professionals who have deep knowledge of the condition or issue that is being measured, and then that the measure be tested and vetted by all the various parties at interest in a consensus fashion so that we have a single measure that everybody can agree on that is then used for the multiple purposes that we have been talking about.

The opposite of that, if I could just make my point in contrast, would be for some folks who do not know anything about clinical medicine to try to come up with the measures. Or another thing not to do is to have competing measures developed by well-intentioned people, but who are——

Senator LINCOLN. Right. And you have said that before. I guess what I was hoping you would say is that you cannot put that information out there in a vacuum if you have, particularly individuals and patients, who have multiple chronic issues.

Dr. ROPER. Right.

Senator LINCOLN. I mean, measuring the quality of one practice on one condition or one chronic disease without putting it in the arena of all of the other chronic diseases that are—I mean, just from my own personal experience with my father, who had the onset of Alzheimer's quite at an early age, it was a long journey we traveled.

But as he aged with different chronic diseases, until we were able to get to the Center on Aging where we had one professional who was kind of managing all of those chronic diseases, we were not getting the results or the quality out of the treatment for one specific one because we then would end up with another problem and it would exacerbate the problem we had tried to fix.

Dr. ROPER. Sure. You raise a whole bunch of very important issues, and I can just respond. It is very important that quality measures be appropriately adjusted for co-morbidities, that is, other illnesses that a person might have, and that we do severity adjustment so that we are truly comparing appropriately. Addition-

ally, your question makes the point that we need multidisciplinary care that is brought together in an integrated fashion for caring for people across a continuum of time and settings, particularly folks with chronic illnesses.

Senator LINCOLN. Well, I have three last questions I would like to just get out, and, if you want to answer them, that is great. I am the last one here.

Mr. Lee, this may be something you might be able to respond to. What are other countries' approaches? Are we looking at those? Are we using information that other countries are gaining from their types of approaches to quality measures and other things like that?

Dr. Nussbaum, you mentioned, when discussing with Senator Wyden, about information and how important information is to patients, having those choices, having that information and choices. I do not disagree with that, but I think we also have to take into consideration, after going through the new Part D with Medicare—I represent a State that ranks 48th in the country in terms of income, which means I have a disproportionate share of low-income seniors who are disproportionately in rural areas, which means they are harder to serve.

When the answer came to them, go to the Internet for information or call an 800 number, it was useless. It is the same thing with hospice, for instance. Until the hospice representative comes to your home, you do not realize, and information that is presented to you does not really give you the value and the quality that comes from that service as opposed to the person.

That is when it does go to money, unfortunately, because to have enough people who can really translate what the care and the quality of the care is when you bring those different services to bear, is really important when you are dealing with a population that does not use the Internet, that is intimidated by a 35-, 45-minute wait on an 800 number, and who may not be able to interpret the information when you give it to them over the phone or over the computer screen.

And then the last thing is, which nobody else brought up, does malpractice play a role in any of the types of over-use? I mean, we have a lot of great technology out there. Does it play any role at all? So, those are my last three questions.

Dr. SCHOEN. As a practicing physician, I am faced every day with patients who want tests that I believe are unnecessary. They want levels of care that are known to be unsuccessful. As a primary care physician, if that is my patient, I am able to have a conversation and come to an outcome that I think is appropriate. If it is not my patient, if they are interfacing with another physician or going to an urgent care or an emergency room, there is not that relationship and the trust that the information they are getting is helpful to them.

So, yes, I believe a lot of physicians do order things that they believe are not going to really change the outcome of the patients' care, but out of some relative fear of what the patient might do if they happen to be that exception. So, I do think that plays a role.

As far as the information piece, I think it is a huge responsibility to provide that information. Right now, we get paid for patients who come to our clinic, who come to our emergency room, who get

hospitalized. We need to figure out ways of paying for care that goes beyond that, that pays for patient management, case management, those types of things so we can get that information out to people.

Senator LINCOLN. Right. You mentioned that earlier.

Mr. LEE. If I could, Senator. To your question about international comparisons, I think we do have a lot to learn from other countries. We had better learn from them, given how relatively little they are spending for better outcomes. I will give you two examples. One, first in the area of measurement, which we have talked a lot about, is England, Germany, France all have institutes that are looking at comparative effectiveness.

It is an area that we are looking at in this country. We do not have one place to look to as a Nation to see which devices, drugs, treatments make more sense, are more effective, and then can use that in terms of payment design, et cetera. It is called NICE in England, but Germany and France have them as well.

But also on measurement, I think your questions about measurement really go to this issue. England is measuring patient-reported outcomes, functional status. After you have a cataract procedure, can you see better? That is an example of measuring recently that is part of PQRI, but those are the sorts of measures that patients will respond to. So I think we have a lot to learn in looking at functional status: hip surgery, can you walk better in 6 months, in a year? We heard some of the notes about those.

So there are lessons to be learned about measurement, though in many ways we are out front on some of those elements. But there are also lessons learned around payment. I think that we see that, in most of the European countries, there is a lot more focus on payment and reward for primary care.

France has instituted, in the last 2 years, in essence what I would call a medical home payment system. For everyone in France who has what they call "ailment of long duration"—we call it a "chronic illness"—they actually have a medical home where their primary care doctor has a payment to do management, as well as fee-for-service compensation above that. I think we have a lot to learn to make sure that we are having care coordination done right, rewarding primary care, and rewarding integration. We are seeing that being done in France, Germany, and England.

Senator LINCOLN. Thanks.

Dr. NUSSBAUM. Just to add to Peter Lee's comments, the United Kingdom has really transformed its National Health Service to put much more focus on quality improvement and care coordination by its primary care doctor so, in addition to the National Institute for Clinical Excellence, NICE, that looks at comparative effectiveness, we can look at those models of care.

To your second point, and your very compelling statement that seniors living in rural areas without the sophisticated clinical knowledge or tools to explore the Internet, I think this is about both human and humane engagement. For example, at our company we have 4,000 health professionals, largely nurses, many of them who serve as care advocates.

They are care advocates for seniors and others who really need guidance for their health care needs, who work with their doctors,

who can take the time, even though much of it is telephonic, to translate better outcomes of care and identify resources in the community. It is not only acceptable to have these services available telephonically, it is really, for senior populations, for Medicaid populations, about feet on the street. It is about much of rural health care focusing on community services and clinics and other resources that can complement that of the physician health professional.

Senator LINCOLN. And I do not disagree with you, because I have sat there with them, those advanced practice nurses, who were watching screens of maybe 30 or 40 individuals who had been either released from the hospital after a bout with one of their chronic diseases, and they watch their vitals and they call them: Ms. Smith, your blood pressure is up, or whatever. It is enormously engaging and very helpful and it gets at that problem of having to come in, or go back to the hospital, or whatever.

But the problem is, we are not training enough people to put out there for those types of things. That is the other kind of unfortunate part of it. We kind of all have to walk and chew gum up here. We cannot just look to you all for the solutions, but we are going to also have to be incentivizing the training of these types of people to be able to implement it.

Dr. WEISS. So I think that there is very clear message from the international environment. There was a nice paper written recently and published in *The Annals of Internal Medicine,* reminding us that the countries that are seemingly doing much better in outcomes have a clearer and stronger primary care infrastructure. It is a workforce issue, it is a payment issue, and it supersedes the quality issue by itself by a long shot.

Senator LINCOLN. But it is troubling because we use "primary care" as the terminology, whereas, I think people identify more with "medical home" because it is a home where you go, and then that home sends you to the more specialized care, as opposed to primary care, people think, well, I can only go to him if I have a cold or if I have a minor illness. I have to go somewhere else for more serious issues. Maybe it is in our terminology. That is something we need to look at, so that people better understand what the emphasis is on.

Dr. ROPER. The only thing I can add is to say thank you for your careful and nuanced questions, and those of the rest of the committee. This hearing today is important. The fact that quality is now beginning to be seen as one of the three legs of the stool, so to speak, and not just an after-thought that occasionally we give platitudes to, is very heartening. I urge you to keep pushing us.

Senator LINCOLN. Oh, we will. We promise you that. But thank you so much for being here and for sharing with us. I hope you know that we will be calling.

I always stay until the last, because 5 minutes is never enough for me. So, thank you all.

The committee is adjourned.

[Whereupon, at 11:58 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Testimony of Peter V. Lee
Executive Director, National Health Policy
Pacific Business Group on Health

September 9, 2008
Senate Finance Committee

Promoting Quality and Value in Health Reform

Good morning Senators Baucus and Grassley and members of the committee. I am Peter Lee, the Executive Director for National Health Policy of the Pacific Business Group on Health. I appreciate the opportunity to be with you this morning to talk about how the federal government and Medicare can join with leading employers, labor groups, consumers and providers to measure and reward quality and cost-efficiency to foster improvements in a very troubled health care system.

The Pacific Business Group on Health is a nonprofit association of many of the nation's largest purchasers of health care, based in California. PBGH represents both public and private purchasers who cover over 3 million Americans, seeking to improve the quality of health care while moderating costs. Research tells us that quality varies, is often unsafe, and that we are providing far too much inappropriate and unnecessary care – but we are simply unable to identify where those failures exist and either help clinicians understand when they are doing the right thing or help our employees be sure they are ONLY and ALWAYS getting the right care at the right time.

We realize that we cannot accomplish either goal without much better information about who is providing the right care – and toward that end, PBGH has invested in improving our ability to measure the performance of the health system and its various components. For almost twenty years, PBGH has been a national leader in promoting ways to measure the performance of health plans, hospitals, medical groups and doctors. Time and again we have gone beyond measurement, to foster ways those measures get used to help consumers to make better choices, used by plans to change payments and used by providers in quality improvement efforts. Besides representing many of America's largest public and private purchasers, PBGH is proud of its history of working closely with other employer groups, as well as consumer, labor and provider organizations to promote improvements in health care. One recent example of that collaboration is that through the California Cooperative Healthcare Reporting Initiative (CCHRI), which PBGH hosts, we are part of the California Chartered Value Exchange, a collaborative of collaboratives recently receiving designation by the Secretary of Health and Human Services. On the national front, another aspect of that history is reflected in our co-chairing the Consumer-Purchaser Disclosure Project.

As the debate on how best to reform our broken health care system continues, virtually all agree that the current system covers too few, costs too much, and does not deliver consistently high-quality care. Without ensuring quality, access to care may be meaningless. Without addressing costs, care will remain inaccessible for many Americans. More and more Americans will lose insurance and face financial hurdles to getting needed care if we are unable to control costs and create a system that uses resources intelligently.

By building health care value into reform measures, we can ensure that all Americans have not only the opportunity but the reality of getting the right care at the right time. These themes are ones that are shared by employers, consumer groups and labor. Our challenge is to go beyond themes to making performance measurement and payment changes that foster improvement actionable policies in both the public and private sectors.

As a nation we spend far more on health care per capita than any other country in the world -- $6,697 for every man, woman, and child in 2005. Yet, the United States ranks only 37th out of 191 countries in providing quality care, and we have the highest proportion of the population without health care coverage of all industrialized nations. For employers and for consumers – who have faced premium increases of over 125% in the last eight years alone – these costs have stark implications. For many small employers, they are being priced out of the market entirely. And, for large businesses, these costs put American businesses at a disadvantage compared to their foreign competition and add impetus to the last export we want to foster – American jobs.

Americans believe in value – most shop to get the best quality possible for their money. Yet, no one is getting good value for their health care dollar. Our health care system is broken:

- Quality of care varies dramatically between doctors and hospitals, but those differences are invisible to patients.
- Payments reward quantity over quality and fixing problems over prevention.
- Lack of standardized performance measures makes it impossible to know which providers are doing a good job, and those who are not.
- Consumers lack information to make the choices that are right for them.

The good news is that across the political spectrum and the range of interest groups there is agreement that reform must look at coverage and financing, and also at improving the quality and cost-effectiveness of care. The good news is that there are solutions that we can work with. Our challenge, however, is to go beyond the aspirational goals of promoting prevention, better care for those with chronic illness, enhanced competition and improved technologies to concrete and actionable proposals that will improve quality and control costs.

What do we need to do?

First, we must reach for Universal Coverage

While promoting better quality and value is the focus of this hearing, we must keep on our radar the need to expand coverage and the related issue of assuring that coverage does not promote cost-shifting. One of the major implications of health care cost and premium increases is that working Americans are losing their insurance, adding to the ranks of 46 million who are already uninsured. The only reason the recent Census report did not show an increase in the uninsured was the growth in enrollment in public programs. But, the growth in many public programs actually may bode ill for the employers that are staying in the game – as an increasing cost of underfunded public programs and care for the uninsured and underinsured continues to be shifted onto the ever smaller portion of the population covered by employer-based insurance. A recent study that PBGH and CalPERS sponsored in California, found that almost 40% of the hospital costs born by private payers was not for costs of delivering services to those individuals, but rather it was paid to support the relative underpayment by Medicare and Medi-Cal (our Medicaid program). These trends are only getting worse.

Moving toward a Solution: Expand coverage to all. At the state and national level, stakeholders are discussing ways to increase coverage including expanding public programs, mandating individuals obtain insurance, requiring a payroll tax from employers, providing subsidies and providing other incentives for individuals. Whatever the solution, we should seek to cover all Americans. And we need to be sure that coverage includes fair and adequate payment so we are not just moving costs from one sector to the next.

Moving beyond coverage, we must have a health care system that (1) measures performance of providers and the comparative effectiveness of drugs, devices and treatments that gives providers the tools to improve; (2) uses that information to help patients and providers make better choices; (3) changes payments to providers and incentives for consumers to reward better quality; and (4) promote reengineering of care to deliver better quality. The only way to get to such a system is for Medicare – and other large federal purchasing programs such as the Federal Employee Health Benefit Program (FEHBP) and TRICARE – to play a leadership role, in partnership with private purchasers across the country.

The starting point for reforming health care to reward better care is that we must understand what works and who's doing the job right.

The Problem: We know there is huge variation in the quality of health care, but we don't know who is or isn't delivering the right care at the right time. All too often we don't know which drugs, devices or treatments are the right ones. Without better information, providers cannot improve their performance, consumers cannot make better choices and payers cannot know who to reward.

Continuous improvement will not occur based on top-down orders from Washington to "do the right thing." Health care professionals in every community in America want to provide the best quality care and to improve their performance – but can't get far if they don't know how they're doing. And, consumers and purchasers cannot identify and reward high quality efficient care without measures of what works and who's providing the right care. As part of charting out our gaps in performance, we know that too often people of color, limited English speakers and poor people often receive lower quality health care, even when they have the same health care coverage as other populations.

Toward a Solution: We must create a transparent health care system that will foster accountability, incentives for improvement and tools for consumers and providers. As I noted earlier, for almost twenty years PBGH has been active in initiatives to measure and report on provider performance. I'm sorry to say that we have not moved the quality needle nearly as much as we would want. The reason we haven't is that we need concrete steps to assure that robust performance information is public for all providers – which means allowing for the use of Medicare data – and we need to be sure that costs are part of the equation, with valid information about the relative cost-effectiveness of providers and treatments. While some interest groups may pressure members of Congress and state legislatures to keep cost and quality information hidden, protecting the health of Americans should come before protecting the commercial interests of any particular manufacturer or provider. Some examples include:

- CMS should routinely make available the Medicare claims data base to qualified "Quality Reporting Organizations" via HIPAA-compliant agreements. This would enable employer-sponsored and individually sponsored health benefits plans to lower premiums and raise quality of care by supporting private sector efforts through the single permitted use of the data of generating health care performance measurements, based on the aggregated claims of multiple beneficiaries.
- We need a major national initiative to measure and compare the effectiveness of drugs, devices and procedures – this must include formal economic analysis that can be trusted by all stakeholders by being transparent and rigorous. If we are going to improve the quality and value of health care, the results of these assessments must be used by public and private plans in benefit design, coverage, payment and in patient decision support.
- Develop robust, independent systems for collecting and reporting performance results on patients' outcomes, cost and patients' views of care and whether the right processes of care are being delivered by doctors, medical groups, hospitals, nursing homes, and other providers.
- Assess quality of care in a standard way that allows for easy and fair comparisons. This means using national measures where they exist and developing measures that can become standards where they do not.

- Medicare and private plans collecting race and ethnicity information to enable the measurement and public reporting of health care quality information to ensure everyone benefits from improvements and allowing us to know where disparities exist so they can be addressed.

We must provide consumers with useful quality, price and treatment information

The Problem: Health care consumers cannot compare the quality or efficiency of care offered by medical practitioners, clinics and hospitals or the various treatment options available to them to make good choices.

Toward a Solution: Americans need tools to help them make good health care decisions. Some examples include:

- Tools will come in many flavors, from many sources – including federal and state governments, health plans, non-profit consumer groups and private vendors. The federal role must be first and foremost to make sure that there is valid information these groups can use to compare quality and cost-efficiency of medical treatments and providers.
- Private health plans are increasingly offering not just tools, but incentives for their enrollees to improve their health and make better choices among providers. Medicare should follow the same path to investigate how beneficiaries can be given tools and incentives to make better choices.

Align payments to providers and incentives for patients to foster better quality care

The Problem: Our health care system pays providers for the number of treatments and procedures they provide and pays more for using expensive technology or surgical interventions. It is not designed to reward better quality, to support care coordination or prevention or encourage patients to get the right care at the right time. While there are literally hundreds of efforts to reform payments occurring across the country, without Medicare's leadership these efforts will be too small and run the risk of distracting instead of focusing health care providers on delivering better care.

Toward a Solution: Design the payment system to reward providers for giving the right care at the right time and encourage patients to be actively engaged in their care. Some examples include:

- Public and private payers – health plans, Medicaid, and Medicare – should use common measures to assess provider performance.
- Reward those who provide truly needed care – not care that is of unlikely benefit to patients. In both the measurement arena and in payment, there is far too little discussion of overuse and whether care is appropriate. The fact that overuse is one of the priority areas identified by the National Priority Partnership effort being facilitated by the National

Quality Forum is good news. Beyond looking to the forthcoming recommendations from that group in November, one specific action Medicare can take is to support shared decision making processes. This support can take the form of both providing incentives to patients to get coaching and reducing payments to providers in cases where preference sensitive care (i.e., care for which there is more than one medically reasonable choice, with choices that differ in risks and benefits – such as treating chest pain from coronary artery disease or early-stage prostate cancer) was delivered in the absence of patient participation in decision-making.

- Providers who deliver high-quality, cost effective care or who improve significantly should be rewarded. Medicare's efforts on both the clinician and facility fronts should be expanded.
- We need to rebalance the payment equation to better compensate providers engaged in preventive care, time spent coaching patients and coordinating care for those with chronic conditions; and relatively decrease payments for procedures and testing. The recent MIPPA provision that related to the work-value weighting was a small step in this direction, but MedPAC's recommendation to establish a budget neutral payment adjustment is right on the mark. Why? Not only does the current payment "get what we pay for" – large amounts of procedures, many of which are of uncertain benefit – we are generating a pipeline of specialist physicians who will see every patient as the "nail" for whom their "hammer" is the appropriate instrument. We need to begin signaling now for today's and tomorrow's physicians that we will reward primary care.
- Medicare along with private payers must embark on rapid cycle demonstrations to move away for the quality-blind fee-for-service "pay for quantity" approach. Piloting the medical home is one example of such an effort. Others include paying for episodes of care rather than quantity of services. This means paying once for the total package of treatments necessary for a medical condition, rather than paying separately for each treatment. Congress, however, must balance the need for rapid cycle testing with the urgency which cries out for change. Launching demonstrations and pilots that allow for expansion are needed, but Congress should call on Medicare to move payments to reward coordination, quality and efficiency. Changing payments to promote quality cannot and should not happen overnight – but it can and must happen. Congress can foster this movement by requiring CMS to report on how Medicare spending is indeed patient-centered and rewarding better performance. Potential reporting elements include:
    - Percentage of total Medicare payments that reward better care, participation in reporting programs or improvements in delivery (such as e-prescribing);
    - Percentage of total Medicare payments that specifically foster and reward care coordination;

  - Percentage of Medicare payments for care that is either of uncertain value because of gaps in evidence or for which there is no demonstration that the patients' values and preferences were incorporated in the decision process.
- Congress and CMS deserve credit for small steps taken to rectify the undervaluation of primary care and steps to reform payments to promote better quality and cost-effectiveness. Beyond the specific actions taken, Congress should assure that patient-centeredness and value are at the core of the assessment of the relative value of Medicare's payments. Currently CMS seeks input from a range of sources, including the AMA/Specialty Society Relative Value Scale Update Committee (the "RUC") – through which evidence from and voting by the medical specialties themselves is garnered. As the AMA notes – "the RUC has created the best possible advocate for physician payment, the physician." We need to re-boot Medicare's process to have the regular review of the relative value of health care services framed NOT by those who receive the payments, but rather by those who receive the care and pay the bills. CMS should establish a formal advisory process that is structured so that a majority of its members represent public and private payers, patients and patient advocates, and the critical involvement of physicians and other clinicians is assured in a way that is balanced such that half of them should be from primary care specialties. This new, patient-centered value review process should certainly still look to specialty societies to inform their deliberations, but should actively go beyond those societies as it seeks evidence to review and revise relative value adjustments framed by what patients need and improving value.

Promote reengineering of health care to deliver higher quality

The Problem: Our current health care system uses outdated methods to deliver care and as a result all too often delivers unnecessary or poor quality care at a high-cost. Doctors, hospitals and other providers still rely on paper to record and transfer information, making care delivery slower, more error-prone and harder to measure and coordinate than it should be. Additionally, patients are not regularly given written information about their care and treatment, making it difficult for them to remember and manage their care effectively.

Toward a Solution: Encourage the rapid evolution to a health care system that is informed and information rich. We need to insist that doctors and consumers be rewarded for using both personal and scientific information when making treatment decisions. Just as Congress did with your recent move in providing incentives for e-prescribing, we need to create incentives to USE information in care. Examples include:

- Build on the recent payments for e-prescribing to assure that those systems are actually being used – call on CMS to assure that "using" e-prescribing means actually looking at your patients list of current medications before writing a new prescription.

- Medicare should consider the circumstances it can and should reimburse providers for electronic consultations with patients.
- Implement information technology, including where all of a patient's health records can be centrally stored electronically, allowing easy access to a patient's complete medical history by both providers and patients.
- Allow providers such as physician assistants, nurses, pharmacists, nutritionists and dietitians to provide more care for which they are appropriately trained, such as working in settings like retail clinics.
- Medicare payment reforms should support care coordination and pay for episodes of care so providers have incentives to redesign care settings to encourage medical providers to work in teams.
- Payment changes such as the medical home and adjusting payments to support primary care are needed to compensate medical professionals for spending time with patients helping them learn to manage their own health and care.

In conclusion, I would remind the Committee that far too many patients today are not receiving the care we know they should. Far too many doctors and other clinicians are being paid to do more not to provide care coordination or better care. Most providers are paid the same whether they deliver high quality or low quality care, irrespective of their cost-efficiency. Wasted spending that buys no incremental health likely exceeds 25% of current spending. The trends and current reality calls on you to act with the urgency felt by employers and by all Americans. We must change these dynamics – consumers must have the performance measurements and incentives to make the best choices; and providers must be given the tools to improve and be rewarded for doing a better job.

Private purchasers are looking to Medicare to be their partner – but without Medicare working in parallel and taking major steps forward the actions of the private sector are bound to lose to the concerted opposition from industry. The federal government needs to promote markets – both directly as a purchaser and by supporting the information every American needs to get better care. As I've noted, there are key leadership steps that Medicare and the federal government must take, including (1) creating comparative performance information not just for providers, but for treatments that will be used in payment and incentives; (2) rebalance Medicare payments to reward primary care and care coordination; and (3) establish a new CMS payment review process that is physician-informed, but patient-centered. These three steps, along with many others, will move us toward a health care system that is patient-centered and sustainable. Thank you for the opportunity to be with you today.

TESTIMONY

Improving Health Care Quality: An Integral Step Toward Health Reform

Samuel R. Nussbaum, M.D.
Executive Vice President, Clinical Health Policy and Chief Medical Officer
WellPoint, Inc.

Testimony presented before
the Senate Committee on Finance
September 9, 2008

WELLPOINT

EXECUTIVE SUMMARY:

WellPoint is the nation's largest health benefits company, providing medical insurance for over 35 million members, nearly one in nine Americans. Because of this, our capability and responsibility to positively impact health care is great. We embrace this responsibility and are advancing innovative solutions to improve health care quality, safety, and affordability for our members and for all Americans.

Determining What Works in Health Care and Advancing Quality Through the Sharing of Clinical Knowledge: Our medical policies determine what procedures, devices, genetic tests and specialty pharmaceuticals are clinically appropriate through rigorous clinical review and collaboration with physicians in academic medical centers and medical and specialty societies. We also conduct clinical outcomes and comparative effectiveness research to determine how various therapies, treatments, and pharmaceuticals work in the real-world. These strategies advance high-quality, cost-effective care.

Promoting Change in the Delivery of health care with Physicians and Hospitals: To change the system, we have to change how we measure and reimburse providers. Pay-for-performance programs assess physicians and hospitals on evidence-based quality indicators and reward them for better health outcomes, patient safety, and member satisfaction. Our Blue Distinction Centers of Excellence network promotes higher quality care in areas such as cardiac and transplant surgery by vetting facilities against a stringent set of clinical quality requirements.

Advancing Quality Through Integrated Care Management, Consumer Engagement, and Health Information Technology: Member focused strategies guide members to better care options, while actively engaging them if they require more complex treatments or care of chronic diseases. We use health information technology, to provide comprehensive, real-time clinical information to providers at the point of care to drive quality in the emergency room and in the physician's office.

Improving Population and Member Health: WellPoint's mission is to improve the lives of our members and the health of our communities. This commitment is measured through performance on the Member and State Health Indices, where domains in screening and prevention, care management, patient safety, and clinical outcomes assess our success at comprehensively improving quality. We are the first and only health benefits company to directly link success in improving our member's health with the compensation of every associate in the company.

Improving National Health and Pharmaceutical Safety: WellPoint's Safety Sentinel System™ advances national health safety by effectively and rapidly monitoring the safety of pharmaceuticals and other medical therapies. By identifying and verifying Serious Adverse

Events, we will enable faster, more informed decision making by regulatory agencies, health care professionals, and our members.

As our healthcare system continues to evolve, WellPoint remains committed to driving quality outcomes, safety, and affordability, as an individual health care stakeholder and together as part of the health care system. In furtherance of our Nation's aligned health care quality goals, we respectfully request the Committee embrace the following strategies:

- Support the Institute of Medicine recommendations for the establishment of a national clinical effectiveness assessment program;
- Continue to create incentives for the adoption of e-prescribing and health information technology;
- Adopt and support innovative payment methodologies that reward quality and superior clinical outcomes;
- Partner with WellPoint on national drug, vaccine, and health care safety initiatives.

I. INTRODUCTION

Mr. Chairman, Senator Grassley, and distinguished Members of the Committee, I am Dr. Samuel Nussbaum, Executive Vice President, Clinical Health Policy and Chief Medical Officer of WellPoint, Inc. It is an honor and a privilege to appear before you to discuss how WellPoint is advancing health care quality and safety in the United States. WellPoint provides medical insurance for over 35 million members across the country, representing nearly one in every nine Americans. Our subsidiary companies serve an additional 30 million individuals in the United States through programs and services including life and disability insurance benefits, pharmacy benefit management, dental, vision, and behavioral health benefit services, as well as long-term care insurance and flexible spending accounts. National Government Services, our Medicare Administrative Contractor serves over 22 million Medicare beneficiaries in 26 states.

We recognize that with the largest membership of any private insurer, our ability to positively impact health care is great. We also recognize that with that ability there is a responsibility far beyond processing claims: to advance health care quality, safety, and affordability, and to invest in innovative solutions to address the persistent health problems our country faces and anticipate and mitigate the population health challenges of the future. While national in scale, we deploy health improvement strategies locally through our Anthem Blue Cross and Blue Shield and UniCare plans and our diverse subsidiary organizations that include pharmacy benefit management care and specialty pharmacy management, disease management, behavioral health, radiology management, and health guidance companies.

WellPoint NextRx PBM

- Largest health plan owned PBM

PrecisionRx Specialty Solutions

- Distribution and management of specialty pharmaceuticals

Anthem Behavioral Health

- Integrated behavioral health management

Lumenos

- Consumer-driven health solutions

Health Management Corporation

- Disease and integrated care management

HealthCore

- Health outcomes and health services research

American Imaging Management (AIM)

- Radiology management

Resolution Health, Inc. (RHI)

- Data analytics and personal healthcare guidance

The issue of quality improvement is a complex one, and many national organizations have focused on the comprehensive analysis of quality during the past decade, including the Institute of Medicine, the National Quality Forum, physician, specialty and trade associations, delivery systems, and insurers. I would like to focus my remarks today about WellPoint's strategy to improve quality as a provider of health benefits, care management, and health improvement programs. WellPoint's five-part strategy to advance and improve health care quality focuses on:

- Determining What Works in Health Care and Advancing Quality Through the Sharing of Clinical Knowledge;
- Promoting Change in the Delivery of Health Care with Physicians and Hospitals;
- Advancing Quality Through Integrated Care Management, Consumer Engagement, and Health Information Technology;
- Improving Population and Member Health; and
- Improving National Health and Pharmaceutical Safety

Through the coordination of these strategies, and the coordination of our local plans and subsidiary companies, WellPoint is making a positive impact on health care quality and public and population health. As we will discuss throughout this testimony, however, the success of these strategies is dependent on cooperation and collaboration across our industry, among our networks of physicians and hospitals, and with our federal, state, and local health improvement partners.

II. DETERMINING WHAT WORKS IN HEALTH CARE AND ADVANCING QUALITY THROUGH THE SHARING OF CLINICAL KNOWLEGE

The Institute of Medicine provides a strong foundation for defining and analyzing health care quality in the United States. Nearly twenty years ago, the IOM defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with professional knowledge." Through its 1999 and 2001 publications "To Err is Human: Building a Safer Health System," and "Crossing the Quality Chasm: A new System for the 21st Century," the IOM highlighted the need for improved patient safety and quality, and set forth the IOM's six aims for quality health care. These six aims are widely accepted across the health care system and suggest care should be: safe, effective, patient-centered, timely, efficient, and equitable. I raise these landmark IOM reports not because I believe they are new to this committee, but rather, to reaffirm what we already know. As company, as an industry, as a health care system, and as a nation, we have been working to address these critical quality issues.

There is rapid emergence of fundamental knowledge of biology, technologies and pharmaceuticals that hold promise for breakthroughs once thought impossible in science and medicine. Yet, we also know through research by RAND and others, that existing, proven, and

established guidelines are only followed 55% of the time.[1] These variations in care cross all demographics and age groups, as recent studies of our most vulnerable populations suggest that 35% of recommended screenings and preventive care are not delivered to our elderly Medicare/Medicaid population[2], and only 68% of recommended care for acute medical problems, 53% of recommended care for chronic medical conditions, and 41% of recommended preventive care is delivered to children.[3] Variation even exists among our country's leading academic institutions, where Wennberg demonstrated a three-fold variation in hospital days and use of clinical procedures during the last six months of life.[4] Finally, we know that there is no correlation between cost and quality and that actually an inverse relationship exists, where the most expensive care for Medicare beneficiaries is also of the poorest quality.[5]

Many health policy and heath service researchers believe that as much as 35% of what is today considered "standard" medical care has not been demonstrated to improve health outcomes. While unprecedented advances in health care services have the potential to improve health, it is important that we ensure that medical practice is based on the best, most cost-effective treatments. We need to identify those new drugs, technologies, therapies, and procedures for which clinical appropriateness has not been shown, or has been shown for only a limited sub-population and appropriately manage their use or non-use.

Case Study: Bone Marrow Transplant for Treatment of Breast Cancer

- Bone marrow transplantation (BMT) for breast cancer entered medical marketplace in 1980s before meaningful effectiveness studies were done.
- Initial reports were promising and use of therapy expanded:
  - Through 1990s, over 30,000 women received BMT in the U.S., including at academic medical centers and cancer centers
  - Under pressure from patients, doctors, lawyers and lawmakers, health insurance companies provided coverage
  - Congressional mandate in 1994 for insurers for federal employees; 12 states enacted legislation mandating coverage
  - Total estimated cost of these procedures: >$5 billion over 10 years
- 1998 to1999: Five clinical trials involving 2,000 women demonstrated:
  - No difference in survival
  - Reduction in quality of life in women receiving BMT
  - Delayed research and introduction of promising therapies

[1] McGlynn, E.A, S.M. Asch, J. Adams et. al. 2003. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine* 348 (26): 2635-45

[2] Zingmond, D. S.; Wilber, K.H.; MacLean, C.H.; Wenger, N.S. 2007 Measuring the Quality of Care Provided to Community Dwelling Vulnerable Elders Dually Enrolled in Medicare and Medicaid. Medical Care. 45(10):931-938, October 2007; Yu, S.M., Bellamy, H.A, Kogan, M.D., Dunbar J.L., Schwalberg, R.H., Schuster, M.A. 2002. Factors that Influence Receipt of Recommended Pediatric health and Dental Care, Pediatrics Vol. 110 (6) December 2002, pp. e73.

[3] Mangione-Smith R, DeCristofaro AH, Setodji CM, Keesey J, Klein DJ, Adams JL, Schuster MA, McGlynn EA. The Quality of Ambulatory Care Delivered to Children in the United States The New England Journal of Medicine, Vol. 26, No. 5, Sept 2007, pp. 644-649.

[4] John E Wennberg, Elliott S Fisher, Thérèse A Stukel, Jonathan S Skinner, Sandra M Sharp, and Kristen K Bronner; Use of hospitals, physician visits, and hospice care during last six months of life among cohorts loyal to highly respected hospitals in the United States British Medical Journal 2004 328: 607

[5] Medicare claims data: and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001." JAMA 289, no. 3 (2003); 305-312.

Removing unproven treatments and technologies from clinical practice and enhanced coordination of care will allow financial "headroom" for innovation. With advances in personalized medicine and science, healthcare professionals need to determine what are the right treatments, for the right patients, in the right clinical settings. This requires informed clinical review, and independent input from medical specialty societies and academia.

Medical Policy and Technology Assessment: At WellPoint, our technology assessment and clinical reviews are at the foundation for clinical decision making and address all medical procedures, devices, genetic testing, and specialty pharmaceuticals. Our medical policy development process involves input from premier academic institutions, physician representation from thirty-three (33) medical specialty societies, and consideration of the standards of care in our communities. The Medical Policy and Technology Assessment Committee and its subcommittees in behavioral health and hematology and oncology, meet at least quarterly, and more often as necessary, to review emerging clinical research that is published or presented at national meetings. Our medical policy decisions are extensively researched, and vetted externally to ensure the most comprehensive and clinically informed policies possible.

Example: Medical Policy and Technology Assessment Process

- 215,000 new breast cancer cases each year in the United States
- 25-30% of women with breast cancer express the HER2 protein
- Trastuzumab (Herceptin®) recombinant DNA monoclonal antibody targets tumor cells that over express HER2 protein
- In 2005, two major clinical trials presented to American Society of Clinical Oncology (ASCO) expanded indications for this biological therapy
- Within two weeks, WellPoint Hematology-Oncology Medical Policy Subcommittee evaluated results and adopted a new medical policy position consistent with reported clinical studies
- Specific duration of treatment remains uncertain but current recommendation is for up to one year at cost of about $35K

In support of our belief that transparency is a pre-requisite to quality, all medical policies with citations to the supporting clinical research are publicly available to members and physicians on our Anthem Plan websites and are presented in various physician forums. Additionally, we encourage device manufacturers and clinicians who disagree with these policies to contact us with additional information, should it exist, to guide decision making.

Pharmacy and Therapeutics Committee: Our pharmacy and therapeutics process places drugs with superior clinical results on preferred coverage positions on our formularies. In addition, as will be discussed later, our goal in quality is for our members to receive drugs that will reduce risk or improve management of their medical condition. Our Pharmacy and Therapeutics (P&T) Committee consists of two subcommittees to consider first the quality, then the economic

impact of pharmaceuticals. We take this approach because while cost must be a consideration, it must be secondary to what is in the best healthcare interests of our members

Quality is assessed by the Clinical Review Committee (CRC), composed of 29 independent practicing physicians and medical experts. The CRC determines the clinical appropriateness of drugs through a critical review of the current research, guidelines, and treatment criteria. The CRC places drugs into one of four categories: favorable; comparable; insufficient evidence; or unfavorable, and develops scientific and clinical compendia for each drug class. After the CRC has established the clinical foundation, the second subcommittee of the P&T Committee, the Value Assessment Committee then considers the CRC's clinical placement, as well as financial data to determine the highest value formulary placement of drugs for our members.

Public/Private Partnerships that Drive Quality: Recognizing that advancing clinical quality and consistency goes well beyond the needs of our own membership, WellPoint actively participates in public and private quality organizations and initiatives whose goals for quality improvement in healthcare are aligned with our corporate strategies.

- ***Institute of Medicine***: We contributed to and actively support the recommendations of the recent Institute of Medicine Report, *Knowing What Works in Health Care: A Road Map for the Nation*. We critically evaluate the available research on current and emerging therapies: what research is valid and warrants consideration and conversely, what should be ignored as biased, uncontrolled, or clinically/statistically not valid. We support the IOM's organizational framework for evidence-based clinical policy development and advocate the establishment of a national clinical effectiveness assessment program to identify and evaluate clinical services with highest potential for quality and health improvement.
- ***National Quality Forum***: We support the National Quality Forum (NQF) and its strategy to develop and implement a national health care quality measurement and reporting standards. We serve on the Board and co-chair the Health Plan Council where, together with other public and private sector leaders, NQF is used as a mechanism to bring about change in health care quality and patient outcomes, workforce productivity, and health care costs by endorsing voluntary consensus standards, including performance measures, quality indicators, preferred practices, or reporting guidelines. The NQF also promotes the use of these standards by linking quality measurement to strategies for quality improvement, providing leadership and education opportunities, disseminating information, and exchanging knowledge and ideas that do not require the development of formal consensus. We also support the efforts of the National Priority Partnership to set national priorities and achieve real healthcare reform in the next five years.

Outcomes Research and Comparative Effectiveness: While scientifically validated medical policies, well-researched drug effectiveness designations, and the establishment of comprehensive clinical quality metrics provide a strong foundation for quality improvement, it is important that we continuously monitor and evaluate the effectiveness of treatments,

procedures, therapies and pharmaceuticals to identify, minimize, and/or eliminate quality gaps. WellPoint's clinical research subsidiary, HealthCore, Inc., performs clinical outcomes and comparative effectiveness research to advance high-quality, cost-effective care. HealthCore studies use clinical, laboratory, and drug information to determine how therapies, treatments, and pharmaceuticals work in the real-world, outside of the compliance-guaranteed clinical trial environment. Several examples of recently completed HealthCore research include.

- ***Breast Cancer Disparities***: Although higher mortality rates in African-American women with breast cancer are well documented, our study focused on identifying the underlying causes of these higher mortality rates, and represented one of the first studies to examine health disparities within an insured population. While insurance is an important predictor of the quality of health care one receives, this study demonstrated that even after removing that factor, racial and ethnic disparities in health care delivery still exist. The studied found insured African-American women were diagnosed at a later stage of breast cancer, and were less likely to receive state-of-the-art hormone therapy when compared to the Caucasian insured population. The results were presented at the American Society of Clinical Oncology (ASCO) annual meeting and are being translated into culturally sensitive strategies to reduce health disparities in breast cancer treatment.
- ***Blood Growth Factors***: We studied erythrocyte stimulating factors (red cell blood growth factors) to identify existing treatment patterns and optimize the management of patients receiving this important class of drugs while preventing cardiovascular deaths as a result of over-treatment. Our study showed that 25% of darbepoietin and erythropoietin alpha use did not fully meet oncology clinical guidelines. As a result, a prior-authorization program which was implemented to guarantee that these drugs were being used in accordance with clinical appropriateness guidelines. The program resulted in safer treatment of our members and significant cost savings through the avoidance of unnecessary care.
- ***Statins***: Statins are a class of drugs that lowers the level of cholesterol in the blood by reducing the production of cholesterol by the liver. Using our real-world drug and laboratory data, we analyzed the probability of whether therapeutic substitution of generic simvastatin for a brand drug (e.g. Lipitor or Crestor) would lead to an optimal LDL-C goal. The results showed that 63% of our members could be effectively treated with generic simvastatin versus a brand drug. Because a switch to generic simvastatin would also yield significant savings for our members, as a result of lower co-pays we developed member and physician education and online tools to encourage this clinically appropriate and less costly care.

With more than 125 clinical studies underway, 30 completed studies published in professional journals, and more than 150 completed studies presented at national medical meetings and seminars, WellPoint and our HealthCore subsidiary are advancing quality through real-world outcomes research.

III. PROMOTING CHANGE IN THE DELIVERY OF HEALTH CARE WITH PHYSICIANS AND HOSPITALS

Determining what works in health care is only an initial step in achieving quality in health care. Clinical policies, outcomes data, comparative effectiveness research results, and quality metrics will have no impact on health unless we transform clinical evidence into clinical action. By broadening the dialog with and among our physicians and hospitals, a foundation of trust is built, enabling collaboration on efforts to improve outcomes. It is through these relationships that we develop our most promising opportunities to improve care.

Pay-for-Performance Programs: In 2007, WellPoint's Pay-for-Performance programs rewarded physicians and hospitals with more than $157 million in incentives (approximately $100M for physician programs, and $60M for hospital programs) for increased quality.

- ***Quality Physician Performance Program (Q-P3^{SM})***: Q-P3^{SM} is WellPoint's incentive-based performance programs for physicians. The program incorporates effectiveness measures using nationally recognized or endorsed quality measured from groups such as: National Quality Forum (NQF); National Committee for Quality Assurance (NCQA); Joint Commission for the Accreditation of Healthcare Organizations (JCAHO); Ambulatory Quality Alliance (AQA); American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI). Where there are no nationally recognized quality metrics, we work directly with the medical societies to develop performance and monetary metrics.

  In the clinical category of heart disease, we partnered with the American College of Cardiology (ACC) and the Society of Thoracic Surgeons to define evidence-based clinical indicators for cardiac care and created the Q-P3^{SM} scorecard.

JC AMI Section
• Aspirin at arrival
• Aspirin prescribed at discharge
• ACEI/ARB for LVSD
• Beta blocker at arrival
• Beta blocker at discharge
• Smoking cessation advice
JC HF Section
• LVF assessment
• ACEI/ARB for LVSD
• Discharge instructions
• Smoking cessation advice

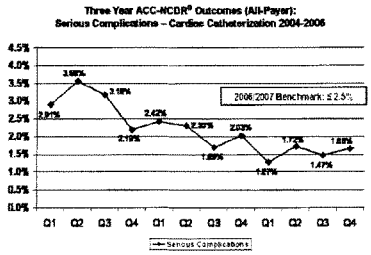
ACC-NCDR Section
• Rate of serious complications – diagnostic caths
• Door to balloon time for primary PCI <=90 min
• Door to balloon time for primary PCI <=120 min
• % of patients receiving Thienopyridine
• % of patients receiving statin or substitute at discharge
• Rate of serious complications – PCI
• Risk-adjusted mortality rate - PCI
Bonus Section
• Generic Dispensing - Statins

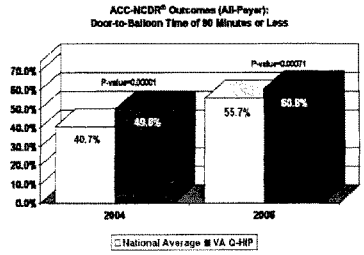
- ***Quality-In-Sights Hospital Incentive Program (Q-HIP^{SM})***: Q-HIP^{SM} is a hospital quality program involving voluntary reporting nationally vetted and recognized evidence-based quality indicators in three categories: patient safety; patient health outcomes;

and member satisfaction. In addition to these measures, our hospital program also incorporates quality metrics and P4P incentives for important patient safety initiatives and is summarized below:

Patient Safety Section (25% of total Q-HIPSM Score)	Patient Health Outcomes Section (60% of total Q-HIPSM Score)
• JCAHO Hospital National Patient Safety Goals	**ACC-NCDR Section** • 7 ACC-NCDR Indicators for Cardiac Catheterization and PCI
• NQF Recommended Safe Practices	**JCAHO National Hospital Quality Measures** • Acute Myocardial Infarction (AMI) Indicators • Heart Failure (HF) Indicators • Pneumonia (PN) Indicators • Surgical Care Improvement Project (SCIP) • Pregnancy Related
• Rapid Response Teams	
• Patient Safety and Quality Improvement Measures	
Member Satisfaction Section (15% of Total Q-HIPSM Score)	**CABG Indicators** • 6 STS Coronary Artery Bypass Graft (CABG) Measures
• Patient Satisfaction Survey	
• Hospital-Based Physician Contracting	

Our review process is transparent. We audit and externally validate the submitted hospital all-payer data ensuring the reporting hospital is promoting high quality and safe health care *for all patients*. Our QHIP program demonstrated a 5% improvement versus the national average in door-to-balloon time for heart attacks and a decrease below the national benchmark in serious complications for cardiac catheterizations.

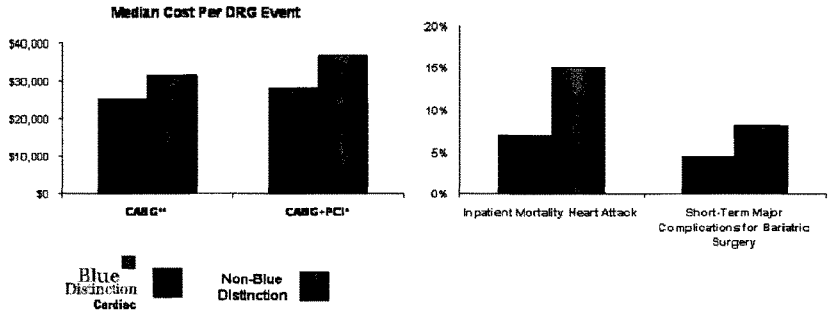




- ***Pay for Performance Lessons Learned***: While we have found pay for performance to be a valuable tool in promoting and enhancing quality care for our members, P4P is not without its challenges. A study examining the effectiveness of P4P programs on physician quality demonstrated that 76% of practices considered "top performers" before the program remained top performers after the program. Conversely, 73% of the lowest performing practices before the program remained low performers even with P4P incentives. As a result, we know programs must be structured to reward not only excellent or exceptional quality, but also quality improvement.

Blue Distinction Program: Our Blue Distinction Centers of Excellence network promotes higher quality care by vetting facilities against a stringent set of clinical quality requirements.

Facilities designed as Blue Distinction must meet rigorous quality and outcomes criteria and demonstrate measurable excellence in prevention of complications, improved outcomes, and low repeated hospitalizations for complications of care. A recent study of Blue Distinction Cardiac center effectiveness demonstrated an 8% lower inpatient mortality rate for heart attacks when compared to non-designated facilities and a financial savings of $6,000 to $8,000 savings for coronary artery bypass graft surgery (CABG). For Blue Distinction Centers for bariatric surgery, we found the short-term major complications for bariatric surgery to be 3% lower when compared to non-designated facilities. Similar high-quality, outcomes-based Centers of Excellence exist for transplant surgery and complex/rare cancers, and we are currently developing programs for orthopedics/lower back pain and infertility.



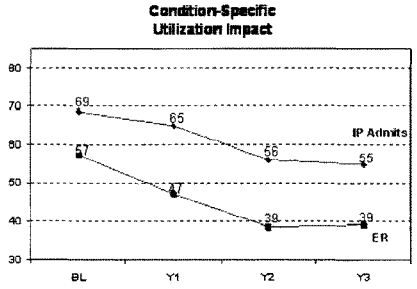
IV. ADVANCING QUALITY THROUGH INTEGRATED CARE MANAGEMENT, CONSUMER ENGAGEMENT STRATEGIES, AND HEALTH INFORMATION TECHNOLOGY

At the core of member health improvement and quality is the member. WellPoint believes in our members, and believes in their ability to take control of their healthcare and play a significant role in their health care decision-making. As a provider of health benefits, we believe it is our responsibility to provide the information, resources, and tools to educate and inform our members on appropriate treatments, and the existence and comparative risks and benefits of viable treatment options. Our member focused strategies are both proactive and reactive, passively guiding members to better care, while actively engaging members in the management of complex treatments and chronic disease. We know that within our member population there is no "one-size-fits-all." Different members have different preferences and personal prioritizations for cost, quality, and outcomes priorities. Additionally, we have a diverse membership presenting unique racial, ethnic, and geographic health care needs. We have developed strategies and programs to identify and meet these diverse needs. Through integrated care management, consumer engagement, and the deployment and use of health information technology, we are providing comprehensive, real-time clinical information at the point of care to drive quality in the emergency room and in the physician's office, where health care happens.

Integrated Care Management: Health care costs are highly concentrated with 1% of our membership accounting for approximately 25% of costs and 5% accounting for 55% of total health care costs. Claims data, pharmacy data, laboratory data and other clinical information drive our predictive models to tailor health improvement approaches for our members. We keep healthy members healthy by reducing risk factors for illness, emphasizing prevention, and providing resources for members to stay healthy. For those with illnesses and chronic conditions that lead to 55% of total costs, we have deployed an extensive suite of programs that improve quality outcomes and reduce health care expenditures. WellPoint's prevention and care management programs advocate and promote an increase in immunizations and cancer screening procedures, and an increase in health care services to mitigate the devastating effects of suboptimal care for chronic illness. Our prevention programs are an investment in the future health of our members.

WellPoint's Health Management Corporation, (HMC) is one of the nation's largest and most experienced population management companies. The more than 4,000 health professionals in our organization improve the health of our members with a comprehensive suite of health and wellness, disease management, and lifestyle management solutions called ***360° Health***. 360° Health provides information and guidance on managing chronic conditions, as well as healthy lifestyles to increase members' awareness and motivation around their conditions. This improves compliance with established care guidelines, enhances workforce productivity, and reduces hospitals stays for our members. 360° Health employs a multi-specialty approach that includes physicians, nurses, registered dieticians, clinical social workers, pharmacists, exercise physiologists, and respiratory therapists to coordinate healthcare interventions. 360º Health emphasizes risk reduction for complications of illness through evidence- based practice guidelines and patient empowerment strategies.

Examples of successful 360° Health programs include strategies to manage individuals with asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease, heart failure, and renal (Kidney Disease). A recent analysis of these programs demonstrated a 20% decrease in inpatient admissions and a 32% decrease in emergency room visits while a study of WellPoint's Federal Employees Health Benefits Program demonstrated a reduction of 58 inpatient days for every 1,000 members.



Management of Emerging Technologies and Procedures: Specialty pharmaceuticals and outpatient diagnostic imaging have rapidly risen to be the fastest growing segments of medical expenditures in the United States. Driven by advanced technology imaging services such as MRI, Nuclear Medicine, and PET scanning, outpatient diagnostic imaging costs have increased by an average annual rate of approximately 15% in the commercial market. Between 2000 and 2006, the amount of imaging services per Medicare beneficiary increased by 62%, double the

rate of increase for Medicare physician services overall[6]. Similarly, specialty pharmaceuticals now represent >20% of all drug costs, reaching $73 billion in total expenditures and monthly per patient costs averaging $1,000 to $1,500 for both commercial health benefits companies and CMS. While advances in diagnostic imaging and specialty pharmaceuticals represent impressive advances in medical science and technology, their true impact on health care quality is dependent on ensuring a clinically appropriate test or drug is delivered only to those patients for whom the these expensive new technologies have been proven to be of benefit.

- ***PrecisionRx Specialty Solutions***: PrecisionRx is WellPoint's specialty pharmaceutical management company. PrecisionRx's goal is to assure that members prescribed these new biological agents achieve the best possible outcomes from their treatments. PrecisionRx Specialty Solutions strives for 100% guideline adherence. Our new state-of-the-art medication distribution center in Indianapolis ensures optimal dosages and medication safety. Care Coordinators work directly with members to schedule timely delivery of medications; educate and monitor drug regimens for diseases such as hepatitis B, hemophilia, rheumatoid arthritis and cancer; and encourage therapy adherence. Clinical pharmacists evaluate diagnoses to determine the appropriate therapy, review prescriptions for accuracy and safety, and provide individualized counseling, while registered nurses track the progress of treatment and develop goals for managing potential side effects

- **Appropriate Imaging Technology and Radiation Safety:** American Imaging Management, Inc. (AIM), is WellPoint's radiology management subsidiary that advances imaging service quality by developing and deploying programs to improve appropriateness of outpatient advanced imaging through the application of evidence-based clinical guidelines. Prior to acquiring AIM, we conducted a study of the longer-term impact of radiology management in our Colorado plan that demonstrated a reduction in CT and MRI utilization growth trend from 23% to only 1% over a three-year period.

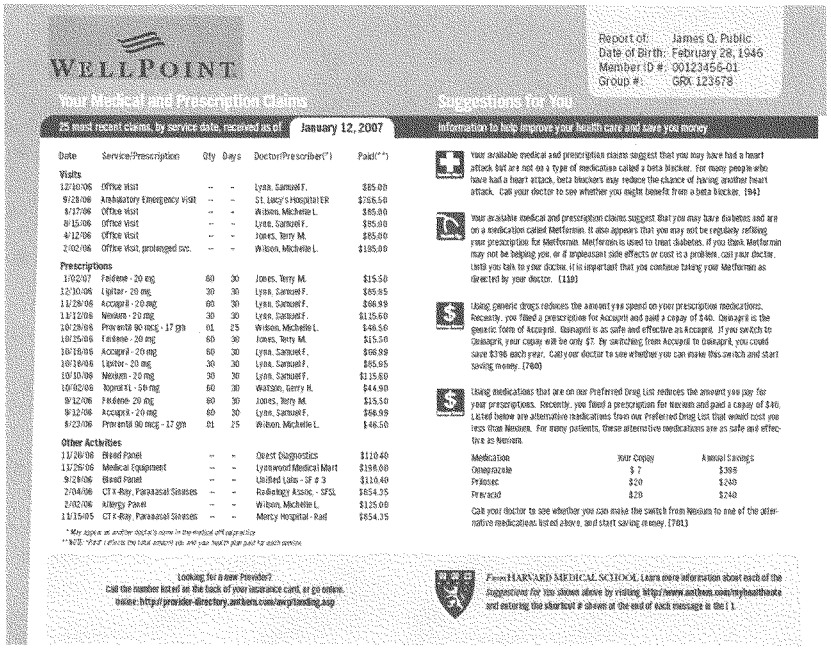
  In addition to the increasing costs of diagnostic imaging, there is growing concern for patient safety due to radiation exposure from excessive diagnostic imaging. AIM has recently launched a Patient Safety Program to increase awareness of radiation dose associated with advanced imaging procedures. One of the program's tools is an interactive radiation awareness website (www.americanimaging.net/safety) that allows users to obtain information on the use of a specific imaging procedure and the amount of radiation associated with that procedure.

Consumer Engagement and Informed Decision-Making: At WellPoint, we are committed to helping our members take control of their health and play an active role in health care decision making. We believe that by providing information on quality, cost and outcomes, and by

[6] GAO, MEDICARE PART B IMAGING SERVICES: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices June 2008

educating members on treatment options and the importance of following care guidelines, we can increase quality, improve health and decrease costs.

- ***Providing Actionable Information to Consumers through Resolution Health Inc.***: One of our most promising approaches for driving improved quality is the clinical messaging technology of Resolution Health, Inc. (RHI), a WellPoint subsidiary. RHI integrates and analyzes medical and laboratory claims data through an evidence-based rules engine. The output of this analysis generates clear, actionable clinical alerts, or messages regarding health improvement, patient safety, and member cost-saving opportunities. These clinical messages for optimal care are developed by faculty at Harvard Medical School. There are patient and physician messages currently deployed that identify gaps in care that a patient is receiving, such as a medication or laboratory test is required for a specific clinical condition or a member is not being adherent to a therapy prescribed, or preventive clinical guidelines such as cancer screening, are not being followed.



WELLPOINT

Report of: James Q. Public
Date of Birth: February 28, 1946
Member ID #: 00123456-01
Group #: GRX 123678

Your Medical and Prescription Claims

25 most recent claims, by service date, received as of: January 12, 2007

Date	Service/Prescription	Qty	Days	Doctor/Prescriber(*)	Paid(**)
Visits					
12/10/06	Office Visit	--	--	Lynn, Samuel F.	$85.00
9/28/06	Ambulatory Emergency Visit	--	--	St. Lucy's Hospital ER	$766.50
8/17/06	Office Visit	--	--	Wilson, Michelle L.	$85.00
8/15/06	Office Visit	--	--	Lynn, Samuel F.	$85.00
4/12/06	Office Visit	--	--	Jones, Terry M.	$85.00
2/02/06	Office visit, prolonged svc.	--	--	Wilson, Michelle L.	$195.00
Prescriptions					
1/02/07	Feldene - 20 mg	60	30	Jones, Terry M.	$15.50
12/10/06	Lipitor - 20 mg	30	30	Lynn, Samuel F.	$85.95
11/28/06	Accupril - 20 mg	60	30	Lynn, Samuel F.	$66.99
11/12/06	Nexium - 20 mg	30	30	Lynn, Samuel F.	$115.60
10/28/06	Proventil 90 mcg - 17 gm	01	25	Wilson, Michelle L.	$46.50
10/25/06	Feldene - 20 mg	60	30	Jones, Terry M.	$15.50
10/19/06	Accupril - 20 mg	60	30	Lynn, Samuel F.	$66.99
10/18/06	Lipitor - 20 mg	30	30	Lynn, Samuel F.	$85.95
10/10/06	Nexium - 20 mg	30	30	Lynn, Samuel F.	$115.60
10/02/06	Toprol XL - 50 mg	60	30	Watson, Gerry H.	$44.90
9/12/06	Feldene 20 mg	60	30	Jones, Terry M.	$15.50
9/12/06	Accupril - 20 mg	60	30	Lynn, Samuel F.	$66.99
8/23/06	Proventil 90 mcg - 17 gm	01	25	Wilson, Michelle L.	$46.50
Other Activities					
11/26/06	Blood Panel	--	--	Quest Diagnostics	$110.40
11/26/06	Medical Equipment	--	--	Lynnwood Medical Mart	$198.60
9/28/06	Blood Panel	--	--	Unified Labs - SF # 3	$110.40
2/04/06	CT X-Ray, Paranasal Sinuses	--	--	Radiology Assoc. - SFSL	$854.35
2/02/06	Allergy Panel	--	--	Wilson, Michelle L.	$125.00
11/15/05	CT X-Ray, Paranasal Sinuses	--	--	Mercy Hospital - Rad	$854.35

* May appear as another doctor's name in the medical office practice.
** NOTE: *Paid* reflects the total amount you and your health plan paid for each service.

Suggestions for You

Information to help improve your health care and save you money

Your available medical and prescription claims suggest that you may have had a heart attack but are not on a type of medication called a beta blocker. For many people who have had a heart attack, beta blockers may reduce the chance of having another heart attack. Call your doctor to see whether you might benefit from a beta blocker. [941]

Your available medical and prescription claims suggest that you may have diabetes and are on a medication called Metformin. It also appears that you may not be regularly refilling your prescription for Metformin. Metformin is used to treat diabetes. If you think Metformin may not be helping you, or if unpleasant side effects or cost is a problem, call your doctor. Until you talk to your doctor, it is important that you continue taking your Metformin as directed by your doctor. [110]

Using generic drugs reduces the amount you spend on your prescription medications. Recently, you filled a prescription for Accupril and paid a copay of $46. Quinapril is the generic form of Accupril. Quinapril is as safe and effective as Accupril. If you switch to Quinapril, your copay will be only $7. By switching from Accupril to Quinapril, you could save $396 each year. Call your doctor to see whether you can make this switch and start saving money. [760]

Using medications that are on our Preferred Drug List reduces the amount you pay for your prescriptions. Recently, you filled a prescription for Nexium and paid a copay of $46. Listed below are alternative medications from our Preferred Drug List that would cost you less than Nexium. For many patients, these alternative medications are as safe and effective as Nexium.

Medication	Your Copay	Annual Savings
Omeprazole	$ 7	$396
Prilosec	$20	$288
Prevacid	$28	$240

Call your doctor to see whether you can make the switch from Nexium to one of the alternative medications listed above, and start saving money. [781]

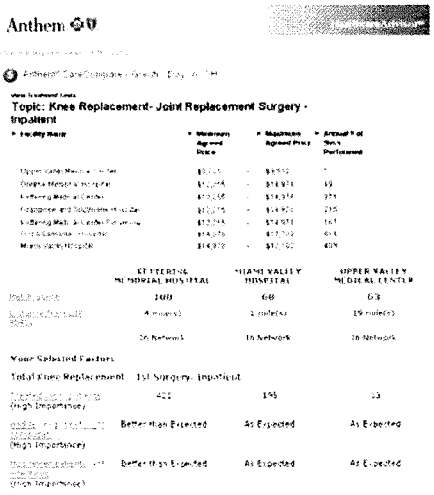
Looking for a new Provider?
Call the number listed on the back of your insurance card, or go online.
Online: http://provider-directory.anthem.com/awp/landing.asp

From HARVARD MEDICAL SCHOOL: Learn more information about each of the *Suggestions for You* shown above by visiting http://www.anthem.com/mybesthealth and entering the shortcut # shown at the end of each message in the [ ].

RHI messaging can be deployed through mail or online to members, physicians, and our clinical case management associates to guide informed decision-making and higher-quality, more cost effective, and safe health care. A controlled study comparing program effectiveness for approximately 1,000 members who received this actionable clinical information compared with 1,000 members who received customary care demonstrated positive results, with an over 10% difference in compliance with established care guidelines and increased savings to the members of the RHI intervention group. Additionally, 100% of those members who received this information rated the messages as "easy to understand" and 100% wanted to continue receiving the information.

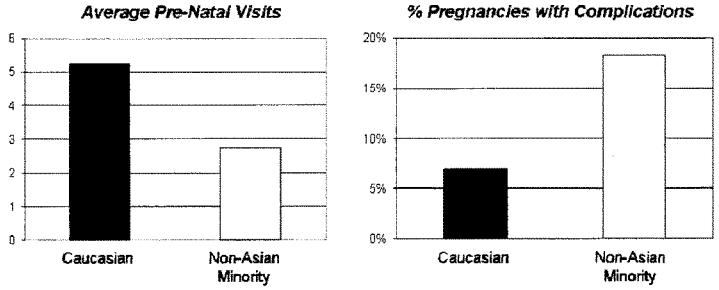
- ***MyHealth Record***: Additional member clinical quality and safety support is available through WellPoint's MyHealth Record, an on-line personal health record for our members which converts medical claims into a longitudinal personal health record, and also includes drug and laboratory information that can be shared with physicians. Members can access their up-to-date health information, and receive clinical alerts for drug safety and errors/options in care. Members can also learn more about planned or contemplated surgery through the on-line surgical procedure guide that includes animated video depictions of surgery. These tools can be enhanced by the member's choice for the direct guidance of a WellPoint Surgical Advice Nurse.

- ***Anthem Care Comparison*** provides transparent quality and cost information for thirty-nine common medical procedures and services including hip and knee replacements, gall bladder removal, and pediatric / primary care physician office visits. The tool displays total costs for an episode of care using actual hospital, physician, and ancillary service costs and includes information on various quality factors such as number of services performed, the numbers of patients with complications/infection, and availability of an on-site ICU. Bundling the costs by episode of care helps members understand the overall cost of treatment, not just specific à la carte physician and hospital services. By allowing members to assign their own level of importance to each available quality factor, Anthem Care Comparison generates a personalized, prioritized list of hospitals



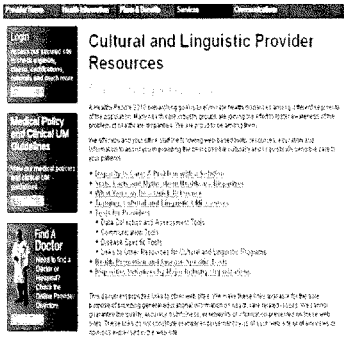
matching the member's own quality preferences. This program started as a result of a partnership with General Motors in Dayton, Ohio, and has been expanded to cities in California, Colorado, Georgia, Indiana, Kentucky, Maine, New Hampshire, Nevada, and Wisconsin. We plan to deploy the program to an additional 20 markets by mid-2009.

Reducing Health Disparities: WellPoint recognizes that disparities exist in health care today. We were especially concerned when we conducted a study of our own associates showing that even among employed, insured, health system-literate, and English-speaking Americans, there are wide disparities in the quality of care delivered and the health outcomes achieved. For example, in the areas of prenatal care, we found that Non-Asian minority WellPoint associates receive significantly less (approximately half) prenatal care when compared to Caucasians and as a result are at higher risk (3-fold) for pregnancy complications. These two factors, in part, led to a $4,900 difference in average cost between non-Asian Minority pregnancy and Caucasian pregnancies.



Due to these findings, we developed and deployed actionable strategies to reduce these disparities including removing financial barriers by eliminating member co-pays for prenatal visits, emphasizing timely prenatal care and promoting the "Future Moms" well baby program, developing referral channels from Human Resources' Leave of Absence unit to the Future Moms Program, and reducing workplace barriers that inhibit associates from taking time off for pre-natal visits.

Beyond our associate population, we are advancing a multi-faceted approach to reducing health disparities and increasing health care quality in our racial and ethnic minority populations. Our member strategies include the development of culturally appropriate interactive media and print materials that guide members to better choices in diet and nutrition, encourage exercise and fitness, and encourage participation in wellness programs to prevent complications before they occur. We provide cultural and linguistic tools to physicians via our provider portal



and offer culturally sensitive disease specific tools for asthma, diabetes, breast / cervical cancer, immunizations, arthritis, obesity, and heart health. Finally, all WellPoint clinical associates complete annual cultural competency training.

As a result of these efforts, WellPoint was awarded the 2008 Corporate Leadership Award presented by the Congressional Black Caucus (CBC) Health Braintrust for our commitment to health equity and strategies to reduce health disparities.

Health Information Technology: Delivering up-to-date clinical information at the point of care can directly promote quality health care. Physicians and patients, if provided accurate and integrated medical information, are capable of making more informed decisions regarding the appropriate course of treatment. While the long-term benefits of wide-spread adoption of health I.T. remain under study, preliminary results from our e-prescribing and integrated health record pilot programs support health I.T. as an enabler of health care quality.

E-prescribing provides efficient, safe and effective drug prescribing. In addition it represents the first step along a path to delivering health care decision support to physicians at the point-of-care. E-prescribing continues to expand at WellPoint with more than 8000 physicians currently e-prescribing and more than 1.1 million e-scripts generated to date. These results still represent only a small percentage of physicians in our networks and numbers of prescriptions. WellPoint acknowledges the challenges faced by physicians considering e-prescribing technology adoption and we have developed a proactive e-prescribing expansion strategy that addresses the major concerns expressed by non-e-prescribing physicians, including implementation and adoption costs and multi-system interoperability to connect the care team.

Our e-prescribing programs reduce or eliminate adoption costs through vendor/industry partnerships that provide free/discounted technology. In addition, WellPoint pays e-prescribing transaction fees. Interoperability, a standard in our programs, ensures compatibility with multiple payers' systems and multiple-PBMs for eligibility, formulary, and drug history. Our programs also promote incremental adoption of health IT, by enabling the deployment of e-prescribing capabilities without full adoption of more complex and expensive electronic medical records. Finally, we have integrated e-prescribing with our pay-for-performance initiatives to provide incentives for health IT adoption. Specific results of our e-prescribing pilot programs are descried below.

- Our Ohio E-prescribing program deployed free Sprint "Smartphones" and office software and extended WellPoint telecom discounts to physicians. Physicians with E-Rx demonstrated 1.5% increase in generic dispensing versus physicians who prescribe by paper in the same geographic area.
- Our "first-of-its-kind" New Hampshire pilot, in collaboration with AllScripts and the National E-prescribing Safety Initiative (NEPSI), integrates our Member Medical History electronic health record and e-prescribing technology and allows physicians to: view patient diagnoses independent of diagnosing physician; view procedural history independent of treating physician; obtain contact information for other treating

physicians; and to perform eligibility checks, receive member formulary guidance, obtain patient drug history functions for most PBMs. Most importantly, this program allows physicians to electronically prescribe for any patient regardless of payer.

These programs support the adoption of e-prescribing by physicians and complement the recently passed Medicare Improvement for Patients and Providers Act of 2008.

Integrated Health Records: Although e-prescribing provides measurable benefits in drug quality, safety, and cost savings, it is most beneficial as a gateway to more widespread adoption of health information technology and deployment of integrated health records. Patients see multiple physicians who prescribe multiple prescription medications that patients fill at multiple pharmacies. Laboratory and diagnostic testing are often performed by different institutions, with results often sent only to the ordering physician. With this disconnect among health care providers, the risk of unnecessary, duplicative, or harmful care is great. By combining physician, hospital, ER, laboratory, imaging, and pharmacy data into a single integrated health record and connecting physicians, patients, and clinical data, a consistently informed virtual care team is created. This enabling of shared, informed decision making at the point-of-care provides the single most promising health information technology innovation to advance healthcare quality.

Launched in June 2007, our Dayton integrated health record (IHR) pilot in collaboration with Kettering Health Network and General Motors combined 150 clinical and administrative data sets into a single integrated health record and deployed these IHRs to 10,000 members and more than 1,000 participating physicians. Initial results of this first year pilot are impressive, and include the following for Kettering Health System's 10,000 employees and their families:

- 10.3% reduction in the total cost per employee for inpatient services;
- 7.4% reduction in inpatient, outpatient, physician, and pharmacy trend; and
- $2 million projected total member cost savings from 2006-2007

Based on the success of this first year proof of concept, we are expanding the project to a regional pilot in 2009. With the continued commitments from General Motors and Kettering Health Network, we will expand the program to more than 100,000 members, including our Ohio-based WellPoint associates. In addition to physician and member expansion, we have also committed to making significant enhancements to the IHR to encourage increased use and further integrate other quality improvement capabilities. These planned 2009 enhanced capabilities include:

- State of the art e-prescribing;
- Integrated disease management with a WellPoint health coach who has access and input to the physician's Electronic Health Record (EHR);
- Health Information Exchange secure messaging to allow remote, on-line patient visits;

- Automated health improvement and disease management programs for tobacco cessation, diabetes, heart disease, and asthma;
- Real-time RHI quality/benefit messaging to the doctor (via an EHR) and patient via a Personal Health Record (PHR);
- Generating quality measures for all WellPoint quality programs such as Blue Precision and for the Physician Quality Reporting Initiative (PQRI)
- Automated Pay for Performance (P4P) rules application in real time with member status on P4P measures reported directly to the physician and member; and
- HIPPA compliant privacy and security

V. IMPROVING POPULATION AND MEMBER HEALTH

The programs just discussed represent promising progress on our path to health care quality, safety, and affordability. But how do we know we are having an impact? Are we actually improving quality and improving health for our 35 million members across the country? In 2007, we set out to answer that question through the development of a WellPoint Member Health Index and in 2008, we are very proud to say that answer is "yes."

Member Health Index: The Member Health Index (MHI) represents our company's commitment to our mission: "Improve the lives of our members and the health of the people we serve." The MHI is comprised of 40 specific measures of health improvement and patient safety in 20 different clinical areas encompassing 4 domains of care: prevention; care management; clinical outcomes; and patient safety. Our care and disease management programs, our hospital quality and safety programs, and our member engagement strategies all converge in the MHI.

The four domains of the MHI were specifically designed to encourage our leadership and associates to focus on improvement in areas that most directly affect member health.

- ***Screening and Prevention***: Preventive screening, early diagnosis, and proactive treatment plans are proven to reduce cost and avoidable care while improving outcomes and mortality.
- ***Care Management***: Chronic diseases account for one-third of the years of potential life lost before age 65, and 75% of the nation's health care costs[7]; our focus on disease and care management and treatment guidelines compliance is critical to MHI success.
- ***Patient Safety***: The landmark Institute of Medicine Report "To Err is Human" estimated that at least 44,000 Americans die every year in hospitals as a result of medical errors. For Medicare alone, $8.6 billion dollars can be attributed to patient safety events.[8] The MHI measures hospital standards compliance, safety outcome improvement, and persistent medication monitoring.

[7] CDC National Center for Chronic Disease Prevention and Health Promotion statistics
[8] The Fourth Annual HealthGrades Patient Safety in American Hospitals Study (2007)

- ***Clinical Outcomes***: These results represent the immediate results of better management of expensive, common, chronic illnesses by reducing ER visits and inpatient stays.

Identifying the metrics by which we can measure members' health was only the first phase of our MHI strategy. We then developed quality improvement initiatives that were most likely to lead to improvement in the MHI results. Clinical leaders from across our company shared their experience and identified the best opportunities and programs for improving health. We implemented initiatives targeted to:

- Increase screening for breast cancer, cervical cancer and high cholesterol;
- Improve management of high blood pressure;
- Enhance diabetes education to supplement WellPoint's disease management program;
- Educate physicians on the appropriate use of antibiotics;
- Encourage appropriate laboratory screening for certain medications;
- Improvement childhood immunization rates,
- Improve in a set of measures of diabetes care proven to reduce complications of diabetes, and
- Ensure follow-up after a mental health hospitalization.

At the end of 2007, we had closed the performance gap between current and target performance by more than the 5 percent goal in clinical areas tracked by the MHI. Improvement was shown in 17 of the 20 clinical areas, which indicated improvement in the overall rate of members getting recommended care. Specific results from the 2007 MHI include:

- Based on the increase in the percentage of women getting recommended breast cancer screening, nearly 68,000 additional WellPoint members were screened in 2007 compared to 2006.
- 66,000 more WellPoint members were screened for colorectal cancer based on the improved screening rates.
- 230,000 more WellPoint members were screened for high cholesterol levels compared to 2006's screening rates

WellPoint is committed to improving the health of our members and is the first and only health benefits company to directly link success in improving the health of our members with the compensation of every associate in the company; in 2007 achieving MHI targets was linked to 5% of the incentive pay for all WellPoint Associates. We set a high bar for success, and it is exciting to see the result of our efforts in the improved health of our members across the country.

State Health Index: In addition to the MHI, we established the State Health Index (SHI) to underscore our commitment to improving the health of our communities. The SHI tracks 23 key indicators of public health established by the Centers for Disease Control and Prevention in the 14 states WellPoint operates Blue Cross or Blue Cross and Blue Shield health plans. We focused on the eight measures of improvement having the most potential to be positively influenced by our health care programs.

As a result of the SHI, measures of public health improved appreciably, exceeding our goal of decreasing the SHI performance gap by 3%. There were significant decreases in heart disease death rates in almost all WellPoint states. WellPoint's state plans will continue to work with local health agencies, health professionals and with community and state leaders to develop programs that address health issues and, in turn, continually improve the health of millions of Americans year over year.

One example of a model program promoting state-wide health improvement is INShape Indiana, an Indiana state sponsored, web-based program that connects citizens with local services and events to help guide healthy choices to improve quality of life. The program empowers individuals to adopt healthy behaviors and provides a series of incentives, including free access to the Indiana State Parks, ice skating at the Indiana State Fairgrounds, discounts on produce, and a number of recognition ceremonies. Additionally, the INShape Indiana web site also serves as a clearinghouse for information on programs, activities, and events throughout the state related to nutrition, physical activity, and smoking cessation. Anthem Blue Cross and Blue Shield of Indiana led the 2008 efforts to incorporate INShape Indiana into existing employer health and wellness programs for twelve large Indiana employers representing more than 120,000 individuals.

VI. IMPROVING NATIONAL HEALTH AND PHARMACEUTICAL SAFETY

We can not hope to achieve health care quality without a healthcare system that at its core protects the safety of its patients. We are all aware of the troubling statistics. Hospital acquired infections exceed 1.7 million, and estimated by the CDC to cause or contribute to the death of 99,000 patients annually. Nearly 10 years ago, in its publication "To Err is Human: Building A Safer Health System: The Institute of Medicine (IOM) estimated that as many as 98,000 deaths a year were attributable to medical errors. More recently it has been shown that patients who had potentially preventable adverse medical events were twice as likely to die during a readmission within 30 days following discharge and 32 percent more likely to be discharged to a long-term care facility.[9] Adverse drugs events lead to more than 7,000 deaths[10], 1.5 million injuries, and 700,000 emergency room visits a year, translating to loss of life, decreased quality of life, and more than $77 billion in avoidable health care costs.

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[9] Adverse Patient Safety Events: Costs of Readmissions and Patient Outcomes Following Discharge. Bernard D, Encinosa W; AcademyHealth. Meeting (2004 : San Diego, Calif.). Abstract AcademyHealth Meet. 2004; 21: abstract no. 1908

[10] Classen DC, Pestotnik SL, Evans RS, et al. Adverse drug events in hospitalized patients. *JAMA* 1997;277(4):301-6.

A coordinated, public-private strategy encompassing all stakeholders in health care is necessary to achieve a safer health care system. A few of WellPoint's programs to advance health care safety are described below.

Hospital Safety and Preventable Errors: Consistent with the Centers for Medicare & Medicaid Services, WellPoint initiated reimbursement modifications in 2008 aimed at eliminating preventable adverse events as defined by CMS and the National Quality Forum (NQF). WellPoint will not pay for any of the following three "Never Events:" surgery performed on the wrong body part; surgery performed on the wrong patient; and wrong surgery performed on a patient. No payment will be made if any of these following events occur: object left in body after surgery; air embolism or blockage; blood incompatibility; catheter associated urinary tract infection; decubitus (pressure) ulcers' vascular catheter-associated infection; mediastinitis after coronary artery bypass graft; and hospital acquired injuries (e.g. fractures, burns, dislocations, etc.)

These modifications help ensure that physicians and hospitals are using appropriate processes, technologies and strategies to address 'never events' and, ultimately, to enhance the quality of care delivered to hospitalized patients. We are working alongside hospitals to address prevention of these events and will continue promote other hospital patient safety initiatives such as:

- The Institute for Healthcare Improvement's (IHI) 5 Million Lives campaign, a voluntary initiative to protect patients from five million incidents of medical harm (through December 2008); and

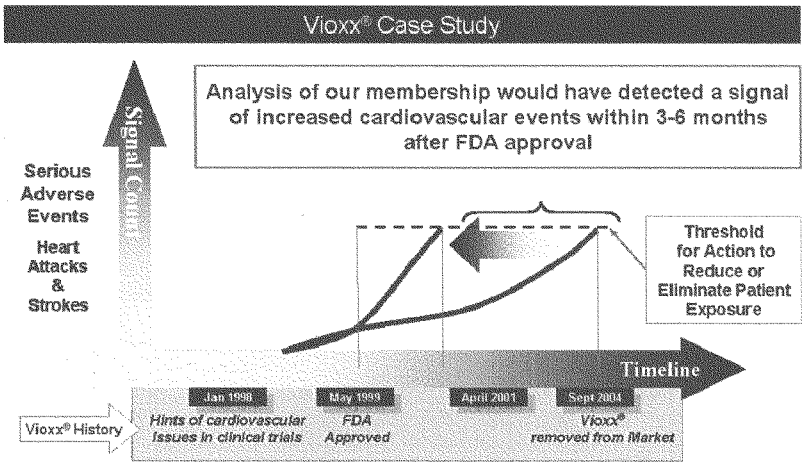
- Leapfrog's patient safety survey to reduce preventable medical mistakes and improve the quality and affordability of health care.

Drug Safety and the Safety Sentinel System™: In April, 2008, WellPoint announced its investment in the development a Safety Sentinel System™ in response to increasing demand to more effectively and rapidly monitor the safety of pharmaceuticals and other medical therapies. WellPoint's Safety Sentinel System™ is being developed in close collaboration with leading government and academic institutions, including the FDA and faculty from key academic institutions, including Harvard University, the University of North Carolina, and the University of Pennsylvania. The Safety Sentinel System is expected to advance national efforts to identify safety risks associated with drugs and other clinical care decisions, allowing physicians and other health care professionals to make more informed decisions about how to treat their patients.

The system will be capable of continually monitoring WellPoint's 35-million member database and identifying increases in health problems among members taking a drug, indicating a potential Serious Adverse Event (SAE). The Safety Sentinel System™ will also make it possible to examine whether particular combinations of treatments could cause serious medical problems, especially in patients with certain diseases. This critical information will allow health care decision-makers including federal agencies, physicians, consumers and manufacturers to move far more quickly than in the past in addressing potential drug risks. Our company's Safety Sentinel System will draw upon the vast amount of data generated by WellPoint's health plans,

including the use of specific medications. It will enable us to identify potential hazards and allow faster, more informed decision making by regulatory agencies and health care professionals.

To demonstrate the capabilities of the Safety Sentinel System™, we applied its algorithms to our historical data for members who had taken Vioxx®. What we found through this analysis, is that had the Safety Sentinel System™ been operational in 2000, WellPoint would have detected a signal of increased cardiovascular events within 3-6 months after FDA approval, nearly three years before Vioxx® was removed from the market.



VII. CONCLUSION

Distinguished members of the committee, our health care system is not perfect. WellPoint is not a perfect company, nor part of a perfect industry. Physicians are not infallible, drugs do not always work as hoped and anticipated, and hospitals are not as safe as they could or should be. Our health care system is expensive, often inefficient, and wrought with competing interests among its many, many participants. One constituency's revenue is another's expense. Just as there is no single cause to our Nation's persistent health care challenge, we know there is no single cure. We must end our failed reliance on increased spending to improve quality, and force a fundamental shift to invest in quality to drive better outcomes, greater safety, and higher value. However, we must do so not as individual health care stakeholders, but together as a health care system.

As our healthcare system continues to evolve, we are committed to collaboration, and respectfully request that this Committee consider and support the following five strategies to improve health care quality for our Nation:

- Support Institute of Medicine recommendations for the establishment of a national clinical effectiveness assessment program;
- Continue to create incentives for the adoption of e-prescribing and health information technology;
- Deploy innovative payment methodologies in federal programs that reward quality and improved clinical outcomes;
- Partner with WellPoint and other health plans on national drug, vaccine, and health care safety initiatives.

Winston Churchill once said "The price of greatness is responsibility," and it is the call of both corporate responsibility and our passion for public health and health improvement that WellPoint's more than 4,000 nurses, 200 physicians, and other health professionals including researchers, statisticians, and public health and policy experts answer each day. We are engaging and empowering members, assisting them in managing chronic conditions such as asthma, obesity, heart disease, and diabetes. We are partnering with our physician and provider communities to facilitate and enhance the coordination of care, while promoting privacy, efficiency and consistency. We are performing analytic research to evaluate and establish standards for health care quality and safety, and to identify and reduce the inequities of ethnic and racial health disparities. From management of our business to management of disease, from outreach to innovation, WellPoint is advancing health care quality and safety across our organization and across our Country associate by associate, member by member, physician by physician, and hospital by hospital. I am proud to appear before you this morning as a physician and as a WellPoint executive, and on behalf of WellPoint, I commit to you that we have the vision, the collaborative spirit, and the focused resolve to transform our industry and positively impact the health of the more than 35 million Americans we insure, and extend the effective programs to the population of our great Nation.

Mr. Chairman, Senator Grassley, and distinguished Members of the Committee, thank you once again for the opportunity to speak before you today, and I welcome the opportunity to answer any questions you may have.

NQF

THE NATIONAL QUALITY FORUM

STATEMENT OF
WILLIAM ROPER
CHAIRMAN OF THE BOARD OF DIRECTORS
NATIONAL QUALITY FORUM

BEFORE THE
SENATE FINANCE COMMITTEE

September 9, 2008

Chairman Baucus, Senator Grassley and members of the Senate Finance Committee, thank you for the invitation to testify on health care quality, one of the most important issues that must be addressed in health care reform. My name is Bill Roper. I am the Chief Executive Officer of the University of North Carolina Health Care System and Dean of the UNC School of Medicine. I also am also Chairman of the National Quality Forum Board of Directors.

It was inspiring to hear so much good news from my esteemed colleagues about ideas and programs that are improving the level of quality in care. I commend the Committee for focusing needed attention on the importance of measuring and improving the quality of care provided to patients in all settings. I also want to thank the Committee for its recent leadership in including support for critical activities performed by the National Quality Forum in the recent Medicare bill.

I intend to cover four points in my comments today. First, I would like to talk about the importance of including quality in the reform equation and describe what it truly takes to successfully focus on quality as a way of achieving access to care that is worth having and reduces costs. Second, I will turn to the role of performance measurement and public reporting in improving the quality of health and health care in America through endorsing health care standards that can guide us down the right path toward improvement. Third, I will outline the importance of having National Priorities to guide reform. Finally, I will turn to some of the critical drivers of reform that need federal leadership, including alignment of payment building high-performing health care organizations.

QUALITY: KEY TO THE REFORM EQUATION

As reform efforts take shape, we have an important opportunity to advance the quality agenda as an integral part of addressing cost containment and coverage. Indeed, the overarching objective of health reform must be to ensure that every American, regardless of race, ethnicity, place of residence and SES, receives timely access to health care *that is safe, effective and affordable.* Expanded access to care becomes almost irrelevant if in the end we're getting care that is poor quality.

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Poor quality care also wastes precious resources and contributes to escalating health care costs. For example, surgical site infections account for up to $10 billion in annual health care expenditures, and patients who contract these infections spend an average of 7 to 10 additional days in the hospital. Without a focus on quality to reduce health care-associated infections, we're wasting time, money, and resources and using hospital beds that could otherwise be available for new patients.

MEASUREMENT AND PUBLIC REPORTING: CORNERSTONES OF QUALITY

There is a lot of truth to the old adage, "You can't improve what you can't measure." I would go one step further and say that in health care, both measurement and *public reporting* must be part of the improvement agenda. Measurement identifies where there are gaps in performance and allows us to gauge progress. Public reporting of performance data provides valuable information to patients choosing high quality providers, purchasers and insurers shaping payment policies to reward quality and efficiency, and physicians making referral decisions.

In short, quality doesn't happen in a vacuum and can't be accomplished alone. To truly be successful, all parts of the health care system – providers, insurers, health plans, purchasers, consumers, and government agencies – must be committing to quality care and agree to conduct measurement, report the results publicly, take action to improve, and evaluate and make mid-course corrections. Transparency is a catalyst for creating an environment that encourages and rewards excellence.

It is always interesting to me that so many people, when they newly confront the powerful role of performance measurement and public reporting in addressing health system concerns, think that this should be the easy part of the reform equation. In fact, measuring and reporting on quality and cost are anything but simple, and I have the battle scars to prove it.

While I was Administrator of the Health Care Financing Administration (now CMS), we began the annual practice in 1986 of releasing information on Medicare hospital mortality. The hospital industry and others initially opposed this effort. However, we enlisted their help and that of many experts in the field to improve the technical quality of the information – all the while making clear that it was a work in progress, and ought not to be relied upon in isolation.

We learned a lot form this effort. To be successful, performance measurement and public reporting must be a highly collaborative effort involving all major stakeholders. It also requires a national quality infrastructure capable of setting national priorities and goals for improvement, endorsing standardized measures, collecting and aggregating data from multiple sources, generating public reports, and redesigning care processes.

The National Quality Forum, working in partnership with CMS, the Quality Alliances and others, has been a key driver of this agenda in recent years. NQF is a private sector standard-setting organization with more than 375 members representing virtually every sector of the health care system. NQF operates under a three-part mission to improve the quality of American health care by:

- setting national priorities and goals for performance improvement;
- endorsing national consensus standards for measuring and publicly reporting on performance; and
- promoting the attainment of national goals through education and outreach programs.

NQF endorsement, which involves rigorous, evidence-based review and a formal Consensus Development Process, has become the "gold standard" for health care performance measures. Major health care purchasers, including CMS, rely on NQF-endorsed measures to ensure that the measures are scientifically sound and meaningful and to help standardize performance measures used across the industry. To date, NQF has endorsed more than 400 measures.

NATIONAL PRIORITIES: COORDINATING OUR EFFORTS

Significant progress has been made in recent years in measure development, endorsement, and public reporting. We've watched the exciting developments and evolution of Hospital Compare, which uses NQF-endorsed measures to allow comparison of hospitals on a range of indicators. For the first time, consumers can learn how a hospital on one end of town compares to another on the other end of town. Hospital Compare now includes more than two dozen measures, and many other measures are in the pipeline.

Despite this growth, there are critical gaps in the portfolio. Hospital Compare covers only three conditions (acute myocardial infarction, heart failure, pneumonia) and one cross-cutting area (surgical site infection prevention). Today's measure sets provide an adequate starting point from which to "jump start" pay for performance and public reporting, but it is important to chart an evolutionary course for measures that will be used by public and private purchasers and other stakeholders in the near future.

Earlier I said that achieving quality isn't simple. But it is more critical than ever. We have reached a vital tipping point – a realization that incremental reforms and continued neglect of our most pressing challenges must end. There is a social and economic imperative to comprehensively rethink and reform America's health care system.

How we get there is the question that remains. That is why NQF convened the National Priorities Partnership, a diverse range of high-impact stakeholders working to align their efforts at reform by focusing on high-leverage areas for improvement. The 28 Partners include drivers of change, such as Peter Lee of the Pacific Business Group, who you heard from earlier today, CMS, AHRQ, the National Governors Association, AARP, and the AFL-CIO. Together, the National Priorities Partnership, convened by NQF, is focusing on seven areas that will yield the greatest gains to bring better health care for families and a stronger health care system for America.

Setting national priorities and goals will ensure that adequate attention is paid to high-volume, high-cost conditions and procedures; measures of "overuse" as well as "underuse": measures for key cross-cutting areas such as safety, care coordination, medication management, and palliative care; measures of resource use and efficiency; and measures of patient engagement in decision-making and outcomes.

DRIVERS OF IMPROVEMENT

When an educated consumer buys a car, the decision is based not just on cost, but on quality and value. We inherently know that cheaper does not equal better, and certainly consumers' focus on quality is what drives innovation and improvement.

Those who are purchasing care should also kick the tires on quality before they sign the check. Otherwise, we aren't using our purchasing power to drive improvement. Let's talk about some of the drivers of improvement.

Managing an illness over time and across settings

We need to get past considering our patients' needs only at the time of their appointments – as fragmented reimbursable services. We need to start asking: when they leave our doctors' offices, when they leave our clinics and hospitals – what are we doing to ensure they don't return sicker, wind up in expensive emergency departments, or worse?

Our measures work best when they address the multiple needs of patients and measure longitudinally – creating a rich history of information that helps us predict, anticipate needs, and ensure effective, continued, and appropriate follow-up care that makes patients better and keeps them better.

These data work best when they are aggregated across health care settings and consider the whole patient and their comprehensive and unique set of needs. This is particularly true for the chronically ill. In health care parlance, we call it the "patient-focused episode."

Aligning payment with quality

We must begin paying for and rewarding quality, if we are to get quality. The pay-for-performance programs of the last decade are a good first step, buy not nearly enough. Fundamentally rethinking and remaking our payment system will be critical to success.

The current Medicare fee-for-service payment system is broken. It rewards volume of services, not value. Separate payment programs for physicians, hospitals, and now prescription drugs accentuate the already fragmented nature of the health care delivery system.

One option for better aligning the payment system to reward value may be to replace the fee-for-service model with bundled payments for managing chronic conditions over a period of time that include built-in follow-up care and warranty-like commitments to achieve positive results for patients. Geisinger Medical Center has done some very pioneering and promising work in this area. Geisinger's ProvenCare℠ charges insurers a flat fee for a bypass that includes 90 days of routine follow-up care. If a patient suffers complications, Geisinger pays for the treatment at its facilities.

Building High-Performing Health Care Organizations

In addition to fundamental payment reform, we must transform the way in which health care is organized and delivered. Achieving higher levels of performance requires new organizational models capable of investing in health information technology; managing new clinical knowledge and skills; designing care processes based on best practices; assembling and deploying multi-disciplinary teams; coordinating care; and measuring and improving performance. Achieving higher levels of performance also requires a greater degree of clinical integration in order to provide safe and effective care to patients with chronic conditions and to accept a bundled payment for a patient-focused episode.

WHERE WE GO FROM HERE

We've come a long way, but we still have much to do. Standardized performance measures are one of the tools we need to get there – to create a source of reliable comparative performance information upon which consumers may rely in making informed decisions about their care; to assure that provider organizations and practitioners are held accountable for the quality and efficiency of their performance; and to provide a basis for establishing performance incentive programs. And, with the groundbreaking work of the National Priorities Partnership, by November 2008 we will have the other key tool in place that we need for success – National Priorities that help all of us align our efforts for the greatest possible impact.

There is no question: America's health care system is capable of immense genius, innovation, and an abiding compassion from professionals who have made making people better their life's work. Let's provide the tools to fuel this innovation and continued improvement.

Thank you again for your focus on quality as you assess health care reform. We look forward to further conversations.

FAIRVIEW

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Testimony of Greg Schoen, M.D.
Regional Medical Director
Fairview Northland Medical Center, Princeton, MN

Before the United States Senate Committee on Finance

"Improving Health Care Quality: An Integral Step Toward Health Reform"

September 9, 2008

Chairman Baucus, Ranking Member Grassley and members of the committee, my name is Greg Schoen, M.D., regional medical director at Fairview Northland Medical Center in Princeton, Minnesota. On the behalf of Fairview Northland and the 2,000 not-for-profit hospitals in the Premier healthcare alliance, I am pleased to have the opportunity to testify before you today.

Fairview Northland Medical Center is a rural 54-bed regional hospital and clinic, located approximately 50 miles north of the Twin Cities. In addition to services in Princeton, area residents can access primary care at three additional clinics in surrounding communities. We are part of Fairview Health Services, an integrated, not-for-profit healthcare network serving Minneapolis-St. Paul and communities throughout greater Minnesota and the upper Midwest. Fairview Northland Medical Center is a member of the Premier healthcare alliance, a hospital quality and cost improvement alliance which operates one of the nation's most comprehensive repositories of hospital clinical and financial information.

Considering that our focus is on improving the health of the communities we serve, I appreciate the opportunity to speak today about Fairview Northland's quality improvement journey. My testimony will describe how our participation in the Centers for Medicare & Medicaid Services (CMS)/Premier Hospital Quality Incentive Demonstration (HQID) project was and is a catalyst for quality improvement at our facility and how we overcame challenges we face as a small, rural hospital to achieve status as a top performer in the project. I will also present some key issues for the committee to consider as it moves forward with its quality agenda in the context of healthcare reform.

Fairview Northland's journey to becoming a top-performing organization started in 2003 when Premier announced a new three-year demonstration project with CMS to encourage improvements to hospital quality. The CMS/Premier HQID project, which has since been extended for an additional three years through 2009, is the first-ever national test of performance-based incentives across a broad array of acute care conditions in Medicare patients. The project includes more than 250 hospitals with participants located in 35 states and provides incentives to hospitals that successfully use evidence-based, widely accepted clinical treatments and measures to care for patients with these conditions: heart attack, heart failure, coronary artery bypass graft (CABG), pneumonia and hip/knee replacement. Rewards come in the form of public recognition and annual quality incentive payments

from CMS to top performers. Those hospitals that perform in the top 10 percent of a clinical area—heart bypass, for instance—receive an incentive payment equivalent to 2 percent of their applicable Medicare base rates; those in the top 20 percent receive a 1 percent payment. In the third year only, those hospitals that were low performers based on year 1 baseline results were financially penalized.

The quality of care provided by HQID participating hospitals has significantly improved across all five clinical focus areas from the inception of the program in October 2003 through September 2007, the timeframe for which the most current data is available. Notably, the range of variance among HQID participating hospitals is closing, as those hospitals in the lower deciles continue to improve their quality scores and close the gap between themselves and the demonstration's top performers. *In addition to the rising thresholds, the data shows a compression of the ranges, or a reduction in variation, across project participants. All hospitals, even the low performers, are making strides in quality improvement.*

- In AMI (heart attack) the variance between the highest and lowest score was 40.68 percent in year 1 and has declined to 18.38 percent in year 4.
- In heart failure the variance between the highest and lowest score was 70.97 percent in year 1 and has declined to 41.24 percent in year 4.
- In pneumonia the variance between the highest and lowest score was 37.64 percent in year 1 and has declined to 24.85 percent in year 4.
- In heart bypass the variance between the highest and lowest score was 31.60 percent in year 1 and has declined to 19.39 percent in year 4.
- In hip and knee replacement the variance between the highest and lowest score was 27.97 percent in year 1 and has declined to 23.89 percent in year 4.

Among the 252 participating hospitals in the third year, 112 hospitals earned an incentive payment. In contrast, there were 1,028 potential areas where participants could receive a negative payment adjustment by falling below the payment adjustment threshold, the ninth decile threshold set in the first year. Only 11 total penalties occurred across nine total providers.

The HQID project has shown that pay-for-performance is a powerful stimulus that can be used to accelerate performance. Participating hospitals have shown performance gains that have outpaced those of hospitals involved in other national performance initiatives. In fact, analyses by Premier using the Hospital Compare dataset showed that participants scored on average 6.7 percent higher than non-participants when looking at a composite of 19 measures shared in common between HQID and Hospital Compare.

The HQID project was extended for an additional three years to test new ways to measure quality, as well as new incentive models. We would like to take this opportunity to thank Chairman Baucus for his support of continuing the project beyond the initial three years. The extension will continue to track hospital performance in the five clinical areas, with flexibility to add quality measures and clinical conditions in the extension's second and third years. During the first three years of the project, only top performers were eligible for incentive payments. In the extension bonuses have been expanded to provide incentives for hospitals that achieve the highest quality improvement, those that attain a defined level of quality, along with those that are in the top 20 percent of quality in each condition. In addition, the extension will allow for penalties for low performers on an annual basis.

As a hospital system, Fairview Health Services decided to participate in the HQID for a variety of reasons. In addition to a long-standing commitment to high-quality care, we believed the HQID

measures would eventually become a CMS requirement. Wanting to be "ahead of the curve," Fairview called on each hospital in our seven-hospital system to participate.

As the medical director for Fairview Northland, I was charged with leading our local effort. When the first set of quality measures was reported, we were surprised by our poor performance. We were in the bottom 10 percent of participating hospitals.

The scores served as a wake-up call that we had work to do. The quest to improve quality started with a straightforward approach to physicians and staff: we can, and will, do better. Our employees — particularly physicians — responded positively to the fact that our hard work would not only improve patient care, but it would also be rewarded with incentive pay from the demonstration project.

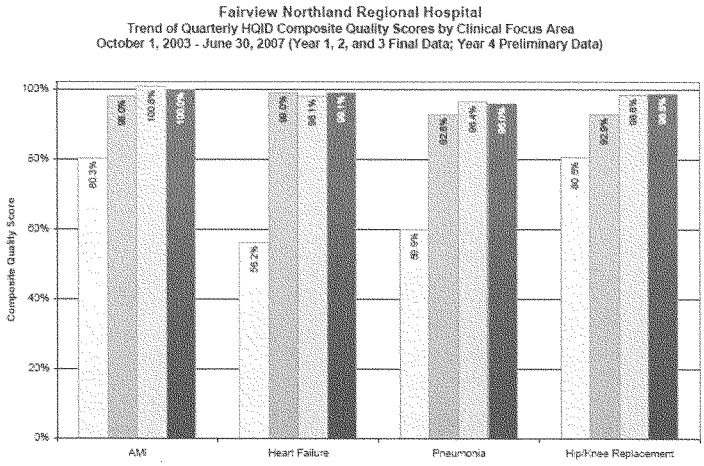
Some of the changes we issued were easier to achieve than others. A common reaction to our low scores was to blame them on documentation errors, meaning the critical care steps were being performed, just not recorded through charting or billing. This proved to be true for several processes. For example, prior to our participation, physicians were conducting oxygenation assessment on patients with pneumonia, but there was no line-item billing code to reflect this work. Based on the way data is collected for this project, it looked like our compliance with this clinical step was 0 percent. A new billing code fixed that problem. This kind of "low-hanging fruit" was a relatively painless adjustment.

The harder work came when we realized we had good people using bad processes. And those bad processes needed to be fundamentally changed. That work was assigned to existing interdisciplinary care teams in the appropriate clinical settings. The teams—comprised of physicians, nurses, X-ray and lab technicians, support staff and administration—had to build new processes to achieve better results. These were the best people to create new processes, since they would have to use them everyday. They created new and better ways to provide care and then hardwired these processes into place. For example, we developed protocols for nurses to initiate care to patients with chest pain systems, such as performing EKGs, administrating aspirin prior to physician notification, and standardizing order sets for care of AMI, heart failure and pneumonia.

We've also incorporated numerous monitoring mechanisms to be sure we stay on track, such as adding prompts in paper documents and order sets for physicians, and hiring staff to audit and monitor compliance. Through focused efforts, we moved from the bottom to near the top of the pack in one year. Since then, we've sustained our efforts and success.

In the first year we participated in the project, we performed in the bottom 10 percent of all project participants in four clinical areas. By the end of year 2, we were among the top 20 percent of project participants in the heart attack, heart failure, and pneumonia clinical areas, and by the end of year 3, we were also in the top 30 percent of participants in the hip and knee replacement clinical area. Our Composite Quality Score, an aggregate of all quality measures (both process and outcome) within each clinical area, improved by an average 29.24 percent over the project's first four years:

- From 80.3 percent to 100 percent for patients with acute myocardial infarction (heart attack);
- From 56.2 percent to 99.1 percent for patients with heart failure;
- From 59.9 percent to 96 percent for patients with pneumonia; and
- From 80.5 percent to 98.8 percent for patients with hip and knee replacement.



Our success is based on a number of factors. First, our hospital administrator supported the work. When the decision to strive for the highest quality possible is supported from the top, it is far more likely that staff and physicians will work together to improve processes and achieve results.

Secondly, our hospital physicians and staff "owned" the process redesign work and therefore were invested in the project. The involvement of those who are responsible for implementing the processes is an integral part of quality improvement efforts. Because we are a small hospital, which presents its own unique challenges, we also had an advantage in that a smaller medical staff and employee population means you can make change faster. Also, the measures were strongly supported by research showing that these were appropriate clinical treatments for the four conditions, so the physicians did not question the validity of the measures themselves.

While we are part of a larger, integrated system, staff at Fairview Northland accomplished the bulk of the work. For us, healthy competition among hospitals within our system spurred us to move quickly and make improvements.

In implementing these processes, we have certainly faced challenges. Any time you change a process, you have to change human behavior, and that takes time. While I have cited a relatively small nursing and medical staff as an advantage to making improvements more quickly, there is a downside to being small. Because our inpatient volumes are small in these condition subsets, a single patient who is not provided all correct clinical measures could affect our scores, enough to drop us out of the top decile and lose reimbursement. However, in the HQID project overall, small hospitals have proven that they can provide excellent care. Thirty-one hospitals with fewer than 100 beds and 12 hospitals with fewer than 50 beds received bonus payments during the first three years.

Our small size also means we have limited resources. We incurred start-up cost and made the commitment to add some staff time to appropriately monitor our efforts. This investment is necessary to maintain results. It is important to note that the project was launched prior to the implementation of the Medicare quality public reporting program which covers all Medicare inpatient prospective payment hospitals. Going forward our biggest concern is the number of

organizations that are requesting or requiring hospitals to report conflicting quality measures. Separate pay-for-performance initiatives in the private-payer market while well-intentioned, add considerable costs for hospitals. Fairview believes in "call for standardizing" measures so that CMS and other payors have the same ones; thus, additional resources do not have to be applied at "no value added."

During the first three years of the project, we received bonus payments totaling $40,445 for our quality achievement. While we are improving quality to provide the very best outcomes for patients and not for the money, having an incentive as a reward in the HQID project for achieving outstanding results is a welcome component. This is especially true for a small hospital with limited resources.

Over the long term, however, standardizing hospital processes brings about efficiencies in the delivery system. In fact, in an analysis released this year, Premier found that as hospital quality continues to improve, hospital costs are declining among participants in the HQID project. According to the analysis of 1.1 million patient records, if all hospitals nationally were to achieve the three-year mortality improvements found among the project participants for pneumonia, heart bypass, heart failure, heart attack (acute myocardial infarction), and hip and knee replacement patient populations, they could reduce hospital costs by more than $4.5 billion annually. The 1.1 million patient records represented in this analysis encompass 8.5 percent of all patients nationally within the five noted clinical areas over the three-year timeline of this analysis.

The same Premier analysis also showed that, if all hospitals nationally were to achieve the HQID three-year mortality improvements across the project's five clinical areas, an estimated 70,000 lives per year could be saved.

A separate study[1] published in Health Affairs last year about hospital performance and evidence-based quality measures and mortality rates found that hospitals in the top quartile of quality performance, compared with hospitals in the bottom quartile on quality performance, had 11 percent lower mortality for acute myocardial infarction, 7 percent lower mortality for congestive heart failure, and 15 percent lower mortality for patients with pneumonia.

There has been concern by some that providing incentives based on a subset of the many aspects of patient care will cause hospitals to "teach to the test" or perform well on the processes that are measured while giving cursory attention to other aspects of care. A recent analysis[2] that evaluated the effectiveness of the HQID project by comparing performance to a group of hospitals involved in another program devoted to heart attack quality improvement revealed that HQID hospitals performed noticeably better on the non-HQID measures (13.6 percent compared to 8.1 percent improvement in the composite score) and also achieved greater levels of improvement on all the HQID measures than the control group hospitals. This would indicate that pay-for-performance hospitals appear to adopt a more serious and comprehensive approach to performance improvement that extends beyond the areas measured in the project to overall patient care.

In conclusion, we believe that aligning financial incentives is the right approach to pushing quality to a higher level. By creating a positive incentive to improve quality, pay for performance is an engine for improvement and can be a framework for fundamental transformation. In addition to aligning

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[1] A. K. Jha, J. Orav, Z. H. Li, A. M. Epstein, The Inverse Relationship Between Mortality Rates and Performance in the Hospital Quality Alliance Measures, *Health Affairs* July/August 2007 26(4):1104–10

[2] Glickman SW, Ou FS, DeLong ER et al. Pay for performance, quality of care, and outcomes in acute myocardial infarction. *JAMA* 2007 June 6;297(21):2373-80.

incentives, we recommend that measure development organizations assure alignment between physician and hospital measures, and that all new measures be tested and publicly reported before being used in a pay-for-performance program.

We also support the government directing attention and resources to lower performing hospitals. As I mentioned earlier in my comments, we achieved 90 percent of the improvement without assistance from any source outside of our 54-bed hospital.

Lastly, when our state quality improvement organization (QIO) came to visit our facility, we were already well on our way to achieving our quality improvement goals, and the QIO staff made comments about how they can learn from us.

Collaboration and the sharing of ways to implement best medical practices is the key to quality success. We support both public and private organizations that conduct such work and encourage Congress to look to them for insights into improving quality of patient care.

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Congressional Testimony
September 9, 2008

Kevin Weiss, MD

Statement of Kevin Weiss, M.D., MPH; President and CEO
American Board of Medical Specialties (ABMS)

Before the U.S. Senate, Committee on Finance

Hearing on Improving Health Care Quality:
A Key to Healthcare Reform

Chairman Baucus, Senator Grassley and members of the Senate Finance Committee, thank you for the invitation to testify about improving health care quality. My name is Kevin Weiss, and I am a physician, board certified in internal medicine and President/CEO of the American Board of Medical Specialties (ABMS).

ABMS is an independent, non-profit organization which for 75 years has been assisting 24 medical specialty boards in developing and using standards to evaluate and certify physicians. The Boards were founded to assure the public that physicians have the knowledge, skills and attitudes to practice in a given specialty. ABMS, recognized as a "gold standard" in physician certification, believes higher standards for physicians means better care for patients and extensive research confirms this.[i,ii] We are pleased that national surveys suggest that over 90% of the general public use Board Certification in their choice of physician.

ABMS's reach is broad and deep – There are over 700,000 US Medical Doctors and Doctors of Osteopathy that hold a certificate by one or more of ABMS' Boards, – and the standards that we set shape both medical residency training programs and physician practices of all sizes in every conceivable setting. The profession's investment in enhancing quality through the Boards is significant, totaling

approximately $150 million annually, and are paid by physician fees. We speak of fees as the certifying boards are not membership organizations. We are funded by physicians voluntarily seeking to prove that they can reach the high mark of initial board certification and, more recently, maintenance of certification (MOC). We are fortunate that the physician community supports and respects our role – with an estimated 85% of the U.S. physician workforce voluntarily going through the certification process as evidence of their support.

ABMS Boards are "public facing" in that we set standards to assure patients about the competency of physicians, and patients regularly seek out board certification as a marker of quality whether choosing a pediatrician, cardiologist, neurosurgeon, radiologist or any other kind of physician. Our Boards are not member organizations, nor do we accept support from the pharmaceutical or medical device industries in order to maintain our independent, standard setting status. Also, our focus on standard setting for the profession is not associated with any discussion about physician payment. In short, ABMS Boards are private sector oversight organizations very similar in mission, for example, to the National Committee for Quality Assurance (NCQA) or The Joint Commission.

ABMS Boards have embraced a new definition of professionalism – embodied in a Physician Charter[iii] adopted by 130 medical organizations across the globe – that commits physicians to a set of principles that resonates with the notion of value-based purchasing that many public and private sector healthcare leaders have embraced, including many members of this Committee. These principles include a commitment to improving quality of patient care, and also recognize that physicians have a key role to play in controlling costs as stewards of the community's scare medical resources.[iv]

In my testimony today I hope to inform the Committee about three key issues:

1) **No single strategy is sufficient to improve our health care system.**

2) **The best model for physician accountability will need to combine performance measurement with other tools for physician assessment, and**

3) **Alignment of public and private sector quality agendas will provide the strongest possible basis for physician accountability and health system improvement.**

Let me briefly provide some detail on each issue. First **we believe that no single strategy is sufficient to improve our health care system.** To cross the chasm that exists in quality, we believe that multiple strategies are needed to leverage the distinct and potentially complimentary roles of regulation, the market and professional accountability. Most physicians in practice are imbued with a deep sense of professional responsibility to provide the best possible care to their patients – but they have not historically had the data to know how they are doing or the tools to help them improve identified weaknesses. The certifying boards have demonstrated that with trusted and actionable data, physicians will get engaged in improving care – thereby tapping into their intrinsic motivation to do well by their patients;

The best model for physician accountability will need to combine performance measurement with other tools for physician assessment. The tools ABMS Boards use to assess physician competency are multi-faceted – and we believe that taken together they provide a comprehensive picture of an individual physician's performance. Research shows that while performance measures are important, they are not sufficient to fully assess physician competency.

The standards that the Boards set and the tools that they use to periodically assess physicians are varied – and together represent a comprehensive picture of physician competency. Examples of these tools include those that focus on performance measures – clinical measures, CAHPS patient experience surveys, and a condensed version of the NCQA physician practice connections (PPC) – in addition to other kinds of evidence based tools. These tools have been rapidly evolving over the last decade as the science of assessment has become more sophisticated and as the physician community has learned about the scope and depth of the nation's healthcare quality problem.

Based on these different kinds of performance measures, ABMS Boards generate web-based reports that provide physicians with the information they need to know how they are doing and to diagnose practice strengths and weaknesses. For example, if a physician is not doing a good job of helping her diabetic patients to control glucose levels, she can examine if it is because she needs to learn about new medications, or because her patients do not understand how to manage their condition, or because her office does not have the practice infrastructure in place to regularly identify at risk patients and bring them in for a visit. This kind of data is actionable and the ABMS Boards require that physicians design and implement a quality improvement intervention in response to the individual reports they receive, and then measure the effects of that intervention on their practices.

While practice-based performance assessment is a key component of Board assessment, many aspects of physician clinical competency do not lend themselves to being represented as performance measures – even as such performance measures become more sophisticated – because of the complex and/or multi-faceted nature of what they are assessing or because many conditions for which people seek care are not common; for example while it is possible to develop performance measures to examine the care of diabetes or breast cancer screening which are important and frequent public health problems, other important patient needs such as the diagnosis and treatment of thyroid disease, viral meningitis or rheumatoid arthritis are thankfully much less common – limiting any role for performance measures in assessment of a physicians skill for such issues. The ABMS Boards have other tools for such assessment that include:

- A secure closed book exam targeted to their medical specialties and scope of practice that assesses whether a physician is staying current in their field. The evidence suggests that this is critical when you consider that 10,000 randomized controlled trials are conducted every year along with the related new medical knowledge that such research generates.
- An evaluation of clinical judgment, through high and low fidelity simulation exercises, which is similar in concept to those simulation exercises that pilots must use to demonstrate their skills.

- Requirements for ongoing continued professional development through required standards for continuing medical education based on self assessment tools with feedback.

While performance measures are beginning to provide a window into practice quality – particularly determining if needed processes have been implemented – they are not able to round out a full picture of physician competency, including diagnostic acumen, clinical judgment, ability to appropriately and efficiently manage care, and grasp of the ever evolving evidence base. The ABMS Boards have been providing that broader assessment, and look forward to integrating our work more seamlessly into the wider accountability framework.

Our last key issue is that only by public and private sector alignment will we achieve the strongest possible basis for physician accountability. Out of a desire to reduce wasteful, redundant data collection and to accelerate improvement, the ABMS Boards have begun to align their assessment methods with those of private health plans, hospitals, CMS and other emerging forces in the quality movement such as NQF and the health care quality Alliances. The focus to date has been in the performance measurement arena – which has taken the form of health plans and hospitals recognizing and/or rewarding physicians for assessing their performance as part on ongoing certification. This has translated into pay for performance rewards, input into placement within health plan physician recognition programs based on quality, recognition in provider directories, and input into hospital staff credentialing programs. In addition, a number of ABMS Boards are helping to facilitate the reporting of clinical data to CMS as part of the Physician Reporting Quality Initiative. These arrangements serve to incentivize physicians to more regularly (in most cases annually) self assess performance – a habit of practice that ABMS Boards are well positioned to inculcate – and allows physicians to collect data once and use if for multiple purposes.

This alignment of performance measurement efforts is an important first step but not adequate to realize the performance gains that our healthcare system needs and our patients deserve. Other areas of alignment include public and private payer expectation that physicians will regularly maintain their certification – which includes ongoing participation in the full range of assessment activities. For more than

a decade, ABMS Boards have been providing time limited certification that must be periodically renewed. Given the evidence that knowledge and skills deteriorate over time[v] – or in other words that practice does not make perfect – it is vitally important that physicians are regularly keeping up and have feedback from a trusted source as to where they are performing well and where improvement is needed. The ABMS Boards are not seeking that payers – particularly the public sector – require ongoing certification out of concern that a requirement will undermine the strong voluntary support that board certification currently enjoys from the profession. However incentives and strongly communicated expectations can go a long way in signaling to the physician community the importance of this driver towards improved quality of care.

The ABMS Boards are developing new kinds of partnerships with public payers, private payers, and particular patients and consumer groups who represent them to get a deeper appreciation about the kinds of information they seek and their expectations for care – and we seek to further such collaborations. For example, ABMS has just embarked on a project with the National Quality Forum (NQF) that will bring together leaders from the major healthcare stakeholder groups at a national summit to discuss how board certification may be better integrated into the accountability framework as well as to gain a deeper understanding of their expectation for the ABMS Boards. The ABMS has also been serving on the NQF National Priorities Partnership Committee and we will be bringing a resolution to endorse the national priorities to the ABMS Board meeting later this month. My colleague, Dr. Bill Roper, will next be discussing this effort in more detail.

In summary, the ABMS Boards are rooted in the profession but firmly committed to serving the public – which is a mission we share with the public sector. Ultimately while market levers, including pay for performance programs and public reporting programs, as well as regulatory requirements may be able to partially shape physician practice , they will not in and of themselves be able to bring about the radical changes needed in the practice of medicine that are necessary to transform our nation's healthcare system. Professional accountability – and the public facing values it embodies – offers a proven mechanism to connect to physicians and engage them in improving patient care. Then perhaps by bringing to bear professional

accountability as offered by the ABMS Boards, along with the emerging efforts in public accountability by Congress through CMS, along with marketplace efforts we can more rapidly achieve the high quality, efficient, and patient-centered health care system that we would all like to see, know is possible, and that our patients deserve.

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[i] Holmboe ES, Wang Y, Meehan TP, et al. Association between maintenance of certification examination scores and quality of care for Medicare beneficiaries. *Arch Intern Med*. 2008;168:1396-1403.

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[iii] ABIM Foundation, ACP-ASIM Foundation, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med*. 2002;136:243-246.

[iv] Cassel CK, Brennan TA. Managing medical resources: a return to the commons? *JAMA*. 2007;297:2518-2520.

[v] Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: the relationship between clinical experience and quality of health care. *Ann Intern Med*. 2005;142:260-273.

COMMUNICATIONS

American Academy of Pediatrics

Statement for the Record

on behalf of the
AMERICAN ACADEMY OF PEDIATRICS

before the
Senate Finance Committee

For

Improving Health Care Quality:
An Integral Step Toward Health Reform

September 9th, 2008

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This statement on children's health care access and quality is submitted on behalf of the American Academy of Pediatrics (the Academy), which represents more than 60,000 primary care pediatricians as well as pediatric medical and surgical subspecialists. The Academy and its members are dedicated to the health, safety, and well-being of children from infancy through young adulthood. With health reform a major concern for many families, the time is right to make the health and well being of America's children a national priority and to fix the broken system under which they receive health care.

Although Medicaid and the State Children's Health Insurance Program (SCHIP) have helped reduce the number of uninsured low-income children by one third over the last decade, millions of children, adolescents and young adults lack basic health care coverage, and constitute nearly one-fifth of the nation's uninsured population. Children need high quality, age-appropriate care and reliable preventive services. There is no better investment than preventing health problems, and promoting healthy development of the nation's children. Especially in the context of children, cutting costs should not be our focus, because the promise of improving quality of care is that money will be saved at the same time that health outcomes improve. An investment in the quality of children's health now will pay dividends in the future.

The Academy would like to thank the Finance Committee for its continued commitment to addressing health reform and for this opportunity to submit a statement for the record.

High Quality Pediatric Health Care

To date most initiatives aimed at improving the quality of care in the United States have focused on adults. However, significant resources could be saved for the entire health system if the chronic diseases that children develop and carry into adult life such as obesity, diabetes and mental health conditions are documented, tracked and addressed (or prevented). Even before considering the health costs that are incurred after the transition to adulthood, poor medical, developmental and mental health care can lead to poor school performance, early dropouts, a poorly trained workforce and an increase in juvenile delinquency.

As Congress addresses child health issues in the context of health reform, it should include an initiative to improve the quality of health care for America's children. Since Medicaid and SCHIP cover one in three of our children, including many of the sickest, Congress should support quality improvement efforts through these programs so that children receive the right care at the right time under Medicaid and SCHIP as well as in private sector coverage.

Enactment of the *Children's Health Improvement Reauthorization Act of 2007* would have made great strides in implementing pediatric-appropriate quality improvement initiatives. The Academy encourages the Finance Committee to consider the following policy recommendations embodied in Section 401 of that legislation as it addresses health care quality for children:

- **Strengthen child health quality improvement activities at the Department of Health and Human Services (HHS).** HHS currently recommends states report limited quality information using four performance measures in the NCQA HEDIS® dataset or measures that are similar. HHS should not only continue this reporting requirement but, in cooperation with the states, providers, and child health experts, update and enhance it to include a richer set of information, including both ambulatory and inpatient care settings. In addition, HHS should work with the states to encourage voluntary reporting of the same set of measures on state Medicaid programs. For each program the Department should provide technical assistance to the states to help them comply with the measure specifications; this will assure the information reported can be used with confidence to develop national performance goals or perform comparative analyses. The Department should also facilitate adoption of best practices in areas such as provider reporting compliance, successful quality improvement strategies, and improved efficiency in data collection using health information technology. The Department should organize seminars/webinars, and provide technical assistance.

- **Dissemination of health quality information.** HHS should be required to gather, analyze and publicly report state by state the data collected on child health quality measures. The data should be published annually. Every three years, HHS should be required to report to Congress on the status of efforts to improve children's health care. The report should address all health care needs of children, including preventive, acute and chronic care and all domains of quality including safety, family experience of care, and elimination of disparities.

- **Development, endorsement, and updating of child-specific health quality measures.** HHS should be provided authority and resources for a program to support the development of quality and performance measures for children's health care services. The program would provide grants and contracts for the development of new measures, advancement of those measures and existing measures through validation and consensus, and updating measures as necessary. HHS should consult with national pediatric organizations, states, consumers and others with expertise in pediatric quality and performance measures to identify gaps in existing measures and priorities for development. In developing a portfolio of measures for use by states, other purchasers and providers, HHS should work with an organization involved in the advancement of consensus on evidence-based measures, such as the National Quality Forum.

- **Demonstration grants on quality and HIT.** The Secretary should have the authority to provide funds to states and child health providers for demonstration programs to evaluate promising ideas for improving the quality of children's health care. The demonstrations may include experimenting with and evaluating the use of new measures or fostering the use of health information technology in care delivery for children. The Secretary should conduct multi-state

demonstrations as needed, such as in testing the validity and suitability for reporting and value-based purchasing of hospital inpatient services for children.

- **Federal matching rate for necessary computer system modifications.** HHS should assure states that the 90% enhanced federal administrative match in Medicaid for computer system development or modification is available for changes necessary for the efficient collecting and reporting on child health measures.

- **Development of a model electronic health record for children.** HHS should financially support the development and dissemination of a model electronic health record (EHR) for children that can be accessed by consumers to demonstrate compliance with school or leisure activity requirements such as appropriate immunizations or physicals. The model EHR should have interoperable capability in conformity with state and federal privacy and security requirements.

- **Include children in Patient-Centered Medical Home evaluations**. HHS should implement and evaluate large-scale Medicaid medical home pilot projects for children. HHS should also support an all-payer pilot project of the medical home model of children.

- **NCQA PPC Support**. Congress should task HHS with an evaluation of the Physician Practice Connection model to determine its impact on the quality of care children receive.

Access to Care for Children

Quality health care is essential for everyone in America, whether child or adult. In the context of pediatrics, however, improving quality in health care depends on coverage to a great degree. With more than 8 million residents under the age of 19 and more than 9 million under the age of 22 lacking access to quality health insurance in a medical home, quality improvement will never be realized.

Pediatricians know that having an insurance card does not guarantee access to care, because payment rates impact directly impact the ability of pediatricians to provide care. Currently, Medicaid pays pediatricians on average 69% of what Medicare pays for similar services. Access and payment are linked and must be addressed in any attempt to improve pediatric health care quality.

The Academy has adopted as an integral component of the effort to achieve access to high quality care for all children the following Principles on Access:

1. Every child must have quality health insurance.
2. Health insurance should be a right, regardless of income, for all children, pregnant women, their families and ultimately all individuals.

3. All health insurance plans should have a comprehensive, age-appropriate benefits package such as that of the Academy.
4. All children should have access to primary care pediatricians, pediatric medical subspecialists, pediatric surgical specialists, pediatric mental and dental professionals, and hospitals with appropriate pediatric expertise.
5. All health plans should have payment rates that assure that children receive all recommended and needed services.
6. Health insurance should be fully portable and provide continuous coverage.
7. Administrative aspects should be streamlined and simplified.
8. Families should have a choice of clinician(s).
9. Health plans should complement and coordinate with existing maternal and child health programs to ensure maximum health benefits to families.

These Principles serve as the standard that the Academy uses to evaluate health care access proposals at the federal level. The only solution introduced in Congress to date that would meet these Principles is the MediKids Health Insurance Act (H.R 2357 / S. 2522). MediKids would guarantee a child's right to high quality health care with comprehensive, age-appropriate benefits in a medical home. The Academy believes that MediKids is a solution to the growing problem of uninsured children. The MediKids Health Insurance Act would create a system that would achieve the Academy's goal of quality health insurance for all children regardless of family income.

The Patient-Centered Medical Home

The Academy introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the Academy expanded the medical home concept to include the following operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

Joining with the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association, the Academy jointly published a set of patient-centered medical home principles. These principles call for care that is led by a personal physician involving a team of professionals at the practice level. Also recommended is care that is coordinated and integrated through information technology and registries, care that actively involves and supports children and families, care that is guided by evidence-based medicine and clinical decision support tools, and care with expanded hours and open access.

Major delivery and financing reforms are needed in government and private health insurance to support the patient-centered medical home model, which will advance the provision of comprehensive care for infants, children, and adolescents. Referred to as a "Family- or Patient-Centered Medical Home," this model of care incorporates expanded access and communication, improved coordination and integration of care, changes in administrative processes, active patient and family involvement, and quality improvement.

Quality and safety are hallmarks of the patient-centered medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients and families actively participate in decision-making and feedback is sought to ensure their expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide family-centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Although the Academy pioneered the medical home concept and has long supported the medical home model of care, pediatric practices have not had the financial support of public and private payers to organize their practices to fully implement this model of care. Pediatric practices, for example, provide telephone and email communication with families, team care, consultation and coordination with specialists and other services providers, and patient and family education and support. Moreover, financial support is seldom available to offset the implementation and ongoing administrative costs related to new health information technology and quality improvement programs.

The National Committee on Quality Assurance, with endorsement from the Academy and other medical organizations and payers, has adopted a set of standards to measure and recognize practices that have implemented specific medical home functions. Derived from the conceptual frameworks of the chronic care model and from the Institute of Medicine's Crossing the Quality Chasm report, this tool – called, Physician Practice Connections – Patient-Centered Medical Home (PPC-PCMH) – is organized according to nine standards: access and communication, patient tracking and registry functions, care management, patient self management, electronic prescribing, test tracking, referral tracking, performance reporting and improvement, and advanced electronic communications (See Appendix for PPC-PCMH tool.) Points totaling 100 are associated with each standard, and three levels of recognition are possible: Level 1 totaling 25-49 points, Level 2 totaling 50 –74 points, and Level 3 totaling 75-100 points. Payment amounts are aligned with scoring levels.

Although these NCQA medical home quality and payment standards are increasingly being adopted by public and private payers, they are by no means the only approach for measuring and reimbursing practices offering a medical home standard of care.

Nevertheless, Congress should adopt a similar, if not identical model to encourage real quality improvement in the context of the patient-centered medical home.

Conclusion

It is time to make the same federal investment in quality and performance measurement for children's health care that has been made for adults. Children are not small adults; they have unique medical needs that must be addressed in any reform of the American health care system. Pediatric providers can only go so far in their efforts to improve pediatric quality without a federal commitment. Federal government leadership is essential to expedite the work that is needed to implement comprehensive reform in pediatric care. As a result, the American Academy of Pediatrics thanks the Senate Finance Committee for its commitment and extraordinary work in supporting pediatric quality improvement as part of SCHIP reauthorization, but strongly urges the Finance Committee to evaluate any health care reform legislation from the pediatric perspective in order to ensure that children throughout the nation have access to high-quality medical care to insure a healthy America for the future.

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Statement for the Hearing Record

Senate Committee on Finance

September 9, 2008 Hearing:

Improving Health Care Quality: An Integral Step Toward Health Reform

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The National Association of Children's Hospitals (N.A.C.H.) is pleased to submit the following statement for the hearing record. We are grateful that the Finance Committee has chosen to hold a series of hearings on health care reform. We believe health reform will be necessary to improve health care access and outcomes for the nation's children. More specifically, we believe it will take a special focus to make sure that health reform works for children. This is particularly true in the area of improving health care quality.

Children's Health Care Quality: Current Status

When it comes to getting the right care at the right time, insured children in this country fare even worse than adults, according to a recent study conducted by the Rand Corporation, Seattle Children's Hospital Research Institute and the University of Washington's School of Medicine. The study found that children received only 68 percent of recommended care for acute medical problems, 53 percent of recommended care for chronic medical conditions and 41 percent of recommended preventative care. Children with asthma received just 46 percent of the care they needed.1

Further, children are not receiving immunizations at a rate that meets national goals. For asthmatic children, who are at high risk for complications due to influenza, less than 30 percent were vaccinated during the 2004-2005 influenza season.2

Efforts to improve children's health care quality are linked with the need to ensure health coverage and access for children. Lack of insurance, under-insurance or discontinuous insurance

Mangione-Smith, R., et al, "The Quality of Ambulatory Care Delivered to Children in the United States", New England Journal of Medicine, Vol. 357 No. 15:1515-1523, Oct. 11, 2007.

MMWR, Influenza Vaccination among Children With Asthma, United States, 2004-2005 Influenza Season http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5609a2.htm?s_cid=mm5609a2_e (Accessed February 26, 2008)

significantly affects children's access to health care. A recent study found that uninsured children were four times as likely as children with public insurance to use a hospital emergency room as a regular source of care in 2006.3 Children who lack insurance are significantly more likely than children with insurance to delay needed care due to high costs and to have an unmet medical need. However, as the Rand study noted, getting children covered isn't enough. Disparities based on socioeconomic status persist; and the magnitude of disparities seems to increase as children age, indicating that the health system is not responding as well as it should. Additional steps are required to ensure that necessary care is delivered. That will require greater investment in health information technology systems as well as increased attention to documenting and measuring quality of care for children.

Improving Health Care Quality for Children: Legislative Efforts

Congress, under Finance Committee leadership, began to take steps to advance health care quality for children. Specifically, Section 401 of H.R. 973, the *Children's Health Insurance Program Reauthorization Act of 2007* (CHIPRA) included language which would have provided federal leadership in requiring quality measures for children's health care in Medicaid and SCHIP, and federal investment in developing and advancing pediatric quality measurement, health information technology and innovations in the delivery of children's health care. By including Section 401 in CHIPRA, Congress recognized the need to make this investment to give states and other payers, providers and consumers a full portfolio of evidence-based and nationally-recognized pediatric measures from which to choose for assessing and improving children's health care.

Unfortunately, this portfolio does not exist today. Children are too small a share of the health care marketplace to stimulate the private sector investment needed. In general, the federal government has been focused on quality measurement for the adult population, through Medicare, not children. Medicaid and SCHIP currently lack the authority and resources to invest in the development of evidence-based pediatric quality measures. Such measures cannot be developed and maintained on a state-by-state basis. A cohesive national approach and federal leadership are needed to efficiently produce and utilize quality measures relevant to the needs of children and adolescents across all care settings.

Improving Health Care Quality for Children: The Challenge

While the quality provisions in *CHIPRA* would provide an important step toward improving children's health care quality, much more needs to be done to facilitate system reform in the delivery of children's health care.

N.A.C.H. has developed a set of principles which articulate the elements necessary to make health care reform work for children. One principle is that system reform is should be an integral part of health care reform. Ensuring access to both affordable coverage and affordable care will require system reform for a high performance, high quality health care system that can integrate health care services and align incentives to improve outcomes and control costs. The administrative structure and policy of children's public coverage currently do not provide the

3 Id.

national leadership that is essential to achieve these goals. Congress should provide the Secretary of Health and Human Services with the authority and resources the department has said it lacks to support and encourage improvements in the quality and delivery of children's health care. For example:

National quality measures and public reporting

The federal government should support the development of health care quality measures for health plans and providers. The measures should be evidence- and consensus-based to the fullest extent possible. The process for selecting measures and reporting should be consistent with processes used in other federal efforts. The Secretary of HHS should assess the availability of current measures and the need for future measures through consultation with pediatric professional and provider organizations, health care quality organizations, states/connectors, parent consumers, and others. Funds should be provided for the development, testing and evaluation of pediatric measures across the domains of quality.

The federal government has been a leader in promoting quality improvement and measurement through its Medicare program. As the federal government moves forward with measures of quality and performance through Medicare, the infrastructure created should encompass pediatric as well as adult measures.

Comparative effectiveness research (CE)

The federal government should support pediatric comparative effectiveness research. Funds should be used to promote and fund new clinical trials and reviews of existing research to determine the effectiveness of alternative processes for the treatment of children's illnesses and conditions, beginning with chronic illness dissemination of information would help guide medical decision making toward the most appropriate care.

Health Information Technology (HIT)

Funds should provide subsidies to providers to encourage adoption of HIT technology and promote the development of health information exchange networks. HIT systems developed to support quality adult health care cannot simply be applied to children's health care. Funds should support the development of a model pediatric electronic medical record and standards to ensure that any electronic health record system used to care for children includes a level of functionality that will meet the needs of children – reducing the implementation costs of customizing adult-focused systems. Studies have estimated savings from the widespread adoption of HIT.

Appropriate agencies in HHS should work with pediatric providers and stakeholders to develop requirements for the necessary features of an interoperable pediatric-specific HIT system that is commercially available. It is inefficient and highly costly for individual pediatric providers to be forced to customize existing HIT systems designed for adults, as is currently taking place at many children's hospitals.

Funds should also support initiatives, which can demonstrate improvements in the delivery of care, achieve savings, and be widely implemented through collaborative provider networks and pilot projects. For example:

Collaborative Improvement Initiatives

The Alliance for Pediatric Quality – comprised of four national pediatric organizations, bringing together hospitals and physicians – is working to spread proven collaborative improvement initiatives using evidence- and consensus-based quality measures, and benchmarking to bring about immediate, measurable change in the quality of children's health care. In the first phase of their efforts, the Alliance has had significant success, focusing on two priority areas – patient safety and chronic care.

The pediatric intensive care collaborative decreased catheter-associated blood stream infection rates by 70 percent. The collaborative is now in its second phase, encompassing approximately 20-30 percent of all pediatric intensive care units in the country. The improvement collaborative for pediatric inflammatory bowel disease increased compliance with best practices to over 90 percent; and the asthma initiative to improve performance in practice expanded to five new states, bringing quality improvement resources and coaching to primary care settings and state-based coalitions to sustain support. These wide-scale, highly effective efforts require continuing support, much like earlier demonstration projects conducted by Medicare.

Pilot medical home projects

Supported by a grant from the Agency for Healthcare Research and Quality, Community Care North Carolina is demonstrating how medical homes and community-based, physician-led networks can improve care, enhance access and decrease overall costs. The program, which began in 1998, saved the state about $120 million in 2004. North Carolina Medicaid officials have urged their state to increase physician payment fees, which are now at 95 percent of Medicare, and consider adequate physician payment a key to success.

Conclusion

N.A.C.H. firmly believes that health care reform holds the promise of advancing health care for children by providing coverage, improving access to appropriate providers and improving health care quality. Such an improvement can only be accomplished if policy makers focus on the unique aspects of children's health and development and create plans that are designed for children.