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Hearing on Developing a Viable Medicare Physician Payment Policy
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I. Overview

Chairman Brady, Ranking Member McDermott, and Members of the House Ways and Means Health Subcommittee, on behalf of HealthPartners, I am grateful for the invitation to submit the following testimony to the Subcommittee. My organization shares the belief that the replacement of the SGR with a viable Medicare physician payment policy is a critical element of the comprehensive approach to health care reform in the United States. Moreover, we believe that a broad-scale shift from fee-for-service payment to value-based payment is important throughout our health care system. We applaud all efforts to find thoughtful and workable solutions and we are very pleased to be part of the discussion here today.

The reform and repeal proposals released so far have included a phased approach that we think is wise and sequenced properly.

These phases essentially describe the same path we have taken as we have advanced meaningful physician payment reform in Minnesota. HealthPartners has played an integral role in the gradual strengthening of the alignment between physician payment and patient value in Minnesota over the past 20 years.

I will offer some of the details in this testimony. In doing so I hope to support our firm belief that the elements of payment reform in Minnesota are replicable, scalable and can contribute to a model for the rest of the country, including Medicare. And because much of the piloting of this work is complete and tools are established, we suggest that the implementation of these steps could happen much faster than they have in our state.

I speak as a board-certified family physician with 25 years of clinical experience. In my current role as Medical Director for the HealthPartners health plan, I direct a team of medical directors in the development of policy and strategy. For much of my career, I was a partner in an independent clinic practice in the suburban Twin Cities, which became part of the HealthPartners system in 2002.

As both a practicing physician and medical director, with a view of both care delivery and health plan operations, I have been involved in integrated efforts to improve cost and quality of both care and coverage throughout my professional career. I understand the wariness and skepticism that some physicians have about value-based payment because I once shared it. I have come to understand, however, that value-based payment systems – if built thoughtfully and properly – can be not only workable but desirable for physicians and an accelerant of improved health, better experiences and improved affordability for patients.

We assert that the national implementation of such a system is now possible and badly needed. Using our total cost of care and resource use measures (described below) as a foundation for measuring relative performance between groups and for measuring year-over-year trend for a

given group, we have structured a shared-savings payment model that has worked in real-world circumstances. We believe CMS can do the same, and that doing so would provide enormous benefit to Medicare and our nation's health care system.

I wish to thank the Alliance of Community Health Plans for helping to bring our work in this regard to your attention. While my testimony will focus on the HealthPartners organization, the members of the Alliance, spread across the nation, could each tell a story of innovations they support that fit well with the proposals for SGR Repeal and Reform.

II. About HealthPartners

Founded in 1957, HealthPartners is the largest consumer-governed, non-profit health care organization in the nation. We are dedicated to improving the health of our members, patients and the community.

We provide a full-range of health plan services including insurance, administration and health and well-being programs. We serve more than 1.4 million medical and dental health plan members nationwide, and are the top-ranked commercial plan in Minnesota. Our care system includes serves more than a million patients with more than 1,700 physicians; five hospitals; 50 primary care clinics; 21 urgent care locations; and numerous specialty practices in Minnesota and western Wisconsin. Our Dental Group has more than 60 dentists and 21 dental clinics. We also provide medical education and conduct research through our Institute of Education and Research.

Sixty percent of HealthPartners members receive care through our contracted network representing the vast majority of providers in our market.

Our Medicare plan has the highest rating (five stars), achieved by only 11 plans in the nation in 2013. We serve nearly 50,000 Medicare members through our health plan.

III. Aspects of the Minnesota market and diversity of physician practices

As a leading market for value-based payment reform, Minnesota is known for having large, well-known multispecialty groups and non-profit health plans such as our own at HealthPartners. This leads some to the conclusion that meaningful progress in payment reform can only be achieved in markets with similarly structured health care systems.

The Minnesota care market is actually quite diverse, however, with many mid-sized and smaller clinic systems throughout the state's urban and rural areas. Our experience has shown that system size is no barrier to effective participation in a value-based payment system, so long as the system is structured with the needs of these kinds of clinics in mind.

As I consider the idea of value-based physician payment systems, I instinctively view them through the lens of my previous experience as a member of a 13-physician, single-specialty,

private physician practice. Our group operated three clinics in the northern Twin Cities suburbs, accepting insurance coverage from a broad mix of payers including Medicare and Medicaid. Each clinic served a different demographic mix. Our first clinic served a largely white, middle-class population, the second served an exurban and rural population, and the third served a diverse community with a burgeoning population of first-generation Hmong, Somali, Eritrean and Korean immigrants (the Twin Cities has long been a center of refugee resettlement, and Minnesota's foreign-born population growth rate outpaces that of the nation).

In the late 1980s and early 1990s, my group was surrounded by the first-wave of practices being acquired by larger groups. We recognized that it was critical to our business to be able to demonstrate that our quality was equal or better than others in the area, regardless of our size, our diverse patient demographics and the differing issues we managed in serving our communities. Our first work was centered on improvement in diabetes quality and outcomes. Using paper-based tools, and with our small size lending some agility, we began to make meaningful progress.

This work was accelerated when we became a member of the Institute for Clinical Systems Improvement, or ICSI. It was founded as a collaborative of 20 different medical groups in our area, established by HealthPartners, the Mayo Clinic and Park Nicollet Health Services, and remains active today on an even larger scale with its membership having comprised most Minnesota physicians for the past decade. HealthPartners has invested approximately \$30 million into the founding and expansion of the group, and other organizations have invested an additional \$25 million. This does not include the investment of time and expertise from the provider community. The goal of the group was to develop shared protocols and best practices, but also to foster the skills necessary within clinic systems to perform the work of quality improvement.

The vital enabling work of ICSI is not unique to Minnesota. Many other regions in the nation have similar collaborative organizations with likeminded missions. ICSI is aligned with the Network for Regional Healthcare Improvement, a national membership organization for regional health improvement collaboratives, whose members support improved healthcare for 40 percent of the U.S. population.

My independent practice joined ICSI as small, primary care practice group, knowing that our results would ultimately be reported publically, and we consistently performed at a higher level than much-larger systems on quality measures. We continue to see smaller practices achieve excellent results with this kind of support. In 2012, for example, a 15-physician practice in suburban Minneapolis, Northwest Family Physicians (also an ICSI member), achieved the overall highest cost and quality rating of the 18 Twin Cities-area primary care physician groups participating in our health plan network.

IV. Building blocks: Support the shift from volume to value

Over the past 20 years, HealthPartners has implemented a series of initiatives, independently or in partnership with other organizations, to encourage the steady evolution to performance- and

value-based payment. Early on, we used the tools we had available to us at the time, and we have since adopted new tools and methods as our approach has matured. Fee-for-service payment still accounts for the majority of our payment to providers, but its proportion is shrinking as a share of payment thanks to the adoption of these measures and the introduction of shared savings contracts based on the total cost of care methodology. In the early phases of these changes, providers have an inherent downside risk as they make investments to improve their ability to manage based on these new objectives. If they have made changes to staffing to manage patients more closely and do not earn the shared savings, that investment could be seen as lost revenue. Even so, as the payment model evolves, direct downside risk has become a part of our agreements.

We provide several examples of tools we have used to support this transition below.

a. Bonus payments for practice improvement

Since 1997, the HealthPartners Partners in Excellence program has provided financial bonuses and public recognition for medical or specialty groups achieving stretch targets for performance on clinical quality, patient experience, and affordability. Financial rewards are based on medical or specialty group performance as measured by Minnesota Community Measurement, the HealthPartners Clinical Indicator measurement set, and the HealthPartners Consumer Choice satisfaction survey.

b. Grants

In addition to bonuses, we also have provided direct grants to provider groups to encourage operational changes and development of necessary infrastructure to make value-based incentives possible. We have found, in general, that providing grant money upfront is more successful than withholds or fees after the fact in this transitional period. It also allows us to direct revenues to providers without creating a new category of fee-for-service payment at a time when we are working to move steadily away from that model. We do not see this as a long-term strategy.

c. Withholds

Beginning in 2001, HealthPartners introduced payment withholds with incentives for meeting cost, quality and total cost of care targets. As our approach was originally structured, providers earned this withhold back based on negotiated focus areas and reasonable but meaningful targets for performance on quality or focus on the development of quality improvement building blocks.

Some of the topics over time have included:

- Payment for progress on quality measures with the greatest room for improvement
- Paying for chronic illness management and coordination; rather than for sickness only
- Encouraging use of and paying for use of online technology and supportive care; rather than only in-person, exam-room care.
- Gathering patient-reported race and ethnicity data to give clinics a way to judge their own performance on health care disparities

In recent years, this withhold has become a mechanism for adding downside risk to shared savings agreements. While withholds are still in place, they have become a less prominent part of our approach as other, more powerful tools have become available to us, including more aggressive shared savings targets.

d. Investments in community collaborations

As noted in the above example of ICSI, we are strong supporters of community partnerships that lead to sharing of data, best practices and common systems of measurement.

e. Establishment and shared use of publicly reported cost measures

For more than a decade, HealthPartners has used the Total Cost Index (TCI) to assess cost and efficiency differences among primary care groups, specialty groups and hospitals. A provider's TCI is a measure of efficiency, intensity and price of care delivered compared to the average for similar providers. "Total cost" includes all care, such as lab tests, x-rays and care from specialist physicians and hospitals. Ratings are calculated using claims data submitted by medical groups and hospitals that show diagnosis and treatment for HealthPartners members. Ratings are then displayed on a scale of 1 to 4 dollar signs, with one dollar sign indicating lowest total cost of care. Compared to their peers, lower-cost providers are more efficient in diagnosing and treating conditions, charge a lower fee for delivering care, or both.

f. Establishment and shared use of quality and patient experience measures

HealthPartners quality assessment ratings are based on clinical quality as well as patient experience surveys, in which members rate quality of care and service. HealthPartners collects clinical quality measures across our regional network and also draws upon reputable third-party sources, such as Minnesota Community Measurement (described below), that collect, analyze, and publicly report measures of clinical quality. These measures are based on standards established by organizations such as the National Quality Forum and the Institute for Clinical Systems Improvement, as well as measures developed by Minnesota Community Measurement.

g. Supporting region-wide uniformity in reporting

HealthPartners works closely with Minnesota Community Measurement (MNCM.org), which is a nonprofit organization established in 2000 and dedicated to improving the quality of health care in Minnesota by publicly reporting quality results. Founded by Minnesota's health plans and the Minnesota Medical Association, it has helped to pioneer collaborative health care reporting in the state. It involves a multi-stakeholder process and an extensive set of measures, some of which are nationally endorsed by the National Quality Forum. Medicare has also adopted some MNCM-developed measures for national reporting initiatives. By submitting data to a secure, direct data submission portal, local medical groups are able to participate in pay-for-performance programs based on their full population of patients. All health plans in Minnesota rely on MNCM as the foundation of quality-based incentives.

Minnesota Community Measurement measures include clinical quality measures reported at the clinic and medical group level as well as at hospitals. There is also a cost of care comparison page for over 100 common procedures. In December 2012, Minnesota Community Measurement selected the HealthPartners Total Cost of Care measure (described below) as the standard it will use to represent relative cost performance across all reported groups.

Minnesota Community Measurement issues clinical quality reports in 15 different clinical areas including a five-component diabetes measure, four-component vascular disease measure, asthma, depression, colorectal cancer and other preventive screens, among others. There are also patient satisfaction and health information technology measures. Where appropriate, as with asthma, specialty clinics are included in the measures. New specialty measures are under development to expand the scope beyond the primary care-dominated portfolio of measures now in use.

As a part of the process for selecting the Total Cost of Care Measure, Minnesota Community Measurement came to agreement on a patient attribution model it will use. It is important to note that all of this work results from a collaborative involving providers and payers.

An expectation of the members of the collaborative is that, wherever possible, health plans will use these measures as the source of performance results when crafting quality improvement or incentive programs. HealthPartners and the other plans in our market have done well in meeting that expectation.

One example of aligned and transparent reporting of clinical quality supported by incentives is the comprehensive diabetes measure. To get credit for this measure, a patient needs to be at target for Hemoglobin A1c (blood sugar control), high blood pressure, LDL cholesterol, being tobacco free, and taking aspirin when appropriate. When first reported a little over a decade ago, the community average for this measure was 7-8 percent. In the most recent reporting year, that average is now 40 percent with one of the top performers at 60 percent (a family medicine clinic). In fact, a solo family physician scored 59 percent, and a rural community clinic scored 58 percent. All of the health plans in this market have used improvement on this measure as a part of their quality incentive programs.

V. Associated benefits

In addition to enabling value-based payment systems, the incorporation of the systems and initiatives listed above has enabled a wide range of desirable, associated benefits within our community including reductions in preventable hospital admissions/readmissions, reduced non-urgent emergency room visits, reduced unnecessary lab testing, reduced use of higher-cost drugs when generics are available, avoidance of care in higher-cost settings when another venue is available, and price increases.

At the same time they have helped us track and improve preventive care, provide coordinated care for patients with chronic/complex conditions, practice evidence-based care, reduce healthcare disparities in our community, and reduce waste.

I will cite one specific example. About 10 years ago, our data indicated that our health plan members were showing increased utilization of hi-tech diagnostic imaging, which can be costly, sometimes unsafe, and can lead to further unnecessary care. Faced with the implementation of radiology benefit management programs by all health plans in our market, providers worked to create a decision support tool in our EHR supporting evidence-based use of MRI and CT scans.

Then, called to do so by providers and in collaboration through ICSI, we shared this decision tool with other groups in our market that use the same EHR, and all major health plans in our market agreed to accept use of it in place of prior authorization.

Through this, we estimate that our community has avoided 75,000 unnecessary scans with the associated savings of tens of millions of dollars, seen the saving of an estimated 20 lives from reduced exposure to medical radiation, and reduced prior authorization times from 10 minutes to seconds – all while providing a better patient experience.

VI. A breakthrough enabling step: Nationally endorsed, freely-available standardized measures for total cost of care and resource use

Total Cost of Care, or TCOC, is a name for a method of measuring health care affordability. TCOC measures are powerful analytical tools for health plans, providers, medical groups, government agencies, employers and others with a stake in reducing health care cost trends. They can help pinpoint ways to make health care more affordable without sacrificing quality or experience. Over eighty percent of HealthPartners health plan claims originate from care systems with which we have total cost of care agreements in place.

Many organizations have experimented with TCOC models in recent years. HealthPartners has developed a TCOC model that is unique in a significant way. In addition to consideration of cost of care provided to a patient (or “Total Cost Index”), it also incorporates an innovative approach to measuring resources used in providing that care (or “Total Resource Use Index”). When used in combination, these measures yield more comprehensive, revealing and actionable results than cost measures alone.

Until recently, there has not been a nationally accepted, standardized TCOC measure endorsed by a major standards-setting body. This was the impetus, in January 2011, for the inaugural call for national voluntary consensus standards for TCOC measures by The National Quality Forum (NQF), which represents health care stakeholders including consumer organizations, health plans, health professionals, providers, public and community health agencies, public and private purchasers, health care research and improvement organizations supporting industry. NQF’s unique structure enables private- and public-sector stakeholders to work together to craft and implement solutions to drive continuous quality improvement in the American healthcare system.

The NQF review measured four key factors: 1) evidence of the importance and relevance of the measures, 2) whether the measures deliver consistent and credible results, 3) usability and 4)

feasibility of implementation. Following review by a dedicated 21-person steering committee, member and public comment, and a member vote, the NQF Board of Directors on Jan. 31, 2012, announced the organization's first-ever endorsement of a full-population TCOC measurement approach.

As NQF-endorsed standards, the HealthPartners Total Cost of Care and Resource Use measures complement existing quality measures to provide a much-needed, common reference point supporting the development of accountable care organizations (ACOs) and payment reform models. Providers, insurers, government agencies, employers, consumers and other organizations can use the measures to manage costs, drive affordability and improve delivery of healthcare.

For example, the measures allow employers and consumers to compare healthcare providers based on value and cost over time. Providers can use the measures to better understand and manage cost drivers within their systems. Health plans can use them to drive development of new payment approaches and benefit designs while improving transparency of provider performance reporting. Using the measures, HealthPartners has outperformed Minnesota, regional and national risk-adjusted cost of care benchmarks for three straight years.

HealthPartners has publicly released a depth of information about the Total Cost of Care and Total Resource Use measurement approach into the public domain at no charge, such that others can use the same measurement approach within their own organizations. This release includes guidance on using the measures, technical guidelines, detailed scientific background, reference guides and sample applications.

Multiple organizations around the country, such as Priority Health in Michigan, have taken advantage of the free license to use the TCOC measure to begin to introduce the tool in their market. In addition, Dartmouth, working with us, is using the measure on a national commercial claims database in an effort to produce a Dartmouth Atlas of health care cost and resource use similar to the one they have produced using Medicare claims data.

VII. Total Cost of Care as a foundation for value based payment and cost transparency

As noted above, the Total Cost of Care measure is the foundation of payment reform HealthPartners began four years ago. Using Total Cost of Care as the measure of cost performance, we negotiated agreements with providers that included shared savings evenly divided for groups that had costs better than projected trend targets. To ensure continued quality, groups are not eligible for the shared savings payments if quality performance measures slip. As of this year, over 80 percent of our health plan members go to clinics operating under a shared savings agreement. The newest of these contracts have introduced downside risk from the chance of losing withhold dollars if groups fail to meet target performance levels on cost.

Our partnership with providers in these shared savings contracts means it is in our mutual interest for them to perform well in these agreements. Using the Total Cost of Care measures as the foundation, we bring timely information on cost performance in a series of reports highlighting areas of opportunity for reduced resource use. We can also highlight where

providers are using high-cost referral partners that are hurting their performance, which has led some to change referral patterns and others to discuss problems of high cost with their referral partners. These reports come to the providers showing data no more than five months old. Combining this broad view of cost and resource use by patients within and outside their system with the more timely information available in their EHR, provider groups have begun to make targeted changes that have impact.

We also use the Total Cost of Care measures as the source for our reporting of cost to our members. That is the best way to ensure that the results we show them are based on results providers use to make management decisions. Employer reporting, as well, is based on Total Cost of Care data, driving a consistent source for consistent views across all the stakeholders we serve.

It is important to recognize that shared savings agreements are inherently transitional. As the best performers begin to come up against the limits of effective and efficient care for their patients, they will have less shared savings opportunity. We are in the early stages of developing newer models that continue to make the most effective and efficient care the most successful model for the financial performance of care systems.

There is another important point in this discussion. We have made these reforms on a foundation of fee for service payment, which still accounts for the majority of revenue that flows to providers. This has served as a way to use a familiar-though-flawed transactional framework while beginning to build the skills necessary to perform in newer models.

VIII. Summary

HealthPartners supports the goals of the Proposal and we applaud the bi-partisan congressional efforts to shift Medicare physician payment policies away from fee-for-service and toward payment that rewards performance, quality and value. In summary:

1) The Minnesota payment reform example is strong, but the solution is not Minnesota-specific.

Although the above list of tools available in our market will not necessarily be the same as those available in other markets, we do believe these and others are available, or can develop, in any market. We know other markets have unique challenges and unique strengths, but no market is incapable of making progress on this type of reform. It took us twenty years to get to this point, and we believe lessons learned here and elsewhere can significantly compress the timeline for making progress across the country.

2) The building blocks are available and present the chance to move ahead on a reasonable (3-5 year) timeline.

There are now ample, real-world examples that performance-based physician payment systems can work and work well. Of particular and timely import are the total cost of care and resources

measures newly endorsed by the National Quality Forum and available in the public domain, free of charge.

3) The potential opportunity is enormous.

The adoption of value-based payment policies by CMS would leverage one of the nation's most significant opportunities for assuring continued attention to high-quality care in measureable terms while grappling with the clear national concern about the cost of care. Because of Medicare's prominence as the single largest payer in the nation, fixing the SGR could become a powerful force in aligning incentives in a way that is consistent with the work already underway in the commercial market.

On behalf of HealthPartners, I again thank the Members of the Subcommittee for the opportunity to present this perspective. We look forward to continuing to support and assist in this important work in the months and years ahead.