



February 6, 2012

## Written Statement to the Health Subcommittee of the House of Representatives Ways and Means Committee, as requested by subcommittee Chairman Wally Herger

Thank you, Chairman Herger, Congressman Stark, and Members of the Subcommittee for this invitation to testify on programs that reward physicians who deliver high quality and efficient care.

### Section 1. Background on John L Bender, Miramont Family Medicine, and NCQA

I, **John L. Bender, M.D., FAAFP** am a board-certified family medicine physician, a Fellow of the American Academy of Family Physicians, and the senior partner at Miramont Family Medicine based in Fort Collins, Colorado.

**Miramont Family Medicine** [www.miramont.us](http://www.miramont.us) is a network of four **Patient Centered Medical Homes** in northern Colorado delivering full spectrum primary care services in suburban and rural communities. Since 2002, Miramont has grown from one physician, one employee, and one computer in one location to 14 providers, 50 employees, 4 locations and over 80 computer workstations networked through an integrated data center, serving over 27,000 patients.

In 2008 Miramont received **NCQA** level III recognition for its Patient Centered Medical Home model and in 2010 won a national HiMSS Nicholas E. Davies Award of Excellence for outstanding achievement in the implementation and value from health information technology. In 2011, The Colorado Academy of Family Physicians Foundation named Miramont the Patient Centered Medical Home of the Year.

The **National Committee for Quality Assurance** is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality founded in 1990. The process for achieving NCQA level III required Miramont to devote significant time and capital investment in 2008, including the extensive documentation of having met 9 separate Standards each broken down into numerous separate Elements graded on a point system with a 100 total possible points. The Standards for being an NCQA recognized Patient Centered Medical Home at the time included such domains as patient tracking and database registry functionality, care management, patient self-management support, electronic prescribing, test tracking, and performance reporting of various evidence-based health care metrics (see attachment 1).

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## **Section 2. Background on the Multi-Payer Patient Centered Medical Home Pilot study.**

Interest by the private sector in the Patient Centered Medical Home delivery model began to grow at the beginning of the decade. As early as 2000, **Dr Paul Grundy, IBM Corporation's Global Director for IBM Healthcare Transformation**, recognized that the ongoing costs of health care for IBM's employees, including the legacy costs to its retirees, were the key driver to labor cost differentials between IBM's less competitive work force in the United States and its workforce abroad. Dr Grundy became a champion of the Patient Centered Medical Home at that time, and my information that follows is from personal conversations with him and attendance at speeches he gave. He realized that the cost of health care delivery to IBM's US workforce was close to \$8,000 per person per year, nearly double what IBM was incurring in health care costs for developing nations and other nations abroad where it employed labor. At the same time, the World Health Organization was releasing data suggesting that the United States was only 37<sup>th</sup> in the world for important health care outcomes such as neonatal mortality and longevity. Dr Grundy used the health care purchasing power of IBM to compel a group of five large national commercial health insurers, (WellPoint/Anthem/Blue Cross Blue Shield, United Health Group, Humana, Cigna, and Aetna) to agree to test the Patient Centered Medical Home model in two statewide pilots. Dr Grundy believed that the profound erosion of the primary care workforce in America was the key driver to escalating costs confounded by poorer quality. He was also influenced by the work of **Barbara Starfield, MD, MPH, Distinguished Professor at John Hopkins University Schools of Public Health and Medicine**, whose landmark studies demonstrated the cost containment abilities of properly designed primary care delivery systems.

The commercial health insurers agreed to participate in short term multi-payer pilots in two states, Colorado and Ohio (chosen as IBM has larger concentrations of employees here). Colorado's pilot launched first, convened under the title of **The Colorado Multi-Payer Patient Centered Medical Home Pilot project**. The convening organization, the Colorado Clinical Guidelines Collaborative (now known as **HealthTeamWorks** [www.healthteamworks.org](http://www.healthteamworks.org)), functioned as an alliance of employers, primary care physicians and commercial payers. The Collaborative reached an accord for incentives and payment structuring early on, and then followed the formula recommended by Dr Grundy, that is the three-legged model of Fee for Service (FFS), Per Member Per Month Fees (PMPM) and Pay for Performance (P4P).

**Fee For Service** was retained in deference to the understanding that volumes in primary care were lacking, and volumes incentives were needed to keep consumers out of high cost centers such as Emergency Departments by motivating Patient Centered Medical Homes to develop capacity to see these patients. **Per Member Per Month** fees were necessary to pay for the infrastructure needed in the Patient Centered Medical Home to deliver what is otherwise non—revenue generating activity, such as information technology (IT) enhancements like online patient portals that allow

consumers to access their own health information outside the physician's office, and care coordinators who could work deficiency lists and individually coordinate care with patients to get them to goal without a physician visit. **Pay For Performance** (P4P) payments were made to incentivize the PCMH to not only track and report metrics to a centralized registry, but to ensure motivation to improve quality over time. The self-reported data was chosen over historical claims data, which is fraught with error, yet prior to the pilot was the standard for commercial payers to rate physicians nationally. The payers agreed to let the PCMH pilots collect and report their own data, and over time the pilots learned workflow redesign that produced steady improvement in practice metrics. The metrics were tabulated monthly, then reported back to the practice alongside the other pilot practices, giving the PCMH feedback not only about their own progress, but peer comparison data. Higher performers were then allowed to share success strategies through a number of forums including quarterly collaboratives, where the payers, employers and PCMH representatives could meet face to face for a day or two to exchange information, and also bimonthly telephone conference calls. Finally, HealthTeamWorks used grant funding to provide onsite coaches who would meet weekly with staff onsite at the PCMH clinic to teach and develop workflow redesign strategies. These included implementing Toyota Production Model and PDSA (plan, do, study, act) type innovations as used in other industries. The shared activities between PCMH competitors were always conducted in accordance with Federal Trade Commission anti-trust rules, meaning there was no price fixing, etc. among suppliers, but rather only academic exchanges focused on quality rather than profits. Even the exact amounts paid as PMPM and P4P were kept confidential between the various PCMH pilots, and all contracts were awarded by individual Taxpayer Identification Number (TIN) by the commercial payers. There was never collective negotiating of rates by the physicians.

Over time, the pilots were able to demonstrate improvements in safety and efficiency as well as improved patient outcomes for various metrics, especially chronic disease management such as diabetes and heart/stroke patients. But what really made the Colorado pilot a success was its ability to demonstrate significant cost controls during the same two year period. This data, released privately by the payers to the pilots, now appears to have influenced the commercial payers in the way Dr Grundy and Dr Starfield envisioned. First, was the announcement that the payers would agree to extend the Colorado pilot rather than terminate it April 2012, as originally constructed. Second, was the national announcement by WellPoint, as reported in the Wall Street Journal, Friday January 27<sup>th</sup>, 2012, that "it will offer primary-care doctors a fee increase of around 10%, with the possibility of additional payments that could boost what they get for treating the patients it covers by as much as 50%". Aetna also committed in the same article to roll out payments later this year to primary care physicians who become certified as Patient Centered Medical Homes, both payers evidently influenced by the results of the Colorado pilot (attachment 2).

### **Section 3. Miramont Family Medicine - A case study of Workflow Redesign and Practice transformation in the Patient Centered Medical Home model.**

In 2002, Teresa and John Bender returned to Larimer County Colorado and purchased one of the oldest Family Medicine practices in Fort Collins. The selling sole proprietor, HG Carlson MD and his wife Jean, had run the practice much as they had since the 1970's. They had one additional employee who served as medical assistant, had several thousand paper charts but fewer and fewer active patients, and a single 386 IBM computer used only for billing purposes. John and Teresa found themselves offering a poor product in the health care marketplace. Problems included test results with slow turnaround times, high labor costs with much non-revenue generating activity and waste, no open appointments with little ability to respond to elasticity in demand, no clinical data management, barely any financial data management, high variability in patient experiences from day to day, illegible documentation, and a growing inability to compete with retail clinics, urgent care, emergency departments, etc.

Over the next 10 years, 34 primary care physicians would abandon providing primary care services in Larimer County, 8 of these being actual bankruptcies. During this same time the number of Emergency Department beds in Larimer County would double, and the number of Emergency Room physicians increased by 50%. Further economic pressures in the last two years would compel 169 physicians to abandon private practice and become part of a brand new hospital medical group, created by the local hospital system as their ACO health care delivery strategy that would rely on employed physicians, not independent physician groups.

Yet over the last 10 years, Miramont was able to grow at a rate of 30-34% per year, doubling in size every two years, to four locations in three separate communities with expanded hours including evenings and weekends, labor expansions to fourteen providers (8 physicians, 5 physician assistants, 1 nurse practitioner), fifty total employees, electronic charting, an online Patient Portal, NCQA III PCMH recognition, over 80 company computers operating in a terminal service environment with a centralized data center and 27,000 patients. Because Miramont produced growth while at the same time improving quality, efficiency and outcomes, the **Healthcare Information and Management Systems Society (HiMSS)** bestowed on Miramont a Nicholas E. Davies Award of Excellence for outstanding achievement in the implementation and value from health information technology in 2010.

The obvious question is how did Miramont achieve a rate of growth to be named the fourth fastest growing company in Northern Colorado in 2008 and 2010, while in the same economy virtually no other primary care physician group saw growth in Larimer County other than the hospital owned enterprises?

Miramont started with a leadership and a courage proposition. The leadership proposition was that the physician partners would focus their energies on new models of health care delivery, positioning themselves in the local economy as the choice that offered the most convenience and the highest value in the marketplace. Second, Miramont would function as a true business, not to "profiteer" off of our patients, but in recognizing that if we became the 35<sup>th</sup> office to shutter our doors or the 9<sup>th</sup> primary care physician to bankrupt in Larimer County, that we would not be able to truly meet our most important duty to our patients, which is the value of a long

term sustainable relationship with a family physician they trust. To do so, took courage, because it meant taking on risk and, taking on debt in the form of capital leases to build an expensive IT infrastructure from scratch while still initially operating in a cottage industry nearing the end of its product life cycle. At the time, there were no guarantees of Meaningful Use dollars, as the HITEC Act was not yet even signed.

In 2007 as I gave my inaugural speech as the incoming President of the Colorado Academy of Family Physicians, I compared the scenario to the restaurant business. At the Stanley Hotel in Estes Park, I told a group of 150 physicians, that like Paul Grundy who had likened the product he was buying as “garbage” that we in family medicine were analogous to a restaurant with “bad food”. “What are you doing differently today in 2007 than was being done in your office in 1970?” I then asked them to imagine that if we were in the restaurant business, that we could not just raise the prices on our bad food to generate the investment capital to purchase new cooking equipment or to recruit a fancy Chef from out of state.

Miramont decided it would take money to make money and that the process starts with investing. We pledged that we would make Miramont safer, more efficient, and up to date and we would ensure our own profitability at all times in order that we could be there for our patients for many years to come. We would eliminate as much as possible non-revenue generating activity up until a time that the PCMH model would pay for us to do so. We would find ways to provide needed services in our house, in the free market health care system that we are given. We would find the best Electronic Health Record (EHR) and attain NCQA recognition for a Patient Centered Medical Home. We would build the best product we could in the marketplace such that consumers would choose us regardless of payer source. We would build systems of care that could survive and be profitable regardless of the uncertainty of new health care reform regulations at the state and national level, regardless of SGR threats, because those were not things we could control anyway.

In order to bring about workflow redesign, Miramont pursued multiple quality improvement resources. The first was to apply for and be accepted into the Colorado Multi-Payer Pilot project. Many more physician practices applied to the Colorado Clinical Guidelines Collaborative than there were seats available, but because Miramont had started on the NCQA journey one year earlier, we found ourselves properly positioned to be selected. In May of 2008 we achieved 96 of 100 possible NCQA recognition points and were awarded the highest level of PCMH recognition, level III, by NCQA. We adapted the full tenants of the Patient Centered Medical Home model, including team based approach to care, pre-visit planning (team huddles), registry reporting and review, and after-visit care coordination and test tracking. The work flow redesign was not easy. Some staff were not comfortable with computers, and resigned or were terminated after failing in house training programs. Physicians who did not adopt the new workflows had to be encouraged or later financially curtailed if metrics failed to improve, or if new workflows were not adopted. Customer satisfaction waned at times, as the new workflows oftentimes came with learning curves that initially interfered with wait times. Customers also would at times simply resent the change, especially if they were long term patients. Over time the culture change has led to proper expectation from

staff and patients about what digital medical records mean, and how best to use the technology to achieve goals. More and more customers and staff are now enamored with the progress that has become Miramont, rather than be wearied by the constant change.

**Section 4. Miramont Family Medicine – two years of metrics prove better patient outcomes and the ability to deflect the health care cost curve down.**

Attachment 3 is a sample of the monthly reports that Miramont creates and reports to HealthTeamWorks. There are 364 diabetic patients cared for as Miramont patients as of December 2011, only some of whom were seen in clinic or the hospital that month. In the third table, one can see that Miramont initially was only able to prove that a little over 40% of its diabetic patients had a current A1C laboratory test on file. Over time the metric improved to the target threshold of over 85%. Improving the metric required Miramont to manage population health, which in paper records was nearly impossible. By leveraging the ability to produce and monitor metrics over time, Miramont developed innovative strategies of its own such as adding in-house A1C testing, as well as adapting innovative recommendations from the consensus of other physicians participating in the PCMH pilot, like having standing orders whereby the medical assistant could order the A1C test under physician license as a part of an “order set” if a computer alert notified the medical assistant at check in that the patient was overdue for testing.

Workflow redesign also led Miramont to deploy a medical assistant checklist (Attachment 4). The checklist is color coded, so that if one of the items in red is missed, it can lead to an adverse patient outcome such as hospitalization or death. Blue coloring indicates that skipping the step will lead to inefficiencies later in the day. Green color coding indicates that recording the step is necessary for meeting quality standards that are paid for under the PCMH pilot program. The checklist was developed over a period of a couple of years. If a potentially avoidable poor patient outcome occurred, such as hospitalization or death, a workgroup would discuss the issue, and the checklist would then be revised to include additional or modified steps to help prevent a recurrence, much like an airline pilot would revise a checklist based on feedback from the National Transportation Safety Board.

Global cost reduction data was provided back to the PCMH pilots from the commercial payers in a manner previously unknown to the individual physicians. Although the “claims data silo” enabled some primary care physicians to know whether they cost a payer more, claims data did not disclose global patient care costs, nor could it tell if the extra medical losses a payer incurred by a specific PCMH translated to positive return on investment (ROI) for the global costs of care, especially in the form of decreased hospital or specialist utilization. The new global reports allowed for such analysis.

Attachment 5 is an example of a pilot composite report. By sharing data between groups, individual physicians and practices could be motivated more fully to improve weak metrics and sustain strong ones. Initially groups were hesitant to share data, citing concerns of how it might be portrayed or

even published. Other concerns included Federal Trade Commission violations for pooling and sharing data that might be perceived as collusion. Over time these fears were overcome, and the reality of having actual grades that the PCMH could review themselves and act upon translated into real improvements in quality for health care delivery at the local level.

Global costs for 523 Medicaid patients attributed to Miramont from Sept 2010 to Aug 2011 were provided to Miramont by the Colorado State Medicaid program. In Attachment 6, the total Global costs for the 523 beneficiaries was \$6,084,478 or \$11,633 per person, which is higher than the national average for all citizens, but less than the average for Medicaid beneficiaries. Note that ER utilization for Miramont patients was 178 total visits for the cohort, which is roughly 340 visits per 1,000 Medicaid beneficiaries. In comparison this is 219% below the state average for Medicaid (figure provided by Treo Analytics).

Attachment 7 demonstrates that the average Clinical Risk Grouping (CRG) for Miramont is around 1.4, meaning that despite the fact that Miramont patients are sicker than average, they cost the system less, and have better outcomes. In other words, Miramont's better numbers are not merely from having healthier patients, in fact Miramont appears to attract and retain sicker patients, but Miramont is able to create more health value for this same group over time compared with their peers.

Additional data from United Health Group shown privately to Miramont revealed that for the United Health Care beneficiaries attributed to Miramont, Miramont provided an 83% reduction in hospital readmission rates. Although relative data such as this was provided from time to time by the commercial payers to the pilots, it was generally done so as a slide presentation or some other method to prevent the data from being recorded or externally reported, in part out of the necessity of the commercial health insurer to maintain trade secret status. In general, the data showed Miramont that it decreased Emergency Room and Urgent Care utilization, reduced readmission rates, reduced global costs of care, and improved metrics over time. Individual commercial insurers would need to be contacted separately to provide this testimony to the subcommittee.

### **Section 5 – Rural Health Care sustainability - scalability**

In 2008, a regional hospital system lost over \$500,000 in one year maintaining a small clinic in the rural community of Wellington Colorado. The clinic was closed without almost any notice, and attempts to garner support for a replacement clinic from other multibillion dollar hospital health care systems in the region failed. No plans were forthcoming for state or Federal deployment of a community health center of Federally Qualified Health Center (FQHC). Within 48 hours of the clinics closing, however, Miramont was able as a small private sector enterprise to open a clinic just blocks from the old facility. Utilizing the workflow changes it was developing in the pilot, and scaling the technology of its centralized data center, within the first year the clinic was profitable, and by the end of year two construction was completed on a Small Business Administration (SBA) financed building complete with in-house laboratory, X-ray and drive through pharmacy. Patient centered services included a visiting Psychologist, Physical Therapist and Audiologist, as well as the addition of a

visiting Pediatrician and Obstetrician-Gynecologist. The clinic serves nearly 40% of the community's residents, and represents the only medical services within a 40 minute round trip drive to the community. Like all Miramont locations, it serves new Medicare and new Medicaid patients, and participates in the reporting of metrics to the PCMH Multi-payer Pilot Program. Miramont Wellington has one full time physician, and two physician assistants.

## **Section 6- Summary**

In summary, the process of NCQA recognition and workflow redesign coaching made it possible for Miramont to develop the foundation necessary to improve safety, efficiency, patient outcomes and profitability in the ambulatory care environment. Other benefits of workflow process improvement included a successful Meaningful Use implementation strategy and recognition by the Office of the National Coordinator and HiMSS. Improved clinical quality flowed from measuring population health at the primary care level, and by reporting these metrics to commercial and government payers via a central registry. **This created a business case for continuous quality improvement in the ambulatory care environment that only worked by virtue of being coupled with Patient Centered Medical Home payment reforms such as Per Member Per Month fees and Pay for Performance bonuses, as well as adequate Fee For Service payment to Primary Care. Cost reductions more than offset the increased payments to the individual PCMHs, and private sector health insurance now publically recognizes the value of contracting with PCMHs for health care delivery. Return on investment (ROI) appears to be immediate, within 1 to 2 years, and the workflow changes demonstrated in the pilot are scalable to urban, suburban and rural areas, with practice transformation consistently possible in under 2 years.**

I call on the Health Subcommittee of the Ways and Means Committee of the United States House of Representatives to compel the Department of Health and Human Services to deploy the Patient Centered Medical Home payment model at the national level immediately in the broad interest of conserving our primary care workforce, improving the quality of health care for entitlement program beneficiaries, and reversing the burden of rising health care cost expenditures on the American taxpayer with a system that is proven and is already being adapted in the private sector.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read 'JLB' followed by a stylized flourish and the year '1970'.

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