

*****THIS TESTIMONY IS EMBARGOED UNTIL 10:00 AM,
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**Programs that Reward Physicians
that Deliver High Quality and Efficient Care**

Statement of

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Chairman Herger, ranking Member Stark, other distinguished members of the Committee and Sub-Committee, it is an honor and a privilege to join this panel today and offer my thoughts as you consider different types of incentive realignments within our health care delivery system. My name is Len M. Nichols. I am a health economist, Professor of Health Policy, and Director of the Center for Health Policy Research and Ethics in the College of Health and Human Services at George Mason University in Fairfax, Virginia. My other affiliations relevant to the subject of today's hearing include: Editor-in-Chief of the online Payment Innovation Community, a project jointly sponsored by the American College of Cardiology and the American Journal of Managed Care¹; Board member of the National Committee on Quality Assurance,² Academy Health,³ and the Arkansas Center for Health Improvement;⁴ member of the National Committee on Vital Health Statistics;⁵ and recently I was selected, along with 72 other health professionals from around the country (out of 920 applicants), to be an Innovation Advisor to the Center for Medicare and Medicaid Innovation.⁶ I do want to make crystal clear at the outset, however, my written testimony and spoken views are mine and mine alone and that I do not speak for any organization, public or private, nor for any other person, living or dead.

I am certain there is no need to belabor my first point on this subject for this Committee: we simply must lower health care cost growth to ensure continued access to high quality care for all Americans, including the currently insured and the (hopefully) soon-to-be insured. And while the sense of urgency is great in any student of our health care system or our economy, I want to tell you why I am more optimistic today about our chances than at any time in the past 20 years: health care stakeholders around the country are responding to the incentive realignment signals in the Patient Protection and Affordable Care Act (ACA) and stepping up to the plate to device

¹<http://paymentinnovations.cardiosource.org>

²<http://www.ncqa.org>

³<http://www.academyhealth.org>

⁴<http://www.achi.net/index.asp>

⁵<http://www.ncvhs.hhs.gov>

⁶<http://innovations.cms.gov/innovation-advisors-program>

private sector initiatives, some of which you just heard about, and public-private partnerships that together are our best hope for improving health, improving care, and lowering cost over time.

Despite our serious budget realities, it is important to not panic, to take stock of initiatives that are working well and to spread them, to improve on those that need some work, and to take note of our successes, including the recent slowdown in Medicare spending growth to only 2.5% per beneficiary from 2009-2010.⁷

Now the contemporaneous slowdown in the private health spending (out of pocket plus private health insurance benefit payments) growth to 2.2% in 2010,⁸ is most likely due to the twin effects of the Great Recession, for millions of newly uninsured cut back on needed services as they lost COBRA coverage, either because they could no longer afford it any longer or because their time limits were reached, and of higher cost-sharing requirements relative to reduced family incomes (overall out-of-pocket spending grew only 1.8%).⁹ This last effect would also explain why insurers like Aetna¹⁰ saw large profit increases from way less than anticipated use by the still insured. But the same “coverage loss/higher-cost sharing” rationale cannot explain the Medicare cost growth reduction.

A number of interpretations have been offered, and it is certainly too early for definitive judgments, but the one I find most compelling is that the Patient Protection and Affordable Care Act (ACA) savings provisions, specifically the reductions in overpayment to Medicare Advantage plans and the reductions in automatic increases to the market basket update factor for hospitals, are working as well or better than the Congressional Budget Office (CBO) expected when it scored them in 2010. This is good news in general, and sets us up for even more success as the payment reform pilots and demos coming out of CMMI and the private sector alike work to transform care and improve patient health and quality even as they lower total cost of care, at least off baseline, for all Americans.¹¹

⁷Martin, Anne B., et al. “Growth in US Health Spending Remained Low in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009,” *Health Affairs* 31 No. 1 (2012):208-219

⁸ Computed from data in Martin et al, *Ibid*.

⁹ Martin et al.

¹⁰ <http://www.foxbusiness.com/industries/2012/02/01/aetna-profit-gets-boost-from-low-claim-costs/>

¹¹ http://www.innovation.cms.gov/documents/pdf/CMMIreport_508.pdf

The urgency of sustaining lower health care cost growth in the face of our demographic challenges is widely accepted, and we are going to need every arrow in the quiver, public sector, private sector, and preferably turbo-charged partnerships among the two. It seems to me we face two broad alternative pathways or “doors” to accomplishing this political, economic and budgetary imperative.

One path entails severely reducing coverage, eligibility and prices paid in public programs¹² or even eliminating the programs altogether.¹³ Presumably this path would also eventually include logically related reductions in the generosity of benefits in the private sector and/or eliminating our current almost \$400B tax expenditure¹⁴ from shielding employer and employee premium contributions from federal taxation. In other words, we could cut our way to fiscal balance, and in so doing reduce access to care for millions of Americans. I fear this pathway would also likely fail to preserve the high value added private sector jobs we need to retain in this country, since hospitals would have no choice but to cost-shift to the private sector, to make up for the public sector underpayment and the growing uninsured population. This would raise private insurance premiums to even more unsustainable levels. In others words, this pathway would likely not even succeed in its narrow goal of balancing public health care budgets, for revenue from a weakening economy would continue to fall.

The alternative pathway is to realign health and health care delivery incentives so thoroughly that we link the self-interest of clinicians, hospitals and all patients with the social interest in cost growth reduction while covering all Americans. Now I admit to a possible conflict of interest here, since incentive realignment across 1/6th of our economy virtually guarantees full employment for health economists and others of our ilk, but I will also state unequivocally and as forcefully as I can, “door number two” is by far the more humane pathway to our shared objective.

To realign incentives with appropriate speed and efficiency, we need new value-based payment systems to be adopted by public and private payers alike. Value, by the way, is increasingly taking on three dimensions: clinical quality, patient experience, and efficiency (or overall

¹² http://cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf

¹³ Volack, Jason M. <http://abcnews.go.com/blogs/politics/2011/12/ron-paul-attacked-for-views-on-health-care>

¹⁴ http://www.ebri.org/pdf/publications/facts/FS-209_Mar10_Bens-Rev-Loss.pdf

resource use). This value construct is also consistent with the new three part aim of CMS and CMMI: better health, better care, and lower cost.

The very good news is there is truly a tremendous amount of ferment across the country on incentive realignment, for most health system stakeholders have come to recognize its importance as the preferred and only real alternative to draconian cuts in access and equity that would result from door #1 above. You've heard about some of that interesting work today from my fellow panelists.

I want to emphasize three points in the remainder of this testimony.

Number 1: While there is a (thankfully) growing recognition that our historical over-reliance on fee-for-service (FFS) payment mechanisms is part of the problem and sometimes creates strong disincentives to improving health and efficiency-enhancing delivery system redesign, FFS payment is also ubiquitous and therefore it cannot be jettisoned wholesale overnight. Indeed, one of the most important tasks for economists, CFOs, practice managers, and clinicians themselves is to develop new business models that will align the self-interest of providers with the social interest in lower cost, better care, and better health. Some new payment models are taking shape and being tested, as you have no doubt heard before and I will describe below, but they are still a long way from being granular and flexible enough to work in the many different contexts of the US health delivery system. And more than likely, we will decide to keep some version of FFS for many and perhaps all providers for at least some patients. Therefore, there is an even more urgent task of developing "transition" business models to enable clinician groups and hospitals to move from FFS alone to better and more sustainable incentive structures and overall quality and efficiency performance without going bankrupt in the bargain. This is a task I and others are now focused on like a laser beam. So stay tuned.

Number 2: The ACA has had a number of salient effects already, in addition to slowing Medicare spending growth. It has signaled to the country that the US Congress has gotten the main point about our health care system; business as usual is over because we cannot afford it, even though we are not now serving all our citizens as well as we should. The Ryan budget, since it included all of the Medicare savings provisions of the ACA, as well as the ensuing and ongoing deficit reduction debate, also contributed to the signal being received throughout our

health care delivery system, but I would argue that the ACA is the major reason behind the private sector incentive realignment efforts that are encouraging us all.

The proof I offer today of the ACA's central role comes from two sources: one, a recent summit conference that America's Health Insurance Plans sponsored on shared accountability, and the other, the growing interest in care innovation initiatives emerging from the CMMI.

In October of Karen Ignangi and colleagues reported the results of a survey of AHIP members that was completed in late summer 2011.¹⁵ At that time there were already 151 patient centered medical home partnerships between physician practices and private health plans, 30 "Accountable care model" arrangements, 16 bundled payment/episode or care partnerships, and 3 full patient-acuity-adjusted global caps, wherein the provider groups bear full or partial financial risk for the care of a defined population and for a specific amount of time.¹⁶ The very organization of her presentation shows how the private sector is mirroring and sprinting ahead with the types of payment reform that CMMI is encouraging pursuant to the ACA: accountable care organizations, primary care transformation, and bundled payment arrangements emphasizing Medicare enrollees. }

The reason I am excited by this dovetailing in model development and payment innovation is that every clinician and clinician manager I have ever met, and I am old enough and have given enough hospital association and medical society keynote addresses to have met quite a few over the years, every single one always expressed a strong preference for one set of incentives from payers, one set of quality metrics, one set of patient acuity adjusters and feedback loops, etc., rather than the byzantine plethora they labor under today. Indeed, without new incentives in place for a majority of patients in a given practice or hospital, it is highly unlikely that care delivery will change from the current focus on volume and uncoordinated care.

And while the ACA may be responsible for the type and scope of interest in payment and delivery reform models being tried now in the 49 states which AHIP reported on, similarly the

¹⁵ <http://www.ahipcoverage.com/2011/10/20/materials-from-ahip%E2%80%99s-summit-on-shared-accountability/>

¹⁶ AHIP updates these counts regularly, for they continue to expand. For more on AHIP's work in this area, see: Higgins, Aparna et al, "Early Lessons from Accountable Care Models in the Private Sector: Partnerships Between Health Plans and Providers," *Health Affairs* 30, No. 9 (2011):1718-27; and "Transforming Care Delivery," *AHIP Issue Brief* January 2012.

spread of these initiatives within the private sector is surely also driving more plans and provider groups to consider the public-private partnerships that CMMI is trying to create around the Comprehensive Primary Care Initiative,¹⁷ the Multi-Payer Advanced Primary Care Practice Demonstration,¹⁸ and through both Pioneer and Advanced Payment ACOs.¹⁹ When providers see the federal government, state government programs, and private payers all focused like a laser beam on reducing costs while better measuring and improving care quality, patient experiences and outcomes, old barrier attitudes like “this fad will go away with the next election,” fade quickly, and suddenly it seems like a very good idea to invest in learning new care coordination techniques and business models.

It is fair to say that many were disappointed with the initial shared savings ACO proposed rule,²⁰ but since then interest in CMMI pilots has been increasing, from 32 full speed Pioneer ACOs to 8 states coordinating large multi-payer collaborations to transform physician practices into patient centered medical homes, 5-7 sets of private plans providing incentives to transform primary care with 75 physician practices each within defined local markets and the as yet unreported but expected (and rumored throughout delivery system circles) very high interest in both the 4 bundled payment models about to be tested and the open ended innovation challenge grants which were just submitted 10 days ago.²¹ Based on what I’m hearing from applicants to that grant opportunity from around the country, interest is very high in this unique opportunity to tell CMMI/CMS what new payment and care delivery arrangements make sense to particulars set of providers, plans, and employers who are indeed willing to pursue the three part aim (better health, better care, lower cost) on the ground in the real world. This is not your father’s “one size fits all” Medicare demo from decades past.

Number 3: Neither public nor private sector payers can remake sustainable incentive structures by themselves. While it has not gotten enough policy attention yet, there is growing awareness

¹⁷ <http://innovation.cms.gov/initiatives/cpci>

¹⁸ <https://www.cms.gov/DemoProjectsEvalRpts/MD/ItemDetail.asp?ItemID=CMS1230016>

¹⁹ <http://innovations.cms.gov/initiatives/aco/pioneer/>; and <http://innovations.cms.gov/initiatives/aco/advance-payment/>

²⁰ <http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2011/May/May-9-2011/Model-ACO-Health-Centers-Skeptical.aspx>

²¹ These initiatives are all described and the counts of participants if underway as of yet are contained in the document referenced in footnote 11.

that a serious problem private insurers face in many markets is local provider market power.²² The best hope for effective incentive realignment in those markets is far more supply-side public payer cooperation, for only Medicare has enough market share to engage some providers in balanced negotiation and only federal antitrust authorities can create appropriately monitored safe harbors to negotiate community-wide incentive arrangements that will achieve the three part aim for all.

At the same time, public sector programs can benefit from increasing their own flexibility to match and support inherently more flexible private sector arrangements. The ACA included long overdue provisions that will finally enable states and communities to acquire and use certain Medicare data alongside what state Medicaid programs, state employee programs, and local private plans may be willing to provide to support common approaches to target delivery and payment reform efforts to the highest value local uses. In addition, discretionary authority that would enable Medicare to piggyback on locally agreed upon private sector incentive arrangements that pursue the three part aim for all patients, providers, and payers would be a very good tool to add to the CMS toolbox. The creativity and focus coming out of and into recent CMMI initiatives, especially the Pioneer ACOs, the CPCI and the Innovation Challenge grants, which are more open ended, provider led and individually tailored than many previous opportunities, are likely to reveal a number of different incentive realignment strategies that may make perfect sense in different parts of the country but not everywhere. As are the private sector initiatives like the ones recently highlighted by AHIP. It would be wise to enable Medicare and the private sector to spread these kinds of innovations in similar if not identical ways, so that more and more clinicians face similar incentives to achieve the three part aim for all patients.

I will close with lessons learned in three of my recent roles. Each has given me a bird's eye view of some of this innovative ferment that spans public and private sectors and that may be useful for you to consider ways to improve the Medicare program while benefitting all Americans.

²² Nichols, Len M. "Making Health Markets Work Better With Targeted Doses of Competition, Regulation, and Collaboration," *St. Louis University Journal of Health Law and Policy* 5(7):7-26; Paul B. Ginsburg, <http://hschange.org/CONTENT/1162/1162.pdf>; Nichols et al, "Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning," *Health Affairs* March/April 2004. *Competition in the Healthcare Marketplace: Hearing Before the Subcomm. on Consumer Prot., Product Safety, and Ins. of the Comm. on Commerce, Science, and Transp.*, 111th Cong. 85-99 (2009) (statement by Len M. Nichols).

First, as Editor in Chief of the new online Community on Payment Innovation,²³ I have learned that good patient registry data can drive awareness and behavior to higher value diagnostic and therapeutic choices by patients and clinicians *together*. And given the general tumult in the health care system, there is considerable interest in new arrangements among and for physicians, ranging from employment by hospitals rather than private practice to direct physician contracting with employer and by-passing health plans altogether. I have also learned, however, that many physicians are simply not aware of key details of the current incentive structures they are paid by today, and therefore it is not surprising they are having a hard time analyzing proposed new models. They have no frame of reference or trusted method of comparison of how they would fare under different scenarios. Therefore much useful teaching, awareness building, and model development must precede wholesale incentive realignment in our country.

Second, as an informal and unpaid advisor to three different communities' applications to the CMMI Innovation Challenge grant initiative, I saw the immense value of having a vision of a true community health system shape the partners that were ultimately recruited to join the efforts. In each case, leadership originated in a different place; a health system agency with a consumer-oriented focus in one case, a local non-profit health plan with a history of collaboration in another, and a forward thinking single specialty group armed with data and commitment in a third. But in each separate case, local employers, hospitals, plans, and of course other clinicians and community voices were recruited (and in two cases, the state Medicaid program), until by the end only Medicare has not yet joined promising local incentive arrangements that are squarely aimed at a sustainable version of the three part aim. The point of the applications and this initiative is to entice Medicare to join the party and others like it.

Third, as a participant in CMMI's new Innovation Advisors Program (IAP), I recently spent 2.5 days in a hotel near Baltimore with 72 of my new best friends. CMMI hopes to deepen our skills in innovation and quality improvement while we bring them new ideas from around the country. Innovation theory and tools are useful and interesting, but the best parts of the meeting were when we talked with each other, sometimes structured sometimes now, about challenges and promising ways to overcome them in different settings and for different types of patients. The very best part was in seeing the energy and talent that is now committed to achieving the

²³ See the link in footnote 6.

three part aim in a wide array of institutions and settings. I would suggest that the IAP is proof there is broad recognition that top down payment and delivery changes will not work, that frontline clinicians and managers and plans and patients all have to work out the details that will work for them where they live and work, and that we need all the tools we can muster, from the public sector, the private sector, the recent reform law, and the God we worship in our own ways, to get this done in time for our health system and our country.

I thank you again for the privilege of offering these thoughts today, and would now be glad to answer any questions my testimony, written or spoken, may spark, today or at your leisure.

