

Testimony of

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**“Legislative Proposals to Promote Electronic Health Records
and a Smarter Health Information System”**

**Hearing by the Subcommittee on Health
Committee on Energy and Commerce**

Thursday, March 16, 2006

Chairman Deal and members of the Health Subcommittee of Energy and Commerce. My name is Ivo Nelson and I lead IBM's Healthcare Business Consulting Services. IBM appreciates the opportunity to testify in support of legislative proposals to promote electronic health records (EHRs) in a smarter health information system.

Today, there is growing consensus that a more intelligent, innovative healthcare system is within reach. Through better use of information technology, experts agree that healthcare quality can be improved and costs restrained, while protecting the privacy of patients and the security of their health data.

The IBM Corporation is fully committed to helping a smarter health information system emerge as a model of 21st century American innovation. We are focusing our software, services and expertise and combination of business and technology experience to support the transformation of healthcare from its fragmented, paper-based current state into a coherent, interconnected system. The objective is to enable the fast and fluid exchange of digital health information, applications and services that will revolutionize all facets of healthcare.

Healthcare is closely aligned with one of the three core values around which IBM organizes and manages our global enterprise: creating "innovation that matters, to the company and the world."

Today, almost everyone agrees that dramatically improving healthcare is the innovation that matters. To that end, IBM is collaborating with other large employers, agencies, providers and standards bodies on a host of efforts to spur the transition to digital healthcare. As a company we are trying to do for healthcare what the ATM system (which IBM helped invent) did to launch a global infrastructure for electronic financial transactions, or what the Internet browser did to catapult the World Wide Web from an academic network into the platform for innovation that it functions as today.

IBM supports legislative provisions that:

- Drive adoption of open standards by the federal government and private industry;
- Commit initial seed funding and make early policy choices that will set the stage for growth of health information exchange; and
- Create incentives in Medicaid and Medicare to reward quality of care, including those that can be measured and rationalized through the use of health information technology (Health IT).

These three areas — open standards, seed funding and policy commitment that catalyze change, and new incentives to reward the quality of healthcare — are the keys we believe, the keys that will open up a smarter information system for healthcare. Not only will this new model of care unlock the value of health information in a networked world, it will help healthcare evolve into a system properly organized around its core constituents—patients—and begin to make costs and quality more transparent to all.

In 2004, the President launched an initiative to make electronic health records (EHRs) available to most Americans within the next 10 years. In 2005, the Senate passed legislative reforms to Medicare reimbursement and Health IT legislation that drives toward these goals. We encourage similar action by your committee and the House in 2006.

Today, I would like to talk about the steps that this committee could take to improve healthcare, first through better use of open technology standards. Where possible, I will use examples of our own conduct and efforts at IBM.

I. Driving Standards Adoption

Achieving the vision of a nationwide health information exchange first requires interoperability: the ability for disparate health information systems to be able to talk to each other and share data in a safe and secure manner. Interoperability and standards are often mistakenly lumped together. Standards are much narrower and specify technical details. Interoperability, on the other hand, is a much broader concept that involves both atechanical and business context.

The success of the Internet itself is overwhelmingly due to the implementation of open standards, protocols, languages and architectures such as HTML, XML, HTTP, PDF and many others. In fact, almost all digital dataflow today depends on an open standard for packets of digital information called IP, or Internet Protocol.

Open standards have been profoundly embraced by most technology companies, as well as governments and the public sector around the world for many years, and for many reasons. Chief among them is that open standards work to ensure compatibility and interoperability that benefits all participants. Broadly speaking, standards have long proven their value in business and society in everything from measurements of weight and size to transformative technologies such as wireless networks.

“Open” standards are those that are freely available to all, and are created by an open decision-making process. In our world of networked information, they speed innovation, integration and collaboration in countless dimensions, including supply chain management, consumer electronics and many forms of communications.

Why is better use of standards so important? In short, better use will facilitate the easier exchange of health information, thereby helping lower costs (e.g. transaction costs), provide better information to physicians and caregivers at the point of care and improve patient safety and clinical quality.

Until we have unambiguous, clinically-relevant coding of chief complaints, prescriptions, laboratory and imaging orders and results, we hobble our ability to learn from this vast corpus of information. Outcomes analysis, long-term effects, and the identification and encouragement of best practices and quality-of-care are all dependent on capturing this

information at the source. Open standards are nothing less than the means to advance the industry towards richer, more evidence-based medicine and a smarter health system.

In many cases, the standards have had long use within care settings and are simply being pressed into use for broader networks that extend across multiple care settings. Standards are used in all phases of patient care and cover everything from messaging and content, to measurement and communication. In some cases, these protocols have already achieved wide adoption, such as the **D**igital **I**maging and **C**ommunications in **M**edicine (DICOM) format. More recently, the National Council for Prescription Drug Programs, Inc. (NCPDP) telecommunication standard was named the official format for pharmacy claims under the Health Insurance Portability and Accountability Act (HIPAA).

IBM's Standards Efforts in Healthcare

IBM has worked with providers, hardware and software vendors to develop and adopt standardized ways of describing health data, transmitting it to other computers, and requesting processing related to that data from other computers. As specific needs for collaboration across networks become clear, new standards are developed and adopted. For example, one of the earlier standards, DICOM, was developed so that x-rays and other medical images could be shared.

IBM is a member of many key healthcare standards bodies including HL7, and was a founding member of the Eclipse Organization a leading open source community. Most recently, IBM made its entire patent portfolio available, royalty-free, to standards bodies working on open, interoperable infrastructure for healthcare and education.

Integrating the Healthcare Enterprise IBM's work on building a nationwide infrastructure for clinical information exchange (the NHIN prototype) has lead it to join an initiative called Integrating the Healthcare Enterprise (IHE). Under the leadership of HIMSS and the Radiological Society of North America, IHE is an architectural framework for exchanging information across the enterprise that can incorporate established standards to allow different healthcare enterprises to use their own choice of hardware and software. In fact, our NHIN prototype is based on IHE's work, as well as the open-standards based Interoperable Healthcare Information Infrastructure (IHII) architecture developed by IBM Research.

What is Still Missing: Federal Transition to Broad Standard's Adoption

Federal adoption of open standards for healthcare diagnoses, treatments and other core elements of medicine is critical to tip the use of these innovation drivers from desirable to necessary. When the government has adopted standards, such as the use of International Classification of Diseases and Related Health Problems (ICD-9) system for billing purposes, its market power provides a sufficient voice to finalize consensus within healthcare. The government was a principle driver for the adoption of ICD-9, CPT/HCPCS, and DRG reporting.

Existing Government Efforts Set the Stage for Adoption of Healthcare Standards

The federal government has led numerous efforts to highlight key standards although adoption has lagged.

Consolidated Health Informatics - In 2004, as part of the Consolidated Health Informatics initiative (CHI), the HHS, DoD, and DVA agreed to endorse 20 sets of standards that enable information to be shared across agencies and serve as a model for the private sector.

Medical Language - The Department of Health & Human Services (HHS) signed an agreement in 2003 to license a standardized medical vocabulary developed by the College of American (SNOMED)

Electronic Medical Records - At the request of HHS, the international standards-setting organization known as **Health Level 7** has established a tentative standard that defines the set of functions needed in an electronic medical record.

E-Prescribing Standards - The Medicare Prescription Drug Improvement and Modernization Act (MMA) requires the Centers for Medicare and Medicaid Services (CMS) to develop standards for electronic prescribing.

Standards Harmonization Contract – HHS/ONCHIT –The Office of the National Coordinator for Health IT/HHS awarded a contract in October of 2005 to the American National Standards Institute (ANSI) to develop, prototype, and evaluate a harmonization process for health IT standards.

However, beyond the initiatives cited here, the broader federal government has been somewhat slow to adopt and drive electronic healthcare standards, and often requests that health information be exchanged using phone, mail, or manual means that don't advance open electronic standards and data exchange. As a result, healthcare care costs are higher and quality is lower than they would be if the federal government was more proactive about implementing electronic standards.

For example, federal agencies mandate reporting of extensive amounts of clinical information, yet don't allow information to be submitted via standardized electronic formats. I have attached FDA drug adverse event reporting requirement – MEDRA <http://www.fda.gov/medwatch/> While this example is drawn from the FDA, each of the agencies has comparable examples of reporting that does not utilize health information technology built on standards.

Agencies need the resources, guidance and clear leadership to move away from these manual reporting systems in favor of standards-based electronic reporting. The Senate legislation includes provision to move the federal government towards standards adoption by establishing an additional requirement for standards in procurement, and requiring the option of standards based reporting to federal agencies. The provision would build on the standards identified several years ago by Secretary Thompson, while allowing further standards to be adopted as they are identified. It also allows the provider the choice of either continuing to report manually or in electronic standards.

II. The Role of Initial Funding and Policy Leadership in Sparking Healthcare Transformation

A smarter health system is clearly desirable – however, history demonstrates that innovation often proceeds slowly at first, before accelerating after a catalytic inflection point. The Internet, for example remained an obscure academic network for several decades before the Mosaic Web browser drove its explosive growth in the 1990s. The DVD player became the most rapidly adopted new technology only after manufacturers resolved two competing technology standards.

The government’s role as an early funder and policy driver is vital during the initial phase of a major innovation such as the one dawning around digitally networked healthcare. Initial funding is the seed that allows healthcare system participants to develop prototypes that translate concepts into implementations. The government also plays a key role as a consensus builder on policy issues, to the benefit of both citizens and businesses. As lessons are learned from prototypes and policy development, new business models emerge over time that can carry innovation forward.

Meanwhile the nature of innovation itself is becoming more collaborative—between commercial enterprises as well as between the public and private sectors—government has a highly constructive role to play in sparking work that will unleash the ability of businesses to drive growth and productivity. A smarter healthcare system is just such entrepreneurial fire ready to be lit.

Finally, with nearly half of all healthcare spending in the U.S. originating with the federal government, the public sector can have a decisively influential role in helping engender a smarter health system for all Americans. IBM hopes to play a similar leadership role, both as large employer seeking to innovate how it delivers healthcare to its workforce, and as a business and innovation partner for many parts of the healthcare ecosystem.

Nationwide Health Information Network Architectural Prototypes.

Funding included in President Bush’s Health Information Technology Plan is an important source of prototype funding. The President has requested \$116 million for his health information initiative in FY 2007. While this represents a small portion of the \$5.5 billion that will be spent on health related information technology, it provides key seed money for prototypes and early learning.

The importance of standards and interoperability are front and center in a several projects pertaining to development of a Nationwide Health Information Network (NHIN). As you may know, IBM is one of four companies awarded a contract to develop NHIN architectural prototypes through a contract with the Department of Health and Human Services, Office of the National Coordinator for Health Information Technology. The four architecture prototype contractors are not building the Network, per se, but each vendor is building a prototype architecture.

The goal of the Nationwide Health Information Network (NHIN) prototype is to demonstrate major concepts that build towards the ultimate goal of a smarter, more connected information infrastructure for healthcare, including the abilities:

- To enable secure electronic exchange of healthcare information between and within healthcare marketplaces that allows for the gathering of necessary public health data while preserving patient privacy.
- To demonstrate how various healthcare marketplaces can be part of this communications network in a manner that is cost-effective and not disruptive to their current models of doing business.

These contracts complete the foundation for an interoperable, standards-based network for the secure exchange of health care information. HHS previously has awarded contracts to create processes to harmonize health information standards, develop criteria to certify and evaluate health IT products, and develop solutions to address variations in business policies and state laws that affect privacy and security practices that may pose challenges to the secure communication of health information.

IBM is following several key principles in developing a prototype architecture for the developing nationwide network. These principles are the result of IBM's experience in healthcare and other sectors. They also arise from IBM's work with many broad-based organizations in this area such as the Healthcare Information & Management Systems Society (HIMSS), the eHealth Initiative, and other information technology vendors, and privacy and technical organizations with whom we collaborate with on a daily basis.

The NHIN project promises to bring about a smarter health system by leveraging the expertise and market interests of the private sector. But it was also structured with an ingenious requirement: the four participating contractors, IBM included, must make their respective efforts interoperate across competing healthcare marketplaces via open standards. If the NHIN project can be thought of as the foundation of a “medical Internet” or digital infrastructure for healthcare, then the importance that the evolving nation-wide integrated system will be based on open standards is quite obvious.

IBM is working on the NHIN with partners in three regional communities:

Fishkill, NY

Taconic Health Information Network & Community (THINC) RHIO
RHIO/Community Leader: Dr. John Blair
2,300 physicians supporting 700,000 patients
Shared data using Healthvision

Research Triangle, NC

North Carolina Healthcare Information and Communications Alliance (NCHICA)
RHIO/Community Leader: Holt Anderson
Competitive, high-tech urban environment

Rockingham County, NC

Also members of NCHICA
Rural environment with NC and VA patients
Small, competitive practices and hospitals

In developing this prototype architecture for the evolving nationwide network, IBM is following several key principles

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Through the NHIN, it is envisioned that healthcare consumers would be empowered to access their personal health records (PHRs) using the same network that allows them to share their medical records with healthcare providers that they see in other communities. IBM's architectural prototype for the NHIN system would not be a single repository of everyone's medical records, but rather an index that points to information stored at the originating provider site. IBM believes that independent healthcare consumers, providers, and communities (as well as regional health information organizations) will set the rules for who can see what information and for what information they need.

Healthcare systems or RHIOs wish to retain control over their enterprise-wide data and will also set the business rules for how data will be exchanged. The NHIN will be a practical, community-centric approach to exchanging healthcare information in a secure, standardized way between healthcare communities in the United States.

At the conclusion of the NHIN prototype project, HHS will have four architectural prototypes to choose from or to incorporate into the adopted NHIN architecture and a dozen communities will have developed practical experience with information sharing.

IBM's prototype architecture, along with the other vendors, is part of a broader effort sponsored by the ONC including related efforts to advance the national health IT agenda. IBM continues to participate in and monitor the other ONC-sponsored efforts by The American Health Information Community, the Healthcare Information Technology Standards Panel (HITSP), Certification Commission for Health Information Technology (CCHIT), and Health Information Security and Privacy Collaboration (HISPC).

The ONC awarded contracts and named inter-related groups may supersede some of the functions and activities related in other aspects of this testimony as they evolve during the coming months. Through a series of contracts, public meetings and coordination activities, these named groups are collectively addressing standards harmonization, compliance certification, processes to develop solutions that address variations in business policies and state laws that affect privacy and security practices.

Personal Health Records

IBM can offer several examples to the Committee of our own funding and policy initiatives that may provide some guidance for similar efforts involving Medicaid. In 2005 IBM announced that it would provide personal health records (PHRs) to its entire U. S. workforce. To protect employees' privacy, the personal health record (PHR) system available to IBMers today is managed by an outside vendor and we have instituted contractual provisions and process controls in order to prevent inappropriate access to employee-specific data.

To establish their personal health record (PHR), our U.S.-based employees begin by entering basic information: medicines, allergies, major conditions, and details on their doctors and insurance coverage. Later this year, employees' personal health records (PHRs) will grow to automatically include medical and prescription drug claims history.

Even this basic information has real utility today. It can be emailed or faxed to a provider—and even sent from a Web-enabled mobile device—or simply stored or printed out for easy access in an emergency or when traveling. The ultimate goal is to enable all types of electronic health information, including one's lab results, prescription histories, medical images and more to flow into the record to form a comprehensive portrait of a patient. Equipping and empowering patients with personal health records (PHRs) is only the start. Enabling such data to flow electronically to doctors, hospitals and other providers authorized by the patient will allow healthcare to become a highly interoperable and innovative - something it is far from today.

Early this week, CMS also issued an RFP on personal health records (PHRs) for Medicare beneficiaries. Yesterday, IBM testified to the Federal Workforce Committee about legislation to extend interoperable Personal Health Records (PHRs) to all federal employees. This Committee has the same ability to leverage existing claims data in state Medicaid programs. IBM urges you to examine the role that our federal government can play in catalyzing interoperable personal health records (PHRs) by providing them to Medicaid beneficiaries.

Just as the value of a network rises exponentially with the number of devices connected to it—the so-called network effect—the power of the personal health record (PHR) will rise dramatically the faster we can build a critical mass. What's more, with a large enough base of personal health records (PHRs), the private and public sectors will create strong incentives for physicians, hospitals, and other health system participants to begin to adopt the infrastructure for healthcare that will improve quality and reduce costs.

Interoperable personal health records (PHRs) will also drive two vital changes in the nature of healthcare itself. First, they will increasingly make the patient the center-point around which healthcare organizes itself. And second, interoperable personal health

records (PHRs) and their related systems will support greater transparency across healthcare, and in many dimensions, including price and quality.

At IBM, the personal health records (PHRs) that we are providing to all of our employees in the U.S. are a prime example of this patient-centered approach. When an IBMer first goes to the Web site for their personal health record, they are offered a financial incentive to complete an employee health risk appraisal, develop a personal preventive care action plan and identify quality hospitals in their area. The process surveys a range of issues including exercise level, family histories and cholesterol control, if applicable. Based on the results, an IBMer can subscribe to receive expert information, articles and advice on how to reducing their risks. It identifies eligibility for additional benefits and services such as disease management and refers employees to those resources. Decision support tools for drug comparison and interactions, hospital quality and Leapfrog results (from the Leapfrog Group's performance measurement system) provide individual support for optimizing benefits quality and costs.

For IBM, the risk assessment tools and the personal health records (PHRs) we provide our workforce are an investment that we recoup through improvements in employee health and the significant cost savings that result. For individual employees, the incentives we provide—to take the assessment, or track their self-paced exercise regimens—are essential to helping us capture these business benefits.

Consumer Centric Healthcare

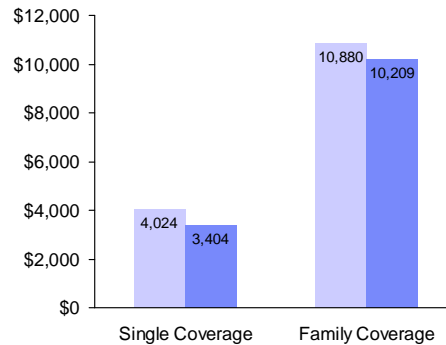
To put IBM's experience with personal health records (PHRs) in some context, I would first like to describe our broader efforts on improving employee health and reducing costs. That backdrop is, in fact, how we progressed to offer personal health records (PHRs) for our employees.

IBM provides health and health benefits of over 500,000 IBMers, retirees and dependents. In total, the IBM Corporation spends over \$1.7 billion on healthcare each year. As a result of our consumer-centric health programs for our employees, IBMers are healthier and have lower health expenses than others in our industry. We have demonstrated that information-rich, patient-centric wellness programs aren't marginal benefits. They are very good business:

- IBM's employee injury and illness rates are consistently lower than industry levels.
- We have documented significant decreases in the number of health risks among IBM employees as a result of participating in our wellness initiatives.
- IBM's disease management programs have demonstrated a 9%-24% reduction in emergency room visits and a 13-37% reduction in hospital admissions resulting in an overall 16% reduction in medical and pharmacy costs adjusted for medical trend over a 2 year period.

With the health improvements, we have seen cost benefits -- IBM healthcare premiums are 6% lower for family coverage and 15% lower for single coverage than industry norms. Our employees benefit from these lower-cost as well -- they pay 26 to 60% less than industry norms. And IBM healthcare premiums have been growing significantly more slowly than U.S. health insurance premiums.

US Average Annual Premiums for Covered Workers:
Industry Average vs. IBM (2005)



Critical Areas for Initial Policy Choices:

Privacy in electronic healthcare is an area of policy development with deep importance, diverse viewpoints, and great need for government leadership, both in terms of driving standards and providing catalytic early funding.

According to a 2005 survey, two-thirds of all Americans report high levels of concern about the privacy of their personal health information, with ethnic and racial minorities and the chronically ill showing the greatest concern:

- Is of a racial/ethnic minority: 73%
- Is not of a racial/ethnic minority: 52%
- Has been diagnosed with a disease: 67%
- Has not been diagnosed with a disease: 63%

One in four consumers reports being aware of incidents where the privacy of personal information was compromised. In addition, they believe, erroneously, that paper records are more secure than electronic ones (66% vs. 58%). (California HealthCare Foundation)

These attitudes about privacy are reflected in the requirements consumers believe are important for electronic health information exchange. Nine of ten consumers want a system that confirms the identity of anyone accessing it. Eight of ten want to personally review who has accessed their information, and to be asked before their information is shared. (Markle) Clearly, privacy issues, and the public's perceptions of those issues, must be addressed in order for the PHR to succeed.

The HIPAA Privacy Rule has provided the bedrock for patient privacy in the U.S. and has established a baseline for privacy and security requirements for electronic health information. Many states have gone further than HIPAA to ensure patient privacy and have adopted policies that further protect patient data when stored and moved in an electronic format. These variations in policies present challenges for widespread electronic health information exchange. To assess these challenges, HHS awarded a

contract devoted to privacy and security. The Health Information Security and Privacy Collaboration (HISPC), a new partnership consisting of a multi-disciplinary team of experts and the National Governor's Association (NGA), will work with approximately 40 states or territorial governments to assess and develop plans to address variations in organization-level business policies and state laws that affect privacy and security practices and pose challenges to interoperable health information exchange. Overseeing the HISPC will be RTI International, a private, nonprofit corporation who has been selected as the HHS contract recipient.

While many see privacy as a potential barrier to health information exchange, most computer systems today include a variety of privacy protections. Most people are familiar with identity-based limitations – personal IDs and passwords that must be entered in order to access a system. With little effort, privacy controls can include roles as well as identity authentication so that a billing clerk or a doctor will have the appropriate level and access to a patient's personal health information. Information technology can also provide tools to monitor who accesses data, create an audit trail for changes the data, and a watermarks to deter data theft and assert ownership of pirated copies. With paper records, there is no automated way to know, for example, if someone has accessed a record inappropriately, or even removed it or copied it.

We have the technology today to protect patients' but if privacy policies are unclear, or built on concepts such as "intent" that are difficult to translate into computer rules, technology will be of little help in formalizing privacy. Creating a smooth interface between privacy policy and technology will require a significant commitment of political will and resources. Here again, the government can play a pivotal role in stimulating and encouraging the development of privacy policies that will enable electronic healthcare to move forward faster.

III. Creating Incentives in Medicare and Medicaid to Reward Quality

Establishing a system of electronic health records (EHRs) for millions of citizens is a major societal shift, and will require a range of incentives to accelerate adoption among various constituencies. Physicians and other healthcare providers will bear the direct costs of implementing electronic health records (EHRs), as well as the indirect cost to transform their established workflow processes to take advantage of these new technologies.

The current healthcare system has well-known flaws in how treatments are reimbursed. The current model rewards the volume of services and not the quality of outcomes. This paradigm results in low quality and rising costs. Those reimbursement flaws reduce the incentive for quality improvement tools such as interoperable electronic health records (EHRs). Reforms in reimbursement methodologies and additional sources of funding will have a dramatic impact on the adoption of the electronic health records (EHRs), and the multitude of systemic benefits they reap.

The effectiveness of “carrots” for performance are why IBM supports incentives to providers to adopt electronic health records (EHRs) and other related health information technology applications (Computerized Patient Order Entry, e-prescribing, etc.).

In fact, IBM is already implementing a “pay-for-use” incentive plan to drive the use of electronic prescriptions.

In New York’s Hudson Valley, where many of our employees live, we are funding a program that rewards doctors each time they use a new system for writing prescriptions electronically. Working with Dr. John Blair and Taconic Health Information Network and Community (THINC) regional health information organization, or RHIO, IBM has agreed to increase the reimbursement physicians receive if they submit prescriptions electronically. We believe that the additional reimbursement we are offering will pay for itself by reducing medication errors and increasing the use of generic drugs.

We urge this Committee to examine approaches to rewarding value through the Medicaid program. This coming year, the federal government will provide over \$300 billion through the Medicaid program. It makes no sense to pay all those providers the same reimbursement rates, if the quality for some greatly exceeds — or severely lags behind — that of others. But today, Medicaid is at best neutral, and at worst negative, toward quality. Medicaid pays for the delivery of a service, not for the achievement of better health.

A number of pay for performance demonstration projects in Medicare are underway (see box, *right*). IBM would encourage the expansion of these pioneering efforts and application to the Medicaid program.

Barriers & Indicators for Success:

Electronic health records (EHRs) and a digital infrastructure to support them will enable a historic

Medicare and Private Sector Pay for Performance Demonstration Projects

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Hospital Quality Initiative (MMA section 501(b)) - focuses on an incentives for reporting an initial set of 10 quality measures.

Premier Hospital Quality Incentive Demonstration - Under this demonstration, CMS is collecting data and provides an incentive related to performance on 34 quality measures.

Physician Group Practice Demonstration (BIPA 2000) - The demonstration rewards 10 large physicians groups for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries.

Medicare Care Management Performance Demonstration (MMA Section 649) – A three-year pay-for-performance demonstration with focused on small and medium-sized physician practices to promote the adoption and use of health information technology to improve the quality of patient care for chronically

Private Industry Efforts - Pay-for-Performance Programs and Purchasers

There are more than 100 pay-for-performance programs across the U.S including Integrated Healthcare Association’s (IHA) pay-for-performance effort in California, The Leapfrog Group’s Hospital Quality and Safety Survey and their new Hospital Rewards Program that rewards hospitals out of a savings fund, and the Bridges To Excellence program, which is an ambulatory care incentive program active in several states.

shift in medicine: rewarding outcomes and improved quality of care rather than simply paying for procedures in today's fee-for-service model. Health IT is invariably linked to this shift in reimbursement because it is needed to help document and measure performance.

Health information technology is a key to successful pay-for-performance for two reasons. First, electronic reporting can reduce the significant burden that performance reporting places on providers. Current performance measures often involve manual chart review and manual processing by skilled professionals. Electronic reporting can reduce the performance reporting burden and ease participation by providers in pay-for-performance programs.



Second, electronic reporting can align with the ongoing care process to actually improve the quality of care a patient receives, not just by documenting end results, but by alerting providers in realtime to any gaps or best practices that may have been overlooked. As a result, performance measurement carried out electronically can move from a description of quality to an operational tool that improves care. Those patients that do not receive appropriate care may be highlighted while they are interacting with providers rather than much later in reports that are submitted to reimbursers.

Naturally, the pay-for-performance model will require the support of doctors and the medical community. Financial incentives under a pay-for-performance program must be:

- Non-punitive (i.e. physicians who are unable to participate in the program should not be subject to negative updates);
- Prioritized, so that physicians are rewarded for achieving improvements for the top 20 conditions identified in the Institute of Medicine's (IOM) "Crossing the Quality Chasm" report;
- Considerate of the critical role of primary care physicians in achieving such improvements; and
- Sufficient to offset physicians' investment in health information technology and other office redesign required to measure and report quality.

We also advise that pay-for-performance programs be implemented along with reforms to change the way that physician services are valued and reimbursed, rather than grafted onto an underlying payment methodology that pays doctors for doing more, instead of doing better.

Of course, one of the most important factors in making pay-for-performance a success is the size of the incentive or bonus relative to a physician's or hospital's total revenues. While no formal studies have yet clearly documented this issue, empirical data suggest that physicians will respond to incentives only if they represent 5% or more of their total revenues.

In conclusion, creating powerful incentives in the federal health programs is necessary if we are to drive improvements in healthcare through the intelligent application of technology. Incentives for quality will undoubtedly lead toward better use of health information technology to improve healthcare. The information technology industry would like the opportunity to drive such a virtuous circle – incentives leading to better use of health IT which leads to improved quality and lower costs. This Committee can start by implementing the pay-for-performance model in Medicaid.

Summary

- The federal government can advance a smarter health system by deeply adopting and supporting open standards.
- The federal government can accelerate the transformation of healthcare through judicious seed funding of prototypes and communities and active leadership in policy areas such as privacy and security.
- Strong incentives are needed to drive adoption of electronic health records (EHRs), and one of the most powerful levers would be to reward the quality of care in Medicare and Medicaid via a “pay for performance” model.