Committee on Ways and Means

Subcommittee on Health

Testimony of Lewis G. Sandy, MD

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Mr. Chairman and Members of the Committee:

My name is Dr. Lewis Sandy and I am Senior Vice President for Clinical Advancement at UnitedHealth Group, a diversified health and well-being company based in Minnetonka, Minnesota. Our mission is to help people live healthier lives, and the goal of all of our innovative work in transparent performance assessment and payment and delivery reform is to improve the quality of care for the millions of Americans we serve.

We have learned four key lessons in advancing quality and cost-effectiveness in care delivery over the years – lessons that can benefit public sector health care programs as well.

- First, physicians benefit from meaningful feedback on their clinical performance to support their continuous professional development and their innate desire to provide the best care possible to their patients;

- Second, patients benefit from actionable information on delivery system performance, as well as coaching and other support services to help them make informed decisions;

- Third, meaningful improvement in quality and efficiency of care requires practice transformation through new models of care, built and supported by new tools and capabilities, such as health information technology;

- Fourth, this transformation requires alignment of incentives for quality and cost-effectiveness across the delivery system, including incentives for both patients and doctors, all supported through new benefit designs.

Let me provide a few examples of the innovative programs we have deployed at UnitedHealth Group, at scale, to advance this agenda, and the lessons we have learned in implementing them. The first example is large scale transparent performance assessment and feedback that provides clear and actionable information about the quality and cost-effectiveness of individual physicians, groups of physicians and hospitals, to assist people in making personally appropriate decisions.

A landmark study published in 2003 in the New England Journal of Medicine noted that people receive evidence-based clinical services just over half the time[1], and the Agency for Healthcare Research and Quality's (AHRQ) 2010 National Quality Report shows, at best, modest improvements in quality of care since then[2]. Physicians know there are differences in quality—an October 2011 Optum Institute/ Harris Interactive survey showed that 64% of physicians say "there are significant differences in the quality of care provided by doctors" in their local area.[3] And yet physicians, extraordinarily busy and dedicated to their patients, often do not have a sense of how their patterns of practice relate to evidence-based standards of

[1] N Engl J Med 2003; 348:2635-2645
[2] http://www.ahrq.gov/qual/nhqr10/Key.htm
[3] http://institute.optum.com/research/featured-publications/sustainable-health-a-manifesto-for-improvement/~/media/OptumInstitute/Page_Elements/Articles/11-27376%20Optum%20Manifesto%20LO8.pdf

care, or how their care compares to that provided by their peers. A 2005 study in Health Affairs noted that only about one-third of practicing physicians received any feedback on their performance.[4]

This gap must be closed. To help do that, eight years ago UnitedHealth Group began perhaps the nation's broadest and deepest transparency program for physician performance assessment: The UnitedHealth Premium Designation Program. This program provides physicians with valuable feedback on their performance, while at the same time enabling patients to make informed health care decisions. We use the extensive data we have from claims, pharmacy, laboratory and other administrative data sources, and analyze care patterns using sophisticated episode-grouper analytic software. This approach analyzes patient care by condition across settings and time, thus representing a more patient-centered view of care.

Our program is grounded in the principle that performance measures should be developed by expert physicians in each specialty area and approved by nationally accredited bodies. As such, we incorporate

[4] Health Aff May 2005 vol. 24 no. 3 843-853

performance measures that have been reviewed and endorsed by the National Quality Forum and the National Committee for Quality Assurance, as well as performance measures developed in collaboration with medical specialty societies and reviewed by committees of practicing physicians. This Premium Designation Program evaluates physician performance on quality and efficiency across 21 different areas – including primary care and specialties such as cardiology and orthopedics.

The Premium Designation Program analyzes the performance of physicians against both quality and efficiency benchmarks. Quality is measured first, and only those physicians who meet or exceed quality benchmarks are then evaluated for cost-efficiency. Quality is assessed using more than 300 national standards and metrics developed by physician specialty societies. Efficiency is measured using more than 230 measures and benchmarks that are risk-adjusted and tailored to each physician's specialty and geographic area to account for differences in average costs. On both dimensions, performance is measured relative to other physicians.[5]

[5] For more information, see: https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Premium%20Methodology/UnitedHealth_Premium_Detailed_Methodology.pdf

We display the results in our provider directories using a "star" format, with one star for quality and another for efficiency. Physicians receive both summarized information as well as access to extremely detailed data, down to the individual patient level in a HIPAA-compliant format. We used consumer focus groups and outside experts to create a readable, usable format for consumers. We created an online reporting and "drilldown" tool for physicians to help them understand their opportunities to improve quality and efficiency. This online system has been well received, with positive feedback from physicians and medical societies.

We have discovered that quality and efficiency variations are significant, and they matter. While the specifics vary by specialty (and we make it a point to share the overall picture with each specialty society, as well as with individual physicians), here are a few illustrative facts:

- Cardiologists who earn a quality designation have 55% fewer redo procedures and 55% lower complication rates for stent placement procedures than cardiologists who did not receive the quality designation.

- Orthopedic surgeons who earn a quality designation have 46% fewer redo procedures and a 62% lower complication rate for knee arthroscopy surgeries than other orthopedic surgeons who did not receive the quality designation.

- For all 21 physician specialties evaluated in the UnitedHealth Premium program, the incremental savings between a Premium designated (Quality and Cost Efficient) physician and non-designated physician is 14%.

This program demonstrates that large scale transparent performance assessment can be done today, and that the information is used by physicians and patients to improve both the quality of clinical care delivery and the choice of personally appropriate care by consumers. But this alone will not achieve transformative changes towards higher levels of system performance. Performance assessment, while a valuable tool for improving care quality, is not sufficient on its own. Performance assessment must be incorporated into an aligned reimbursement system that provides rewards and incentives for demonstrating true value in care delivery.

Thus, we have launched practice transformation programs and payment and delivery reforms, working again in collaboration with physicians and hospitals, to combine support for delivery system improvement with aligned incentives. We currently are piloting Patient Centered Medical Home programs in 13 states. Additionally, our goal this year is to have 8 to 12 Accountable Care Organization projects across diverse communities that will help providers modernize the way they deliver care. These practice models are combined with new payment models that reinforce both the desired direction of practice transformation and are tied closely to achievement of actual, meaningful improvements in quality and efficiency. These include population-based measures of cost-efficiency and direct measures of appropriate key health services utilization[6].

These are significant, and promising, payment and delivery reforms. But even these are not enough. Another key component is consumer empowerment and activation. As I mentioned earlier, it is important to provide people with information that helps them understand the strengths and weaknesses of physicians and hospitals, so they might make more informed, personally appropriate care choices. And, just as with physicians,

[6] Key measures for our new payment programs include a core set of HEDIS measures for quality, quality and efficiency measures such as hospital readmission rates, hospital-acquired infection rates, ER-to-Inpatient admission ratios, physician generic prescribing rates, use of in-network laboratories and specialists, and total cost of care, where statistically feasible.

we have learned that it is important to augment that information with incentive-based health benefit products that further encourage people to use the information, and that can provide lower cost health care for those who successfully do so. The end result: Better quality and more affordable care.

To that end, we have deployed incentives in programs such as our Diabetes Health Plan to help patients with chronic conditions stay healthy and adhere to their physician's recommended care plan. Through such initiatives, physician incentives for improvement and practice transformation are aligned and reinforced by consumer-focused incentives.

Many lessons from our experiences can be applied to public programs.

- First, we have learned that meaningful differences in quality and efficiency of care can be measured, and that they matter. Just as important is how we develop the measures and measurement program. For example, ongoing expert physician and specialty society collaboration is critical in developing appropriate measures for quality, efficiency, patient safety, and other dimensions of

performance. And these measures and the measurement program must be fully transparent.

- Second, this information is only useful if it is presented in an actionable format with aligned incentives. Information alone, while helpful, is unlikely to "move the needle."

- Third, financial incentives must be significant, not marginal. Yet, they cannot increase the overall costs of care. They must come from the savings achieved from ongoing improvements in delivery system efficiency.

- Fourth, financial incentives, even significant ones, cannot lead to true transformation without support for new models of care, new roles such as care transformation coaches, and information technology support. For example, we have learned the importance of embedded nurse care managers in patient-centered medical homes, who provide vital support for care transitions, patient education, and coordination among care providers.

- Fifth, the "supply side" interventions described above can be accelerated by deploying "demand side" programs such as value-based benefit designs, consumer navigation and information resources, and programs to help people become more activated and involved in their own care.

We have learned that individual transparency or payment programs, important as they are as building blocks, are inadequate on their own to significantly improving quality and efficiency in our health care system. Instead, stakeholders must work together to implement an integrated, comprehensive performance measurement program, innovative payment reforms that incorporate quality and cost-efficiency measures along with material financial incentives, transformation of the care delivery process, patient-focused transparency programs, and value-based insurance designs, so that patients are financially rewarded for making decisions that reflect higher quality and cost outcomes.

Programs like the ones I've outlined, developed and deployed in the private sector, with continuous refinement and ongoing collaboration with physicians and other stakeholders, can be applied to public programs such as

Medicare. Innovations in the private sector can be fielded, tested, and refined though rapid cycles of improvement and ongoing collaboration with physicians, thus informing the design and deployment of public sector innovations. Medicare need not start from scratch, nor go it alone. By working with, and learning from, private sector innovations, public programs can more rapidly be modernized to meet the needs of those they serve.

Thank you for the opportunity to share our experiences and perspectives with the Committee, and I look forward to your questions.