CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

nrhi Network for Regional Healthcare Improvement

Testimony of Harold D. Miller

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and
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to the
Subcommittee on Health, Committee on Energy and Commerce
U.S. House of Representatives
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Mr. Chairman and Members of the Committee:

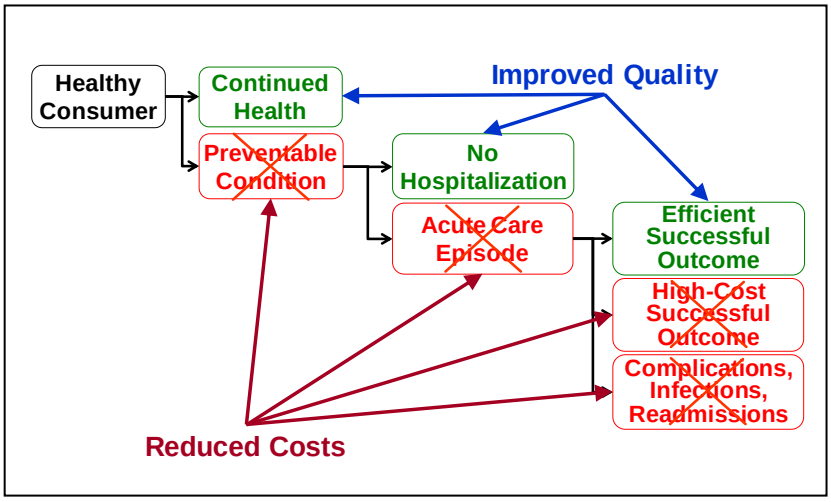
I commend you for working to address the important issues associated with physician payment reform and I appreciate the opportunity to provide input to your deliberations. The following are the major points that I would like to make to you today:

- Healthcare costs can be reduced without rationing, but a major barrier is current payment systems, which financially penalize physicians and hospitals for reducing costs.
- There are two principal ways healthcare payment should be reformed. The first is Episode-of-Care Payment, where physicians and hospitals are jointly paid a single price for all of the services associated with a hospitalization or procedure, including a warranty stating that they will treat any related infections and complications at no extra charge. The second is Comprehensive Care payment, where a physician practice receives a single payment to cover all of the care a patient needs for their chronic diseases or other conditions. These payment systems have been shown to improve quality and lower costs.
- Small, independent physician practices as well as large integrated systems can participate in these payment systems. However, small physician practices need a reasonable transition period and the following kinds of assistance to do so successfully:
  - Access to data and analysis on current utilization patterns and costs;
  - Training and coaching on restructuring of care processes;
  - Transitional payment reforms, such as accountable medical home payments, bundled payments, and condition-specific comprehensive care payments; and
  - Participation by all payers, including Medicare, Medicaid, and commercial plans.
- Because of the wide variation in the structure of healthcare delivery systems across the country, the best way to organize this help is through community-based, non-profit, multi-stakeholder organizations called Regional Health Improvement Collaboratives. Congress can help these Collaboratives support successful payment reforms for physicians by:
  - providing access to Medicare data so they can help physicians identify the best opportunities to improve quality and reduce costs.
  - providing some modest federal funding so that Collaboratives can provide the hands-on help that physician practices need to improve quality and reduce costs.
  - encouraging or requiring Medicare to participate in the multi-payer payment and delivery reforms communities design.

Healthcare Costs Can Be Reduced Without Rationing

The challenge that the Committee and Congress have faced for many years has been how to control costs in the Medicare and Medicaid programs without denying care that patients need or limiting their access to high-quality physicians and hospitals. Although many people seem to believe that costs can't be reduced without rationing, there are three major ways to do so:

- **Preventing health problems from occurring in the first place.** Many illnesses can be prevented through interventions such as immunizations, weight management, and improved diet, and the severity of other illnesses can be reduced through regular screenings (e.g., for cancer or heart disease) that lead to early diagnosis and prompt treatment.
- **Helping patients manage chronic diseases and other conditions so they don't have to be hospitalized as often.** Studies have shown that rates of emergency room visits and hospitalizations for many patients with chronic disease and other ambulatory-sensitive conditions can be reduced by 20-40% or more through improved patient education, self-management support, and access to primary care.[1]
- **Reducing the high rate of infections, complications, and readmissions that occur today when patients do have to be hospitalized.** For example, work pioneered by the Pittsburgh Regional Health Initiative and replicated in other parts of the country proves that such events can be dramatically reduced or even eliminated through low-cost techniques.[2].



All of those things not only can save money for Medicare, Medicaid, and commercial health plans, but they improve outcomes for patients, too.

Current Payment Systems Are a Major Barrier to Higher Value Health Care

The problem today is that current payment systems drive the healthcare system in exactly the opposite direction. For example:

- **Many valuable preventive care and care coordination services are not paid for adequately or at all** (e.g., primary care practices are typically paid only when a physician sees a patient in person, not when the physician speaks to the patient on the phone). Similarly, specialists are only paid for seeing patients in person, not for advising primary care physicians on care management or for time spent coordinating services with the primary care physician. A primary care physician or specialist who hires a nurse to assist with patient education typically cannot be reimbursed for the time the nurse spends with the patient. All of these things can limit the ability of physicians to flexibly design services to best meet a patient's needs, resulting in unnecessary illnesses and treatments.
- **Physicians and hospitals can be financially penalized for providing better quality services.** For example, reducing errors and complications during hospital stays can not only reduce both physicians' and hospitals' revenues, but also reduce hospital profits and their ability to remain financially viable.[3]
- Perhaps most fundamentally, under current payment systems, **physicians don't get paid at all when their patients stay well.**

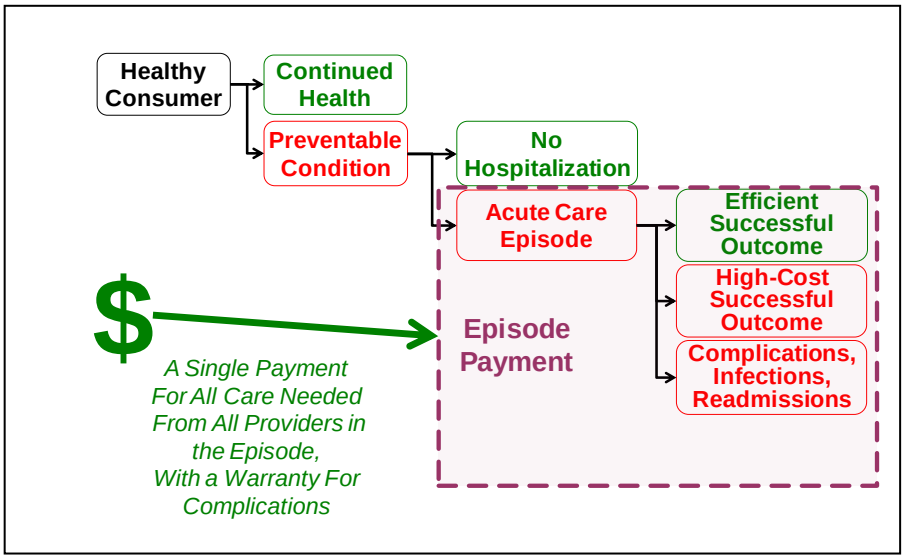
You can't fix those things by increasing or decreasing fee levels or by adding more and more regulations. The SGR obviously can't do it, either. The payment system itself is broken and has to be fundamentally changed.

There Are Better Ways to Pay For Health Care

There are two major kinds of payment reforms that would correct these problems and provide both the flexibility and accountability that physician practices, hospitals, and other providers need to both improve the quality and reduce the costs of healthcare.

Episode-of-Care Payments

One is to use Episode-of-Care Payments to pay for hospitalizations and major acute procedures. Instead of paying physicians and hospitals separately for each service associated with the hospitalization or procedure, they would jointly be paid a single amount for the entire episode. For example, once a patient has a heart attack, a single payment would be made to the hospital and physicians for all of the care needed by that patient for the heart attack. The amount of the payment would be severity-adjusted, e.g., the hospital and physicians would be paid more for caring for a heart attack patient with other health conditions such as diabetes or emphysema.



Moreover, the Episode-of-Care Payment would be designed to cover the costs of treating any related infections and complications that the patient experiences. In effect, the hospital and physicians would be providing a limited warranty on their care, i.e., if the patient experienced a problem such as an infection or preventable complication, the hospital and doctors would treat that problem at no extra charge.

The advantages of Episode-of-Care Payment include the flexibility it provides for hospitals and physicians to decide which services should be provided within the episode (rather than being restricted by the services specifically authorized under a fee-for-service system), the incentive it creates to eliminate any unnecessary services within the episode, the incentive for the hospital and physicians to better coordinate their services, and the incentive for everyone to prevent infections and complications.

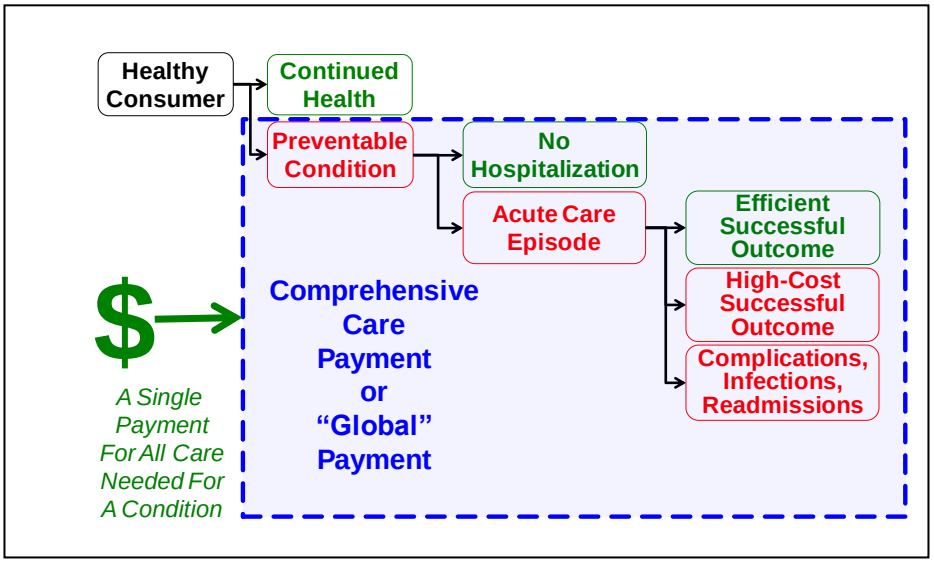
This approach – a single payment for a complete product or service, with a warranty to correct defects at no charge – is how most other industries are paid for their products and services, and it makes sense to use it in healthcare, too.

For example, the Geisinger Health System in Pennsylvania, through its ProvenCare[SM] system, provides a "warranty" that covers any follow-up care needed for avoidable complications within 90 days at no additional charge. The system was started for coronary artery bypass graft surgery, and has been expanded to hip replacement, cataract surgery, angioplasty, bariatrics, low back pain, perinatal care, and other areas.[4] Offering the warranty led to significant changes in the processes used to deliver care, and Geisinger has reported dramatic improvements on quality measures and outcomes.[5]

Comprehensive Care Payments

The major weakness of Episode-of-Care Payment is that it does nothing to reduce the number of episodes of care. If a physician practice is managing the care for patients with chronic disease, we want the practice to find ways to reduce the frequency that those patients are hospitalized, not simply ensure higher quality and lower costs every time they *are* hospitalized. We also want to find ways to reduce the frequency of certain kinds of procedures when there is evidence of overuse that is harmful to patients.

A second payment reform that achieves these goals is Comprehensive Care Payment[6], or what is often referred to as "global payment." Under this model, a physician practice or health system would accept a single payment to cover all of the healthcare services their patients need for their health conditions during a specific period of time (e.g., a year). The amount of this payment would be adjusted based on the health of the patients (i.e., how many conditions they have) and other characteristics that affect the level of services needed. For example, a physician practice would receive a higher payment if it has more patients with severe heart disease rather than mild heart disease, but the payment would not depend on what kinds of treatment the patients



receive. As a result, a physician practice gets paid more for taking care of sicker patients, but not for providing more services to the same patients.

For example, the Alternative Quality Contract implemented by Blue Cross Blue Shield of Massachusetts in 2009 defines a single payment to a physician practice or health system for a group of patients to cover all care services delivered to those patients (including hospital care, physician services, pharmacy costs, etc.), with the payment amount adjusted by the health status of the patients. The physician practice or health system can earn up to a 10% bonus payment for achieving high performance on clinical process, outcome, and patient experience measures. The amount of the payment is based on historical costs for caring for a similar population of patients and is increased annually based on inflation. Outlier payments are made for patients with unusually high needs and expenses, and limits are placed on the total amount of financial risk the providers accept.[7] An evaluation of the first year results showed that participating healthcare providers achieved better quality, better patient outcomes, lower readmission rates, and lower utilization of emergency rooms.[8]

Separating Performance Risk from Insurance Risk

An important feature of both Episode-of-Care Payment and Comprehensive Care Payment is that they give physicians and health systems responsibility for *performance risk* – their ability to manage their patients' conditions in a high-quality and efficient manner –but not *insurance risk* – whether a patient has an illness or other condition requiring care. In contrast, traditional (non-condition-adjusted) capitation systems transferred *all* cost risk to the provider. Insurance risk is really what insurance is designed to address, and under both Episode-of-Care and Comprehensive Care Payments, insurance risk remains with Medicare or a health insurance plan.[9]

Small Physician Practices Can Deliver High-Value Care

Because of the visibility of the outstanding work that the Geisinger Health System, Intermountain Healthcare, Thedacare, and other large systems have done, a myth has developed that only large, integrated delivery systems can manage such payments and deliver higher-value care. But experience has shown that small, independent physician practices can also use better

payment models to deliver higher-quality, lower-cost care. For example, the earliest known example of someone offering a warranty in healthcare was not a large health system, but a single physician. In 1987, an orthopedic surgeon in Lansing, Michigan collaborated with his hospital to offer a fixed total price for surgical services for shoulder and knee problems, including a warranty for any subsequent services needed for a 2-year period, including repeat visits, imaging, rehospitalization, and additional surgery. A study found that the payer paid less and the surgeon received more revenue by reducing unnecessary services such as radiography and physical therapy and reducing complications and readmissions.[10]

Small physician practices will likely need to join together through Independent Practice Associations (IPAs) or other structures to achieve the necessary economies of scale to manage Comprehensive Care Payments. However, physicians do not need to be employed by hospitals or join large group practices in order to do so. There are many examples of how physician practices, including very small practices, are successfully managing these new payment models.[11]

Just like in every other industry, where small businesses are often the innovators, small healthcare providers can be more efficient and innovative than large systems, if we give them the opportunity to do so without imposing unnecessary and expensive regulatory requirements.

Helping Physician Practices Succeed

I've talked to physicians all over the country about these payment reform concepts, and what I've found is that once they understand them, they are willing to embrace them. But they need assistance to implement them successfully, and they need a reasonable transition period.

What kind of help do physicians need?

Access to Data and Analysis on Cost and Quality

Physicians today typically don't know how often their patients are being hospitalized, going to the ER, being readmitted, or getting duplicate tests. Although many people seem to believe that all information problems will be solved by electronic health records, a physician's EHR typically only includes information on the services that he or she provided, not on the

services delivered by other providers. Medicare and health plans have the only comprehensive data on the services patients receive, and physicians typically do not have access to this information, particularly in a timely fashion.[12]

Timely access to such data is critical if a physician is going to be held accountable for costs and quality, particularly if this includes services delivered by hospitals or other providers. However, it is not enough simply to have access to data or even to traditional quality measures that are produced by Medicare and commercial health plans; physicians need useful *analysis* of those data to identify where opportunities exist for quality improvement and cost reduction.

Training and Coaching in Process Improvement

Data can show where opportunities exist to reduce utilization and costs, but physicians also need training and coaching in how to restructure their practices in ways that can take advantage of these opportunities. Not only is this re-engineering not taught in medical school, it is hard for physicians to do it and still keep up with the demands of ongoing patient care.

Transitional Payment Reforms

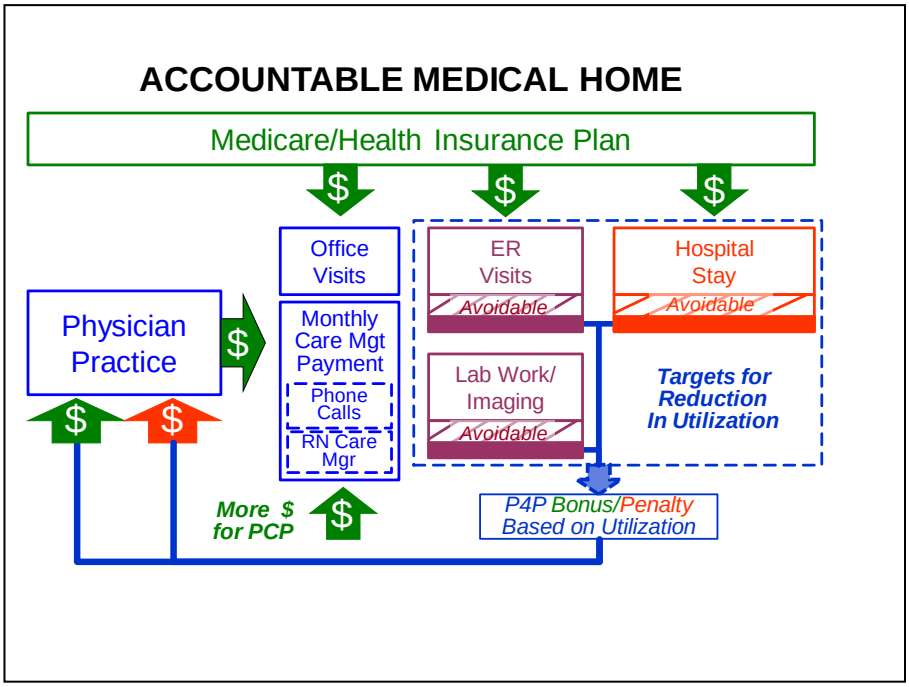
It will be challenging for physicians and other healthcare providers who have been operating under the fee-for-service payment system for many years to suddenly switch to operating under systems such as Episode-of-Care Payment and Comprehensive Care Payment that require greater accountability for cost and quality. As described above, physicians will need new resources and capabilities in order to manage successfully under dramatically different payment models, and it will take time for them to develop these.

However, physicians cannot change the way they deliver care unless payment systems are implemented that support those changes. The solution to this “chicken and egg” problem – better payment systems require better delivery systems, but better delivery systems require better payment systems – is to develop and implement *transitional* payment reforms, i.e., payment changes which will give physicians more flexibility and accountability for costs and quality than they have today under fee-for-service, but less than they would have under the ultimate payment system that would be used, so that the physicians have time to transition their processes and

organizational structures to enable them to develop the capabilities to move to even higher levels of flexibility and accountability.[13]

Examples of the kinds of transitional payment reforms that would be helpful include:

- **Accountable Medical Homes.** This would involve paying primary care practices with three new components:
  - A Care Management Payment would be paid to the primary care practice for each patient (in addition to current fees for individual services) to support better patient education and self-management support, access to physicians by telephone, etc.;
  - Specific targets for reducing utilization of healthcare services outside of the practice (e.g., non-urgent emergency room visits, ambulatory care sensitive hospitalizations, or high-tech diagnostic imaging) would be established that would result in savings greater than the cost of the Care Management Payment; and
  - Bonuses/penalties would be paid to the practice based on its performance against the targets.



- **Medical Neighborhood Payments to Specialists.** Similar to the payment model above for primary care practices, specialists would be paid more to better manage and coordinate patient care, but with specific targets for reducing utilization of expensive services such as hospital care.

- **Bundling Hospital and Physician Payments for Major Acute Episodes**, i.e., making a single payment for both hospital and physician services instead of separate payments, and allowing the hospital and physicians to allocate the payment among themselves to recognize efforts to improve quality and reduce costs.
- **Warranties for Inpatient Care**, i.e., allowing hospitals and/or physicians to set a new price for procedures that would enable them not to charge more for services to correct errors, infections, and other hospital-acquired complications.
- **Condition-Specific Partial Comprehensive Care Payments.** A physician practice or group of providers would be paid a single amount for some or all of the services that a patient will need from some or all providers for one or more of their health conditions over a fixed period of time (e.g., a year). This would replace separate fees currently paid for the individual services that the patient needs for those specific health conditions.

These transitional payment reforms can be designed in ways that save Medicare and other payers money and improve quality for patients. (More detail on these and other transitional payment reforms can be found in *Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care*, Center for Healthcare Quality and Payment Reform, January 2011.) Sections 3021 and 3022 of the Affordable Care Act provide CMS with the authority to implement such models, but it has not yet done so.

Consistent Payment Reforms Across All Payers

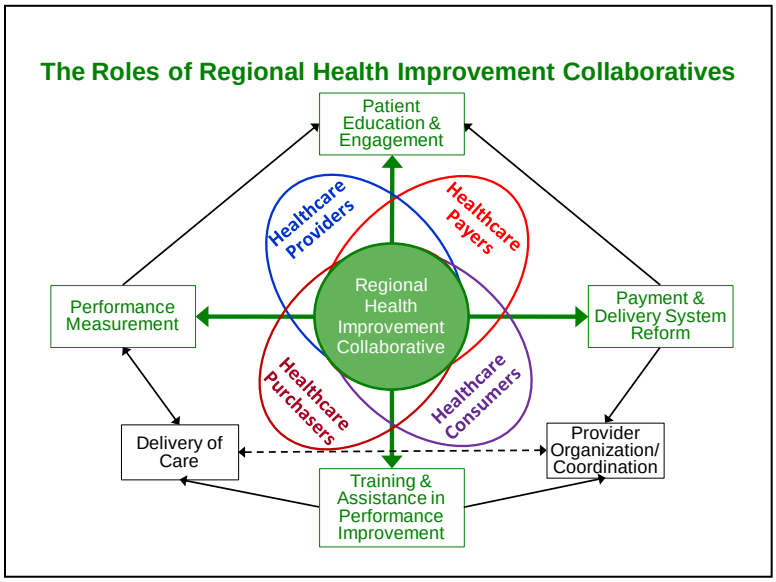
Fourth, physicians need to have *all* payers – Medicare, Medicaid, and commercial health plans – make these payment changes and do so in similar ways. Even if one payer is willing to implement desirable payment reforms, it is difficult and may even be inappropriate for a provider to change the way it delivers care for only that payer's patients.

There are a growing number of communities that have developed multi-payer payment reforms involving all or most of the commercial insurance plans in the community and Medicaid programs. The biggest problem they have faced is that Medicare does not participate, meaning that 30-40% or more of a physician practice or hospital's patients are not included in the payment reforms.

Supporting Community-Driven Solutions

No one-size-fits-all national program can address these needs, since the supports and changes need to be designed and implemented in ways that are feasible for the unique provider and payer structures in each community and in ways that complement, rather than conflict with, the quality improvement activities that are already underway in each individual community. Moreover, since all of the healthcare stakeholders in the community – consumers, physicians, hospitals, health plans, businesses, government, etc. – will be affected in significant ways, they all need to be involved in planning and implementing changes; however, since in many communities there is considerable distrust between different stakeholder groups, a neutral facilitator is needed to help design "win-win" solutions.

A growing number of communities are recognizing that *Regional Health Improvement Collaboratives* are an ideal mechanism for developing coordinated, multi-stakeholder solutions to their healthcare cost and quality problems. A Regional Health Improvement Collaborative (RHIC) does not deliver healthcare services directly or pay for such services; rather, it provides a neutral, trusted mechanism through which the community can plan, facilitate, and coordinate the many different activities required for successful transformation of its healthcare system.



Regional Health Improvement Collaboratives have three key characteristics:

- They are **non-profit organizations** based in a specific geographic region of the country (i.e., a metropolitan region or state);
- They are **governed by a multi-stakeholder board** composed of healthcare providers (both physicians and hospitals), payers (health insurance plans and government health

coverage programs), purchasers of health care (employers, unions, retirement funds, and government), and consumers; and

- They help the stakeholders in their community **identify opportunities for improving healthcare quality and value, and facilitate planning and implementation of strategies for addressing those opportunities**.

There are currently over 40 Regional Health Improvement Collaboratives in the country. Most were formed relatively recently, but some have been in existence for ten to fifteen years or longer. There has been dramatic growth in the number of Regional Health Improvement Collaboratives in recent years, partly due to the rapidly growing concern about healthcare costs and quality across the country, and partly due to proactive efforts by the Robert Wood Johnson Foundation (through the Aligning Forces for Quality program) and the U.S. Department of Health and Human Services (through the Chartered Value Exchange program) to foster the creation of such entities. The leading Collaboratives are members of the Network for Regional Healthcare Improvement, which is the national association of Regional Health Improvement Collaboratives.[14]

Regional Health Improvement Collaboratives in the Network for Regional Healthcare Improvement

Albuquerque Coalition for Healthcare Quality
Aligning Forces for Quality – South Central PA
Alliance for Health (West Michigan)
Better Health Greater Cleveland
California Cooperative Healthcare Reporting Initiative
California Quality Collaborative
Finger Lakes Health Systems Agency
Greater Detroit Area Health Council
Health Improvement Collaborative of Greater Cincinnati
Healthy Memphis Common Table
Institute for Clinical Systems Improvement (Minnesota)
Integrated Healthcare Association (California)
Iowa Healthcare Collaborative
Kansas City Quality Improvement Consortium
Louisiana Health Care Quality Forum
Maine Health Management Coalition
Massachusetts Health Quality Partners
Midwest Health Initiative (St. Louis)
Minnesota Community Measurement
Minnesota Healthcare Value Exchange
Nevada Partnership for Value-Driven Healthcare (HealthInsight)
New York Quality Alliance
Oregon Health Care Quality Corporation
P2 Collaborative of Western New York
Pittsburgh Regional Health Initiative
Puget Sound Health Alliance
Quality Counts (Maine)
Quality Quest for Health of Illinois
Utah Partnership for Value-Driven Healthcare (HealthInsight)
Wisconsin Collaborative for Healthcare Quality
Wisconsin Healthcare Value Exchange

Regional Health Improvement Collaboratives operate programs that directly address the needs of physician practices that were identified earlier. For example:

- **Collecting and Analyzing Quality and Cost Data**. Most Regional Health Improvement Collaboratives have established a mechanism for collecting and publicly reporting data

on the quality of care delivered by physicians. Unlike many quality reporting initiatives developed by health plans and government agencies, these quality measurement and reporting initiatives are developed and operated with the active involvement and supervision of the physicians for whom quality scores are being reported, so the physicians can ensure that the measures are meaningful and the data are accurate. Although many of these measurement systems rely on health plan claims data, a growing number of Regional Health Improvement Collaboratives, such as Minnesota Community Measurement and the Wisconsin Collaborative for Healthcare Quality, are using clinical data from physicians for quality measurement. Some Regional Health Improvement Collaboratives, such as Massachusetts Health Quality Partners, also collect and report information on consumers' experience with healthcare providers. [15]

- **Providing Training and Coaching to Physicians and Other Providers.** Many Regional Health Improvement Collaboratives are working with providers, either individually or in groups, to help them better organize and deliver health care in order to improve quality and efficiency. For example, the Pittsburgh Regional Health Initiative developed a Preventable Readmission Reduction Initiative that worked with primary care practices to improve care for people with chronic diseases and successfully reduced hospital readmissions for patients with chronic obstructive pulmonary disease.[16]

- **Designing and Implementing Multi-Payer Payment Reforms.** Many Regional Health Improvement Collaboratives are already working to build consensus among the multiple health plans and other payers in their communities on the types of payment reforms which should be implemented, so that physicians and other healthcare providers are not forced to deal with multiple, disparate new payment structures. A few Collaboratives have successfully implemented multi-payer payment reforms in their communities. For example, the Institute for Clinical Systems Improvement reached agreement among all of the major health plans in Minnesota on changes in payment to support better primary care for patients with depression.[17] The Puget Sound Health Alliance is co-sponsoring a demonstration project which will give participating primary care practices in Washington State both greater resources and greater accountability for helping patients avoid unnecessary emergency room visits and hospitalizations, similar to the Accountable Medical Home model described earlier.

What Congress Can Do to Support Local Payment and Delivery Reforms

Congress can help support successful community-driven payment and delivery reforms in several ways.

Provide Access to Medicare Data for Regional Health Improvement Collaboratives

It is impossible for physicians to identify where opportunities for cost reduction exist or how to capitalize on them without access to data. Physicians need information on current utilization patterns and analyses of the likely impact of interventions in order to construct a feasible business case for the investment of resources in new care processes.

Although many Regional Health Improvement Collaboratives have assembled multi-payer databases and sophisticated programs to analyze the data, these databases typically do not contain data on Medicare patients, which makes it impossible to identify care improvement opportunities for Medicare beneficiaries or to help physicians and hospitals design changes in care that will improve quality and reduce costs for the Medicare program. In the few communities where Medicare data has been made available, it has typically been several years old. Data that are out-of-date are of relatively little value in communities where there are active efforts to improve the quality and cost of care; indeed, using old data can be counterproductive since it may unfairly imply that problems exist when, in reality, they have already been addressed. Physicians need access to timely information so that they can measure progress towards improvement, and consumers need timely information so they can choose providers wisely and fairly. Ideally, data should be made available within 30 days after claims have been filed.

<u>Congress can help by requiring that Regional Health Improvement Collaboratives gain access to Medicare claims data as soon as possible so they can help physicians identify the best opportunities to improve quality and reduce costs and prepare to participate in new payment models. CMS should provide the data as frequently as possible and as quickly as possible after claims are filed.</u>

Provide Funding to Support Training and Coaching for Physician Practices

Despite the key role that Regional Health Improvement Collaboratives can play in ensuring the success of federal healthcare reforms in local communities, there is currently no federal funding program that provides support for the work that Regional Health Improvement Collaboratives do to analyze data or to provide training and assistance to physician practices. Although the Department of Health and Human Services (HHS) and the Agency for Healthcare Research and Quality (AHRQ) promoted the creation of multi-stakeholder collaboratives through the Chartered Value Exchange (CVE) program, they do not provide any funding for general operating support of Regional Health Improvement Collaboratives.

Congress can help by providing a modest amount of federal funding to Regional Health Improvement Collaboratives so they can provide the hands-on help that physician practices need to improve quality and reduce costs. Successfully reforming local healthcare delivery systems will require many years of persistent effort by these Collaboratives, and so reliable, multi-year funding will be needed to support their efforts.

Encourage or Require Medicare Participation in Local Multi-Payer Payment Reforms

The most successful, high-impact payment reform projects will be those which address the most important quality and cost issues in a particular community, which have support from both consumers and a broad range of healthcare providers, which have participation by payers other than Medicare, and which have effective local mechanisms of monitoring implementation and resolving problems. As noted earlier, a number of communities have implemented or are in the process of developing multi-payer payment reforms, but a major challenge has been the inability to include Medicare as a partner.

Congress can help by encouraging or requiring Medicare to participate in multi-payer payment and delivery reforms that communities design and implement, particularly the kinds of transitional payment reforms described earlier. The Innovation Center created by Section 3021 of the Affordable Care Act provides Medicare the flexibility to participate in such initiatives, but it would be preferable if the Innovation Center announced an explicit commitment and priority for supporting multi-payer payment reforms that have been developed through a multi-

stakeholder process at the community level. This would not only help support existing projects but encourage the creation of additional such efforts across the country.

Thank you again for the opportunity to testify. I would be pleased to provide any additional detail about these recommendations that would be helpful.

Sincerely,

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[13] Miller HD. Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care. Center for Healthcare Quality and Payment Reform, January 2011. Available at www.chqpr.org.

[14] See the Network for Regional Healthcare Improvement website (http://www.nrhi.org) for a complete list of Regional Health Improvement Collaboratives.

[15] Other multi-stakeholder Regional Health Improvement Collaboratives that report on the quality of physician care and involve physicians in the process of developing the measures include the Albuquerque Coalition for Healthcare Quality, Aligning Forces for Quality – South Central Pennsylvania, the Alliance for Health, Better Health Greater Cleveland, the California Cooperative Healthcare Reporting Initiative, the Greater Detroit Area Health Council, the Healthy Memphis Common Table, the Integrated Healthcare Association, the Kansas City Quality Improvement Consortium, the Maine Health Management Coalition, the Midwest Health Initiative, the Oregon Health Care Quality Corporation, the Puget Sound Health Alliance, and Quality Quest for Health of Illinois.

[16] More information on the Pittsburgh Regional Health Initiative is available at http://www.prhi.org. Other Regional Health Improvement Collaboratives that work with physicians to improve their performance on quality and cost include the California Quality Collaborative, HealthInsight, the Iowa Healthcare Collaborative, the Institute for Clinical Systems Improvement in Minnesota, the Louisiana Healthcare Quality Forum, and Quality Counts in Maine.

[17] For more information on the "DIAMOND Initiative," see www.icsi.org.

HAROLD D. MILLER

PROFESSIONAL EXPERIENCE

Executive Director (2008-Present)
Center for Healthcare Quality and Payment Reform

Direct the activities of this national center which develops policies and strategies for transforming the quality of healthcare delivery. The Center focuses on identifying and encouraging action on fundamental changes in payment systems that will give healthcare providers more responsibility for increasing quality and controlling costs of services, and identifying and encouraging implementation of new organizational structures that enable healthcare providers to participate in new payment systems and to more effectively coordinate care for patients.

President and CEO (2008-Present)
Network for Regional Healthcare Improvement

Direct the activities of the national association of regionally-based, multi-stakeholder non-profit organizations that are working to improve the quality and value of health care delivery. NRHI facilitates information sharing among regions and encourages national policies that support regional quality improvement efforts. NRHI's members include the Albuquerque Coalition for Healthcare Quality, Aligning Forces for Quality – South Central Pennsylvania, the Alliance for Health in West Michigan, Better Health Greater Cleveland, the California Cooperative Healthcare Reporting Initiative, the California Quality Collaborative, the Finger Lakes Health Systems Agency, the Greater Detroit Area Health Council, the Health Improvement Collaborative of Greater Cincinnati, HealthInsight, the Healthy Memphis Common Table, the Institute for Clinical Systems Improvement (ICSI) in Minnesota, the Integrated Healthcare Association, the Iowa Healthcare Collaborative, the Kansas City Quality Improvement Consortium, the Louisiana Health Care Quality Forum, the Maine Health Management Coalition, Massachusetts Health Quality Partners, Minnesota Community Measurement, the Minnesota Healthcare Value Exchange, the New York Quality Alliance, the Oregon Health Care Quality Corporation, the P2 Collaborative of Western New York, the Pittsburgh Regional Health Initiative, the Puget Sound Health Alliance, Quality Counts of Maine, Quality Quest for Health of Illinois, the Wisconsin Collaborative for Healthcare Quality, and the Wisconsin Healthcare Value Exchange. In addition to its members, the Robert Wood Johnson Foundation, the Jewish Healthcare Foundation, the California HealthCare Foundation, and the Commonwealth Fund have provided financial support for NRHI and its projects.

Prior to taking over as President of NRHI, organized NRHI's two national Healthcare Payment Reform Summits in 2007 and 2008.

***Strategic Initiatives Consultant* (2006-Present)**
Pittsburgh Regional Health Initiative

Provide assistance to the Pittsburgh Regional Health Initiative (PRHI) in improving the quality of health care services and changing the fundamental structure of health care payment systems in order to support improved quality. Analyses of the financial penalties for hospitals in reducing hospital-acquired infections were featured in *Modern Healthcare* magazine in December 2007. Led a multi-year PRHI initiative from 2008-2010 to reduce preventable hospital admissions and readmissions through improved care for chronic disease patients.

***President and CEO* (2006-Present)**
Future Strategies, LLC

Founder and leader of a private consulting firm specializing in analyzing complex organizational and public policy issues, developing creative strategies for addressing those issues, and using effective communications techniques for building understanding of and support for solutions. Clients have included the Agency for Healthcare Research and Quality, the Commonwealth Fund, the Jewish Healthcare Foundation, the Lawrence County Economic Development Corporation, the Minnesota Department of Health, the North Dakota Healthcare Association, the Pittsburgh Ballet Theatre, the Pittsburgh Post-Gazette, and Point Park University.

Adjunct Professor of Public Policy and Management
H. John Heinz III School of Public Policy and Management
Carnegie Mellon University
(2006-Present)

Teach Methods of Policy Analysis, a capstone graduate course designed to teach students practical techniques for analyzing public policy problems and developing effective solutions to them. Cases cover a wide range of domestic policy issues, including criminal justice, economic development, education, environmental protection, health care, and human services.

***President and Chief Operating Officer* (2001-2005)**
***Executive Vice President (Chief Operating Officer)* (2000-2001)**
***Deputy Executive Director* (1992-2000)**
Allegheny Conference on Community Development
and
***Executive Director* (2004-2005)**
***Deputy Executive Director* (1992 - 2004)**
Pennsylvania Economy League of Southwestern Pennsylvania

***Director* (1995-2005)**
Southwestern Pennsylvania Growth Alliance

***Adjunct Associate Professor of Policy Analysis* (1993-1999)**
H. John Heinz III School of Public Policy and Management
Carnegie Mellon University

***Managing Director* (1997)**
Regional Renaissance Partnership

***Associate Dean* (1987-1992)**
H. John Heinz III School of Public Policy and Management
Carnegie Mellon University

***Director of Issues and Research* (1991)**
Thornburgh for Senate Campaign

***Director* (1986)**
***Deputy Director* (1983-1985)**
Governor's Office of Policy Development, Commonwealth of Pennsylvania

***Chief, Policy Analysis Division* (1980-1983)**
Governor's Office of Policy and Planning, Commonwealth of Pennsylvania

***Research Associate/Research Assistant* (1977-1980)**
Urban Systems Institute
Carnegie Mellon University

EDUCATION

***(A.B.D.) Public Policy Analysis*, Carnegie-Mellon University (1980)**

Completed pre-dissertation work in the Ph.D. program at the School of Urban and Public Affairs (now the H. John Heinz III School of Public Policy and Management).

***M.S., Public Management and Policy*, Carnegie-Mellon University (1977)**

B.S., Mathematics, Carnegie-Mellon University (1977)

AWARDS

Martcia Wade Teaching Award, Heinz School of Public Policy and Management, 2008

One of sixty individuals named “Pittsburghers of the Year” by Pittsburgh Magazine in 1998

Award of Excellence, Southwestern Pennsylvania Partnership for Aging (1998)

Samuel K. McCune Award for Distinguished Service, Presbyterian Association for Aging (1994)

COMMUNITY SERVICE

Member, Board of Directors, National Quality Forum (2009-Present)

Member, Board of Directors, Eastern Area Adult Services (1993-Present); President of the Board (2004-2010)

Member, Board of Directors, Pittsburgh Downtown Partnership (1995-2010)

Member, Board of Directors, United Way of Allegheny County (1997-2002)

Chairman, Volunteer Support Network for Seniors (1994-2000)

Member, Executive Committee, Southwestern Pennsylvania Partnership for Aging (1990-1998)

Chairman, Allegheny County Alliance on Aging (1987-1996)

Member, Steering Committee for Housing and Related Services for Homeless Persons in Allegheny County (1987-1994)

Member, Board of Directors, Association for Retarded Citizens, Allegheny County Chapter (1988-1991)

Member, Board of Directors, Local Government Academy (1988 — 1991)

PUBLICATIONS

"The Foundation for Successful Healthcare Reform," in *Regional Health Improvement Collaboratives: Essential Elements for Successful Healthcare Reform*, Jewish Healthcare Foundation, January 2011.

Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care, Center for Healthcare Quality and Payment Reform, January 2011.

"The Need for Physician Leadership in Healthcare Payment and Delivery Reform," in *Colorado Medicine*, January/February 2011.

Pathways for Physician Success Under Healthcare Payment and Delivery Reforms, American Medical Association, June 2010.

Making Reform a Reality: Ways to Facilitate Better Healthcare Payment and Delivery Systems and Lower Healthcare Costs, Robert Wood Johnson Foundation, June 2010.

"Health Care Payment Systems" in *State Roles in Delivery System Reform,* National Governors Association, 2010.

Creating Accountable Care Organizations in Massachusetts, Massachusetts Hospital Association, November 2009.

"The Future of Payment and Delivery Reform Is (and Has Been) in California," *CAPG Health*, Fall 2009.

"Regional Payment and Delivery Reforms: Critical to Obama Plan's Success," posted September 10, 2009 on the *Health Affairs* Blog.

"From Volume to Value: Better Ways to Pay for Health Care," *Health Affairs*, September/October 2009.

How to Create Accountable Care Organizations, Center for Healthcare Quality and Payment Reform, September 2009.

"Reducing Health Care Costs Without Rationing," *Mass Media*, July 2009.

Paths to Payment Reform, Center for Healthcare Quality and Payment Reform, 2009.

Pay for Innovation or Pay for Standardization: How to Best Support the Patient-Centered Medical Home, Network for Regional Healthcare Improvement and Robert Wood Johnson Foundation, February 2009.

Better Ways to Pay for Health Care: A Primer on Healthcare Payment Reform, Network for Regional Healthcare Improvement and Robert Wood Johnson Foundation, January 2009.

From Volume to Value: Transforming Healthcare Payment and Delivery Systems to Improve Quality and Reduce Costs, Network for Regional Healthcare Improvement, Pittsburgh Regional Health Initiative, and Robert Wood Johnson Foundation, November 2008.

From Concept to Reality: Implementing Fundamental Reforms in Health Care Payment Systems to Support Value-driven Health Care, Network for Regional Healthcare Improvement, July 2008.

Recommendations of the Minnesota Health Care Transformation Task Force, Minnesota Department of Health, January 2008.

Incentives for Excellence: Rebuilding the Healthcare Payment System from the Ground Up (with Pamela Gaynor), Jewish Healthcare Foundation, September 2007.

Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform, Commonwealth Fund, September, 2007.

"Methodology on Adverse Events," *Health Affairs* 26, no. 1 (2007): 293.

"Investing in the Future: Strategies for Human Services in Pennsylvania," in *Leading Pennsylvania Into the 21st Century: Policy Strategies for the Future*, The Commonwealth Foundation for Public Policy Alternatives, 1990, pp. 118-140.

"Making Do: The Effects of a Mass Transit Strike on Travel Behavior" (with Alfred Blumstein), *Transportation*, Vol. 11 (1983), pp. 362-382.

Corrections at the Crossroads: Designing Policy (with Sherwood E. Zimmerman), Sage Publications, 1981.

"Projecting the Impact of New Sentencing Laws on Prison Populations," *Policy Sciences*, Vol. 13 (1981), pp. 51-73.

"Projecting the Impact of New Sentencing Laws on Prison Populations" (with Alfred Blumstein and Jacqueline Cohen), in *Research in Public Policy and Management*, Vol. 1, John P. Crecine, Ed., 1981.

"Crime, Punishment, and Demographics" (with Alfred Blumstein and Jacqueline Cohen), *American Demographics*, October 1980.

"Demographically Disaggregated Projections of Prison Populations" (with Alfred Blumstein and Jacqueline Cohen), *Journal of Criminal Justice*, Vol. 8 (1980), pp. 1-26.

"Design for a Coordinated Paratransit Service for Elderly and Handicapped Persons in Allegheny County, Pa." (with Alfred Blumstein, Keith Forstall, and Richard A. Stafford), in *Transportation for the Elderly and Handicapped: Programs and Problems*, Technology Sharing Office, U.S. Department of Transportation, Washington, D.C., 1978.

Discussion of Organizational Alternatives for Transportation Services in Rural Southwestern Pennsylvania (with Richard A. Stafford), Urban Systems Institute, Carnegie Mellon University, 1976.

"A New Computational Method in the Theory of Spinodal Decomposition" (with J.S. Langer and M. Baron), *Physical Review A*, April 1975.

May 3, 2011

Committee on Energy and Commerce

U.S. House of Representatives

Witness Disclosure Requirement - "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

1. **Your Name:** HAROLD D. MILLER

	Yes	No
2. **Are you testifying on behalf of the Federal, or a State or local government entity?**		X
3. **Are you testifying on behalf of an entity that is not a government entity?**	X	

4. **Other than yourself, please list which entity or entities you are representing:**

CENTER FOR HEALTHCARE QUALITY AND PAYMENT REFORM
NETWORK FOR REGIONAL HEALTHCARE IMPROVEMENT

5. **Please list any Federal grants or contracts (including subgrants or subcontracts) that <u>you or the entity you represent have received</u> on or after October 1, 2008:**

AHRQ: SUBCONTRACT TO LEWIN GROUP TO SUPPORT CVE LEARNING NETWORK
AHRQ: SUBCONTRACT TO PRHI FOR IMPLEMENTING BEHAVIORAL HEALTH IN PRIMARY CARE NETWORKS

6. **If your answer to the question in item 3 in this form is "yes," please describe your position or representational capacity with the entity(ies) you are representing:**

EXECUTIVE DIRECTOR, CENTER FOR HEALTHCARE QUALITY AND PAYMENT REFORM
PRESIDENT AND CEO, NETWORK FOR REGIONAL HEALTHCARE IMPROVEMENT

	Yes	No
7. **If your answer to the question in item 3 is "yes," do any of the entities disclosed in item 4 have parent organizations, subsidiaries, or partnerships that you are not representing in your testimony?**		X

8. **If the answer to the question in item 3 is "yes," please list any Federal grants or contracts (including subgrants or subcontracts) that were received by the entities listed under the question in item 4 on or after October 1, 2008, that exceed 10 percent of the revenue of the entities in the year received, including the source and amount of each grant or contract to be listed:**

Signature: _____ **Date:** 5/3/11