Senate Finance Committee Testimony
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Mr. Chairman, I am Dr. Jim Mongan, president of Partners HealthCare in Boston, an integrated health care delivery system founded by the Brigham and Women's Hospital and Massachusetts General Hospital. I always appreciate the opportunity to come before the Senate Finance Committee where I began my career 35 years ago working as committee staff for 7 years for both Senator Russell Long and Senator Wallace Bennett.

These leaders and their colleagues were grappling then, just as you are 35 years later, with the difficult task of balancing the enormous benefits Medicare and Medicaid bring to our elderly and poor, with the significant cost of these programs to the Federal Budget and our society.

The initiatives you are considering today fall within this tradition – as I believe that pay for performance reimbursement, especially when coupled with the development of information technology has the potential to

maximize the value we receive both as patients and as a nation in health care.

I'll start with a word about our aspirations at Partners HealthCare regarding quality and costs, and then make three key points about your proposed legislation.

At Partners we have a set of five initiatives, which we call our "signature initiatives" to improve quality, efficiency and value across our system:

- The first is to build out an electronic medical record, with embedded decision support, across our system to support evidence based medicine.
- The second is to ensure safety in drug delivery through computerized order entry pioneered at the Brigham and Women's Hospital.
- The third is to use our electronic data to measure quality across our system.
- The fourth is to use our data to identify our sickest patients, and construct disease management programs to assist in their care.

- And the fifth is to use electronic prescribing and test ordering to assure the selection of high quality and cost effective drugs and imaging procedures.

We were among the first health care providers in the country to plunge into pay for performance contracting back in 2000 and we have more than 500,000 patients under pay for performance contracts. This year we have $88 million or 10% of our reimbursement at risk based upon our ability to improve efficiency and quality.

With the benefits of five years of experience there are three main points that I would make relevant to the proposed legislation.

- First, we agree that the thoughtful use of financial incentives can help drive improvement in health care. During the past five years we have seen steady improvement in the quality of care that we provide to our diabetics, our asthmatics and our patients with heart attacks and heart failure. We attribute at least some of this improvement to our initiatives, supported by our pay for performance contracts.

- Second, I can express my strong support for the principles of Medicare value purchasing that are reflected in the proposed legislation. The phased-in approach in particular will be helpful in the development of measures, and the development of providers' understanding. These "report cards" will never be perfectly accurate or completely fair, but we recognize that they serve two important purposes – first, to help health care providers recognize opportunities to improve and second, to provide reassurance that physicians and hospitals are focused on efficiency and quality.

  The devil will be in the details, and it is important that the committee understand that the goal of a "consumer reports" for health care will likely never be fully realized. Anyone who has been a doctor or a patient knows that health care is not a product like a car or television set – it is a series of interactions between at least two people, often many more. Measuring the quality of health care is more like evaluating a marriage than evaluating an automobile. Now we all know that there are good husbands and bad husbands and that some doctors are better than others. But coming up with measures that can use administrative data to distinguish between them is, in the opinion

of many experts, quite difficult. Pay for performance at this stage of development works best in measuring large groups or large hospitals, and less well on the individual physician level. So we should embark on this era of transparency with appropriate humility.

- Third, I agree wholeheartedly with the legislation's emphasis on health information technology. In our system we often say that we need two revolutions to improve health care, an industrial revolution in which physicians start using the electronic tools that can reduce errors; and a cultural revolution in which we reorient ourselves into teams that care for populations of patients. These revolutions are next to impossible without ready availability of information systems like.

Currently about 90% of our academic physicians have these systems while only about 20% or our community network physicians are connected. Unfortunately, the Stark and anti-kickback laws prevent us from providing these necessary tools to our network physicians. That is why a broad exception from these laws, for this purpose, needs to be an essential part of the proposed legislation. I have provided more specific views on this issue to the committee in a separate statement.

To conclude I would urge your support for spreading information technology more broadly, and for appropriately designed pay for performance systems. Both would be consistent with the Senate Finance Committee's 40 year record of support for, and responsible stewardship of our critical health financing programs for our most vulnerable citizens – the elderly and the poor.