Testimony before the House Insurance Committee

Ann Torregrossa
Director
Governor's Office of Health Care Reform

April 22, 2010

Thank you so much for inviting me to testify today on House Bill 2106, which would create an Authority for the Pennsylvania Health Information Exchange (PHIX).

Such an Authority is needed for at least two important reasons:

- to provide a home for the continued work that has resulted from two very successful public-private partnerships; and
- to meet one of the requirements for receipt of federal funding from the Office of the National Coordinator (ONC) which is to have stakeholder involvement in the governance of PHIX (Pennsylvania will be receiving $17.1 million).

Let me tell you a little about these two very exciting public-private partnerships. The first came from an Executive Order which created an Advisory Committee to assist the Governor's Office of Health Care Reform (GOHCR) in the development of PHIX. Two of the people testifying today have served on that committee. We had been diligently working on an RFP to create the Exchange, but the passage of the HITECH Act required all states to accelerate their efforts to establish Health Information Exchanges.

For Pennsylvania, HITECH makes the following federal funds available.

- $1.5 billion in incentive payments for hospitals and other health care providers who have electronic health records that meet the federal "meaningful use" definition. That definition will include being able to transmit health information to health care providers outside of their health system through a health information exchange. The incentives are available starting January 2011.
- $44.4 million for two Regional Extension Centers that will work with small primary care practices to assist them in selecting and implementing an electronic health record (EHR) so they can meet the "meaningful use" criteria needed to receive the incentive payments.
- $17.1 million for Health Information Exchange, which will permit health care providers to share information with clinicians outside their health system.

One of the criteria for receipt of the $17.1 million from ONC was to submit a Strategic Plan containing a plan for governance that included participation by all major stakeholders. As part of the plan development process, we submitted it for public comment. The draft plan proposed that PHIX be governed by an Authority, similar to that in House Bill 2106, with the Board of Directors made up of state officials and other important stakeholders, including health care providers,

consumers, employers, insurance companies, etc. We received only positive comments about this proposal.

The biggest concern voiced, before the Authority is set up, is whether there is a common understanding about how the Authority and the work of building the Health Information Exchange will be funded.

We think that our health information exchange can be completed over the next 4-5 years, building the backbone this year and adding health care providers as they have EHRs that can connect with PHIX. We have a variety of funds to build PHIX. We have the $17.1 million from ONC, and we also believe that Medicaid will be allowed to use 90% federal funding to pay for its pro rata share of health care in Pennsylvania, which is about 17%. Once we have entities connected to PHIX, those entities will pay some subscription payments that will help with operating costs. But, despite all these revenue sources, we estimate that we will have a total revenue shortfall of $11 million over the five year build-out period, which can be met in a number of ways. First, we are talking to insurance plans about voluntary contributions, as was done in Rhode Island. Insurance companies may feel they have a good business case to make these donations given the potential for large savings once PHIX is operational. Secondly, to address this shortfall, we could have health care providers pay more of the cost to connect. Also, other revenue sources could be identified. To put this shortfall in perspective, it is less than $1 for every Pennsylvanian and it should be something we can figure out. We have an RFP on the street and will not know the final cost until the negotiation process is finalized.

The other public-private partnership that we are urging you to include in this Authority is the one that has been involved in transforming how health care is delivered and paid for and that involves patients in promoting their own wellness. This public-private partnership came out of an Executive Order creating the Chronic Care Management, Reimbursement and Cost Reduction Commission. The Commission has been implementing its Strategic Plan for over two years and has involved insurers, provider organizations, state agencies, quality improvement experts, and consumers. All major payors, except Medicare fee-for-service, have sat together with the primary care practices in a remarkable collaboration to figure out, on a region by region basis, how they might provide financial rewards to primary care practices who participate. The state supervision of the discussions on payment provided antitrust protection, which made these agreements possible.

Payors and practices signed a three-year participation agreement. Primary care practices committed to send a multidisciplinary team to seven days of education sessions in the first year to learn how to transform their practice, provide monthly clinical data and narrative reporting, participate in monthly

conference calls, work with practice coaches and expert faculty and apply and receive accreditation as a patient-centered medical home from the National Committee on Quality Assurance. Practices started by focusing on patients with diabetes and pediatric asthma.

The first regional learning collaborative started in May of 2008 in SE Pennsylvania. Nearly two years later, we now have seven Learning Collaboratives operating in six regions of the state, with two more planned for this year. A total of 918 primary care practitioners in 173 practices are caring for 1.1 million patients involved in this quality improvement effort. It is by far the largest such effort in the country. Insurers have committed to pay $30 million additional dollars for qualifying participating primary care practices.

Preliminary results show that patients are healthier, need far fewer hospitalizations, and doctors and other providers are energized and costs have been reduced. Two of our energized physicians will be testifying today about the importance of including this type of initiative in the Authority.

So, what do these two initiatives have to do with one another? CMS is not giving the $1.5 billion in incentive payments that I mentioned earlier to health care providers just because they have adopted an Electronic Health Record for their patients. Rather, providers must demonstrate that they are making meaningful use of that EHR to improve quality and reduce costs. Similarly, Pennsylvania should not have an Authority that just allows transmission of clinical data without providing the structure to health care providers and payors to improve quality and contain costs. Rather, Pennsylvania should have an Authority that allows payors and providers to work collaboratively under the state's antitrust protection to create payment incentives and quality outcome measures that improve quality and reduce the cost of health care.

The financial impact of combining these two initiatives is tremendous. The Pennsylvania Health Care Cost Containment Council (PHC4) reported that in 2009, 20 conditions resulted in $2.5 billion in hospital readmission charges. Work done at Geisinger Health Plan and the University of Pennsylvania shows that having a care manager work with patients within 48 hours of discharge can significantly reduce readmissions. Getting the discharge summary to the primary care practice can be done through HIE. Effectively using that information requires the practice to follow a new care delivery model and have a care manager work with the patient.

If we have learned anything through our Learning Collaborative work, it is that practices cannot respond to 8-10 different pay-for-performance measures from 8-10 different plans. Agreement among payers on quality improvement measures will make it much easier for our health care providers to focus and

achieve the goals established for change. The only way we are going to move the cost curve down and quality up is to move away from a payment system that rewards health care providers for the volume of services provided. Instead, we need to construct a payment system that rewards providers for performance or value – including delivery of care in a coordinated way.

When we discussed with CMS the possibility of this combination of functions in one Authority, they said we would be the poster child for the country. It is exactly that combination of facilitating clinical data exchange, but facilitating its use for health care transformation and payment reform, that they think is necessary to make health care more efficient and improve the health status of our citizens.

We urge you to amend HB 2106 to allow inclusion of work to have consensus-based quality improvement and voluntary payment reform effort included under the Authority. The vast majority of stakeholder representation on our PHIX Advisory Committee were the same for our Chronic Care Commission. One board making sure that the exchange of clinical information is coordinated with voluntary quality improvement and cost reduction efforts makes sense.

It is critical that this legislation be enacted before the end of the fiscal year so the Authority's board can be appointed and assume its responsibilities as soon as possible.

Thank you for your invitation to testify. With me today is Phil Magistro, Pennsylvania's Health Information Coordinator, who is also available to answer questions.