Independent Health.

511 Farber Lakes Drive, Buffalo, New York 14221 716.631.3001 www.independenthealth.com

July 12, 2013

Sydne Harwick
Legislative Clerk, Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Ms. Harwick,

Please find responses to the questions posed by members of the committee on Energy & Commerce as outlined in your June 26, 2013 letter.

Sincerely,

Dr. Thomas Foels
Chief Medical Officer

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**The Honorable Joseph R. Pitts**

1) **From a payer perspective, Independent Health grapples with many of the same issues as CMS does with the Medicare program (albeit on a different scale). From the perspective of someone who has endeavored in such work with providers in New York, do you believe the types of measurement and model programs envisioned under the Committee's legislative framework to be of benefit to the Medicare program?**

Yes, I believe the committee's legislative framework as outlined in the "Discussion Draft: Reform of Sustainable Growth Rate (SGR) and Medicare Payment for Physician Services" contains important, key elements necessary to shift payment toward a pay-for-value program that recognizes and rewards performance and quality.

Specifically, I believe:

- ✓ Quality measures (including functional, process and clinical outcome measures) currently exist and can be further developed that represent and differentiate the ability of primary care physicians and specialty physicians to provide clinical quality.
- ✓ Physicians and professional organizations representing physicians should be involved in metric development, attribution logic, risk adjustment methodologies and scoring systems.
- ✓ That development and implementation of quality measures must precede the broader movement toward alternative payment systems other than fee-for-service (FFS). Bundled payments, case payment, global population-based payments, and/or shared-savings reimbursement each have potential perverse incentives for under-utilization. A robust collection of quality measurements and incentives must be established and operate concurrently with any such alternative payment systems.
- ✓ Public and peer-to-peer transparency of quality measurement is an important element of success for any such program.

I believe additional considerations and discussions are necessary in the following areas:

- ✓ The development of "performance thresholds". Although operationally more challenging, physicians should be rewarded for incremental improvement toward goal. Maximum performance thresholds should be established (ie: at less than 100%) since there are legitimate clinical exceptions to any practice guidelines; performance thresholds should not be established such that they would promote unintended patient harm as the result of inappropriately aggressive medical management nor promote "cherry picking" of patients by practitioners solely for the purpose of improving their performance scores.
- ✓ Clinical quality guidelines should be adopted which specifically address appropriate age/gender and disease co-morbities of the senior patient population. For example, blood glucose (A1C) goals and blood pressure goals for elderly adults may require differing clinical thresholds than these used for middle-aged adults.

- ✓ Physicians must be provided "actionable reporting" of performance in a manner that allows easy interpretation of results, trended reporting to allow providers to understand the impact of their previous interventions to improve care, regional peer comparisons, and educational initiatives (ie: "improvement literacy") to assist them in making necessary improvements in systems of care.
- ✓ Both primary and specialty care physicians should be held mutually responsible for select quality measures. For example, cardiologists should receive reporting and be held responsible for basic quality metrics for diabetic patients under their care, since poorly controlled diabetes constitutes a major risk factor for coronary artery disease progression and stroke.

2) **You state in your testimony that one of the guiding principles of IHA are "substantive and sustainable improvement in quality and affordability of the American health care system will require movement away from traditional FFS reimbursement systems. Would you explain why FFS Medicare undercuts quality and affordability in our health care system?**

The fee for service system reimburses providers and hospitals solely upon a unit of service being performed.

Here are some examples:

- ✓ An office visit to a primary care physician paid as one unit of service under fee-for-service reimbursement: In one scenario, the primary care physician successfully and effectively provides all clinically relevant, guideline-recommended services, including the coordination of all preventive screening, chronic disease testing for diabetes, smoking cessation recommendations, and other recommended anticipatory needs. Another primary care physician, spending in equal amount of time with the patient, might provide few or none of these services. Currently, in both cases, the physician is reimbursed equally with no recognition of the quality of services provided from that office visit.
- ✓ A specialist seeing a patient referred from a primary care physician does not have immediate access to previous x-rays or results of previous diagnostic tests. A physician taking additional administrative time to coordinate care by obtaining the results of these previous tests currently receives no recognition or financial remuneration for care coordination efforts; as a result, radiologic imaging and diagnostic testing have the potential to be repeated unnecessarily.

In these two simple examples of the current fee-for-service (FFS) Medicare payment system, there's no differentiation of clinical physician services being rendered. In the first example, there is no recognition for the significant difference show in visit quality. In the latter example, there is no recognition or incentive to coordinate care in affordable manner.

3) **You state in your testimony that primary care plays a pivotal and foundational role in the transformation to a high quality health care system. I also know that primary care is uniquely positioned in the health care market place to impact cost and quality. With the committee's legislative framework in mind, do you believe it possible to incentivize primary care differently as a way of encouraging even greater quality and affordability in the system? For instance, maybe constructing different types of measures or performance benchmarks could lead to additional benefits in Medicare and patients?**

Yes, I believe that primary care is uniquely positioned to play such a pivotal and foundational role. A primary care physician acts as a "comprehensivist"...uniquely and professionally trained to understand and manage a wide spectrum of clinical conditions. Having an established and ongoing relationship with a patient affords a primary care physician the ability to manage the patient longitudinally over time, both diagnostically and therapeutically. This alone provides value in that the primary care physician can manage the patient in a sequential way over time rather than being compelled to bundle services during a simple single episode of care. Also, the primary care physician is in a unique position to understand and manage co-morbid medical and behavioral health conditions. Lastly, the primary care physician's comprehensive understanding of a patient's social needs can be addressed and factored into the patient's therapeutic plan. The inverted ratios of primary care physicians to specialists in the United States contributes to the significant imbalance of demand which exceeds capacity for the primary care physicians, yet allows enhanced capacity and access to specialists. Furthermore, since most Medicare eligible patients have multiple acute and chronic conditions, specialists (acting as "partialists" rather than "comprehensivists") are unable to manage the full array of contributing conditions that might have warranted the referral visit. For example, diabetes is a strong contributor to cardiovascular disease (heart disease and stroke). A cardiologist, managing a diabetic patient with coronary artery disease, would typically not address or feel it their responsibility to co-manage diabetes. Poor access to primary care and easy access to specialty care thus can contribute to missed preventative management opportunities and care disproportionally focused on the sequelae of uncontrolled disease.

The restructuring of primary care in the United States will require a variety of solutions applied simultaneously. First, expanded training programs must be created to increase the number of physicians pursuing a professional career in primary care. Secondly, newly graduated and established primary care physicians should receive ongoing training and education in population management and team-based systems of care. Thirdly, primary care practices must receive enhanced reimbursement to address and balance the existing distortions in professional reimbursement across specialties and to provide sufficient capital for primary care physicians to reinvest in their professional staff, establish high-functioning care teams and acquire the necessary care management tools and technologies to provide population-based care in an effective and efficient manner. Fourth, measurements and incentives should be created to reward achievement of clinical outcomes, completion of critical clinical process measures, and enhanced clinical efficiency. Timely measurement and feedback on performance, combined

with data transparency, meaningful incentives, and ongoing education (improvement literacy) will help drive cycles of continuous quality improvement.

4) **The legislative framework envisions a system in which providers might identify themselves for the purposes of measures. Do you think that such a system of quality benchmarks and measurements could also be applied to disease states such as diabetes or cancer?**

This is in essence a two-part question. First, providers should be allowed to identify which specialty peer category in which they wish to be measured. For example, many internist physicians are dual-boarded and provide both primary care and specialty care within their practices. Common examples are cardiology and gastroenterology. Depending on the proportion of their professional time spent in each area, they may wish to be categorized under either a primary care or specialty care category. In our experience at Independent Health with pay-for-performance programs, it is important to allow physicians to self-identify their specialty and be placed under the appropriate array of quality metrics.

Secondly, I believe that quality measures and benchmarks can be established for many common disease states. The practical application of such disease- specific measures to physicians will be limited by:

- ✓ The prevalence of the specific disease-state within a physician's Medicare patient population. Conditions with low prevalence will not be able to be measured with statistical validity on an individual physician basis.
- ✓ Measurement should be conducted only when there is significant variation among providers or where median quality performance shows opportunities for improvement. For example, simply because a disease-specific metric can be generated does not mean it should be incentivized; being "easy to measure" differs greatly from "being important to measure".
- ✓ Not all disease states or specialties will lend themselves to measurement in the near term. Efforts should be established to prioritize disease state focus within the Medicare population and develop measurement based upon these priority areas. Not all disease states nor all specialty disciplines require or would benefit from measurement, reporting and incentivization.

5) **You mention in your testimony that no singular payment system is sufficient to simultaneously promote quality, efficiency and effectiveness. Do you believe that entities like Independent Health can help Medicare develop and implement new and innovative payment mechanisms?**

I believe a hybrid approach toward physician payments should be carefully explored. Such hybrid payment systems would incorporate and apply the best attributes of a variety of payment systems accordingly. As presented in my previous written testimony, fee-for-service can be effectively maintained and employed toward potentially under-utilized clinical services. Global population-based prepayment is effective where there are viable, effective alternatives to delivering care other than face-to-face visits. Shared savings opportunities reward providers who work collaboratively with other physicians and institutions to provide effective care coordination. Lastly, quality-based payment serves as an important "check-and-balance" against potential underutilization and creates proper focus on clinical quality opportunities.

Many commercial health plans, including Independent Health and especially those regional not-for-profit health plans affiliated with the Alliance of Community Health Plans (ACHP), have already undertaken innovative approaches toward payment reform. These plans, including Independent Health, have experience and important insight into the design and operational issues associated with alternative payment systems. Existing claims processing systems must be reconfigured to conform to the demands of any alternative payment system. As such, adaptation is challenging. Shared learning among innovative health plans with previous experience would prove of significant benefit to the federal agencies seeking to adopt alternative payment systems.

6) **While primary care and some specialty groups have a long standing history of measure development and performance, others unfortunately lag behind. Do you believe that all provider groups adopting a system of quality measurement will be good for the provision of care in this country, and do you believe that provider specialties that are advanced in these areas might be able to help those who lag behind?**

Please refer to my response to question 4. Medicare should prioritize areas of focus based upon population health needs and opportunities. I do not believe that it is either necessary or wise to work to develop quality performance metrics for each and every specialty. Emphasis should be placed upon where there is demonstrable need for quality improvement.

**7) How important is meaningful, timely feedback on performance for such a system to work?**

Meaningful, timely feedback is, perhaps, the most critical aspect of driving performance. There is now a long and significant history of physician pay-for-performance in the United States. Although there are many variables among these P4P programs, many have had disappointing long-term impact on improving quality.

Key attributes related to performance feedback of successful programs include:

- ✓ Timely reporting, such that changes in a physician's practice pattern can be demonstrated within the shortest interval possible.
- ✓ Trending data, such that physicians can see their progress toward goal over time.
- ✓ Establishing statistical confidence intervals, such that small sample sizes do not result in large fluctuations in performance over time simply due to statistical variation.
- ✓ Peer norms for comparison, especially among regional providers to whom providers most closely relate professionally.
- ✓ Drill-down reporting (to the patient-specific level) that would allow the provider to both confirm the validity of the performance report and take patient-specific action if cared needs are unmet.

Independent Health has a long history of well-established physician-vetted, actionable reporting and would be available to discuss any such reporting in further detail to any interested party.

**The Honorable John Shimkus**

1) **Your testimony touches on one such model the "Primary Connections" practice. You state that shared savings models such as Primary Connections "have fostered greater collaborative efforts between primary care and specialty providers." Would you tell me what types of benefits providers, patients, and taxpayers might enjoy should this committee be successful and encourage broad adoption of shared savings and other alternative payment models in Medicare?**

Fundamentally, any individual patient's health care is delivered by a "team" of providers, a by-product of a system of care composed of multiple individuals. Some clinical teams are easily apparent, an example being a doctor, nurse practitioner and nurse within a solo practice. Other "teams" are less obvious and exist in a virtual sense yet they are collaborative team's none-the-less. For example, a primary care office, endocrinology office, cardiology office, and ophthalmology office is all part of a "virtual team" caring for a patient with diabetes.

Optimal health care is the by-product of an optimal health care team. Unfortunately, "team performance" is neither regularly measured nor reported and, even less frequently reimbursed or incentivized or on team basis.

The current fee-for-service (FFS) payment methodology unfortunately recognizes the efforts of individual team-members (not teams) and does so only based upon volume (activities), not upon the success or outcomes those activities.

Shared savings programs have the ability to measure, report, and reward the efficient and effective performance of collaborative and coordinated care teams. Examples of shared savings opportunities include:

- ✓ Primary care provider offices selecting specialty referral sources based upon their efficiency, effectiveness and service attributes (referrals based upon performance transparency vs. based upon anecdotal relationships).
- ✓ Rewards for improved communication and care coordination among providers in an effort to reduce non-value-added duplicate testing and procedures.
- ✓ Encourages development of new and innovative care systems that are focused on measureable outcomes of efficiency and effectiveness (ex: home care programs as an alternative to an avoidable hospitalization).
- ✓ Holistic care that addresses a patients' full spectrum of health care needs related to their condition in an effort to maximize clinical outcomes. [ex: clinical, behavioral, nutritional, social].

2) **Page 21 of the legislative framework released last week calls for the development of a "process by which physicians, medical societies, health care provider organizations, and other entities may propose" Alternative Payment Models for adoption and use in the Medicare program. Do you believe that model development from private payers and providers like those at Independent Health can lead to reforms that could benefit patients, providers, and taxpayers?**

Many commercial health plans have implemented alternative payment models in recent years. This is especially true among regional not-for-profit health plans, who traditionally work closely and collaboratively with providers within their networks to develop payment systems that are built upon transparency, mutual trust, principles of fairness (win-win) and designed to maximize operational ease for all parties. The Alliance of Community Health Plans (ACHP) is one such organization that represents health plans with alternative payment programs of proven success and sustainability. As there are many "lessons learned" already understood and cataloged by these early-innovator health plans, I would strongly encourage collaboration of CMS and the federal government with such organizations in an effort to speed development and deployment of alternative payment on a national level.

**The Honorable Gus Bilirakis**

1) **How much of these quality measures should be developed for the physician in general or should we have measures for specific diseases? How do we develop quality measures for rare diseases? These are hard to diagnose diseases with small populations. If we do develop metrics for specific conditions, how do we responsibly develop measurements for these conditions when research may be more limited?**

This is in essence a two-part question. First, providers should be allowed to identify which specialty peer category in which they wish to be measured. For example, many internist physicians are dual-boarded and provide both primary care and specialty care within their practices. Common examples are cardiology and gastroenterology. Depending on the proportion of their professional time spent in each area, they may wish to be categorized under either a primary care or specialty care category. In our experience at Independent Health with pay-for-performance programs, it is important to allow physicians to self-identify their specialty and be placed under the appropriate array of quality metrics.

Secondly, I believe that quality measures and benchmarks can be established for many common disease states. The practical application of such disease- specific measures to physicians will be limited by:

- ✓ The prevalence of the specific disease-state within a physician's Medicare patient population. Conditions with low prevalence will not be able to be measured with statistical validity on an individual physician basis.
- ✓ Measurement should be conducted only when there is significant variation among providers or where median quality performance shows opportunities for improvement. For example, simply because a disease-specific metric can be generated does not mean it should be incentivized; being "easy to measure" differs greatly from "being important to measure".
- ✓ Not all disease states or specialties will lend themselves to measurement in the near term. Efforts should be established to prioritize disease states focus within the Medicare population and develop measurement based upon these priority areas. Not all disease states nor all specialty disciplines require or would benefit from measurement, reporting and incentivization.

As a general rule, it is important to "measure what is important to measure" and to resist the urge to measure something simply because it is easy or based upon a perceived need to have a measure for all conditions(both common and rare) or all specialty disciplines. I would strongly encourage the adoption of quality measured based upon a prioritization process based upon:

- ✓ Highest disease prevalence.

- ✓ Greatest performance improvement opportunity (ie: wide existing variation in outcomes among providers or among regions).
- ✓ Clinical areas not receiving sufficient focus or incentivization currently.
- ✓ Favorable return on investment (ROI).
- ✓ Focus may vary by community; attempts should be made to recognize regional variation and the need to measure and incent proportionately (i.e.: create "community report cards" and incent community improvement).

2) **How much input should patient groups have and what type of input into the process should they have when determining these measures?**

I believe patient group might have their greatest impact in helping to delineate community-specific and needs. A patient-centered approach toward metric development contributes to the sense of shared accountability among both patients and providers. A patient centered approach would also facilitate the development of publically transparent provider performance data reporting in a clear, concise and actionable format.

3) **Should the system evolve to allow a direct feedback loop to the doctor? For example, the physician would know that they were paid X because they did or did not do Y to patient Z. Do we want the granular a system, or should the information and payment be done on a more aggregate level?**

Actionable reporting is critical to performance improvement by providers over time.

Physicians must be provided "actionable reporting" of performance in a manner that allows easy interpretation of results, trended reporting to allow providers to understand the impact of their previous interventions to improve care, regional peer comparisons, and educational initiatives (ie: "improvement literacy") to assist them in making necessary practice management improvements to establish improved systems of care.

Meaningful, timely feedback is, perhaps, the most critical aspect of driving performance. There is now a long and significant history of physician pay-for-performance in the United States. Although there are many variables among these P4P programs, many have had disappointing long-term impact in improving quality.

Key attributes of impactful, actionable reporting include:

- ✓ Timely reporting, such that changes in a physician's practice pattern can be demonstrated within the shortest time possible.
- ✓ Trending data, such that physicians can see progress toward goal over time.

- ✓ Establishing statistical confidence intervals, such that small sample sizes do not result in huge fluctuations in performance over time simply due to statistical variation.
- ✓ Peer norms for comparison, especially regional providers to whom providers most closely relate professionally.
- ✓ Patient-specific "Exception reports" so that providers can determine the validity of their performance reports and so that they can act upon unmet clinical needs on a patient specific basis.

Independent Health has a long history of well-established physician-vetted, actionable reporting and would be happy to discuss this in further detail to any interested party.

For example, recent quality improvement efforts at Independent Health involved the application of common diabetic quality metrics to both primary care physicians and to cardiologists who were co-managing these same diabetic patient populations. An important clinical perspective worthy of emphasis is that a patient's underlying diabetic state places them at significantly higher risk for coronary vascular disease. The mere fact that this patient is under the care of a cardiologist may well be an indication that diabetes is a strong contributing causative factor to their current heart disease. Collaborating cardiologists in our program were, at first, reluctant to be held mutually accountable for diabetic quality metrics involving patients under their care, declaring "it is the primary care physician's responsibility to manage diabetes, not mine". Yet, when confronted with performance data demonstrating poor diabetes control and management of patients under their care, cardiologists began to recognize the important role they play in co-monitoring a patient's compliance with needed care.

4) **Is it possible to use physician quality measures to encourage patients to better follow doctor's plan to manage diseases? For example, a newly diagnose diabetic getting a follow up call by the doctor reminding them to check their blood sugar or reminding them to schedule an appointment with a nutritionist. Should these metrics be limited to what is done inside the physician's office?**

Two issues are raised in this question: patient engagement and making primary care physicians and specialists mutually accountable for quality outcomes and performance.

The regard to the former, it would be intriguing to consider establishing an individual "patient report card" that would list out for the patient the services they should be receiving, with an accompanying report of whether these needed services have been met or unmet. For example, although physicians are asked to adopt a best practice clinical guideline for diabetic care management and have various quality measures based upon the tenants of such a clinical practice guidelines, it would be ideal for patients to receive a similar best practice guideline outlining the care they should also follow. If such a document were to be created, patients

would have a much clearer expectation of their disease-specific and health maintenance needs and could themselves, become more fully engaged in conversations with their physicians regarding mutually acceptable disease management goals.

As to the latter issue of holding multiple physicians mutually accountable for quality performance along with primary care physicians, it is important to recognize that fundamentally, any individual patient's health care is delivered by a "team" of providers, a by-product of a system of care composed of multiple individuals. Some clinical teams are easily apparent, an example being a doctor, nurse practitioner and nurse within a solo practice. Other "teams" are less obvious and exist in a virtual sense yet they are collaborative team none-the-less. For example, a primary care office, endocrinology office, cardiology office, and ophthalmology office are all part of a "virtual team" carrying for a patient with diabetes.

Optimal health care is the by-product of an optimal health care team. Unfortunately "team performance" is neither regularly measured nor reported and, even less frequently reimbursed or incentivized as a team.

The current fee-for-service (FFS) payment methodology unfortunately recognizes the efforts of individual team-members (not teams) and does so only based upon volume (activities), not upon the success or shortcomings those activities (outcomes).

5) **Should the quality measure be weighted? If there are 10 things that a doctor can do to increase their performance measure, should they be rated equally for payment bonuses or weighted to account for time or difficulty?**

In regard to the relative weighting of quality measures, there are various important considerations. The most commonly used weighting methodology is to allocate more weight to outcome measures than to process measures. To site a common example, performance would be more heavily weighted to achieving blood sugar control in a diabetic patient (A1C within control; an outcome measure) than to simply obtaining the screening test within the appropriate time period (A1C test complete; a process measure).

Alternatively, one might weight measures based upon some other criteria, for example, placing more heavy weight upon metrics where there exists the lowest current performance level (i.e. largest improvement opportunity) or on individual metrics that might provide the greatest return on investment. It might also be appropriate to vary weighting based upon specific community or regional needs and priority areas. A uniform or standardized national weighting methodology might place too much emphasis on a quality metric needing little additional improvement within an individual community, yet place too little emphasis on a community quality metric truly deserving of additional focus.

One additional methodology for weighting is the creation of a "quality composite index". A quality composite index is the sum of all numerators divided by the sum of all denominators across a spectrum of different and often unrelated quality metrics. An example would be:

$$\textbf{Quality Composite Index} = \frac{\text{Q1 numerator}}{\text{Q1 denominator}} + \frac{\text{Q2 numerator}}{\text{Q2 denominator}} + \frac{\text{Q3 numerator}}{\text{Q3 denominator}} = \frac{(Q1n + Q2n + Q3n)}{(Q1d + Q2d + Q3d)}$$

**Q1, Q2, Q3** = represent three district and unrelated quality metrics

N = numerator or number of patients meeting quality metric goal
D = denominator or number of patients eligible for measurement under that individual metric

**Q1** = diabetic patients receiving A1C test annually
$= \frac{230 \text{ received test}}{300 \text{ eligible}} = 76\%$

**Q2** = post myocardial infraction patients receiving aspirin therapy
$= \frac{22 \text{ received aspirin}}{25 \text{ eligible}} = 88\%$

**Q3** = colorectal cancer screening
$= \frac{49 \text{ received screening}}{75 \text{ eligible for screening}} = 65\%$

$$\textbf{Quality Composite Index} = \frac{(230 + 22 + 49)}{(300 + 25 + 75)} = \frac{301}{400} = 75\%$$

In this example of a composite index, each individual metric is automatically weighted upon the proportion of a physician's patient panel which meets eligibility criteria for that measure. Thus, diabetes (300 eligible) is inherently weighted more heavily than post myocardial infraction patients (only 25 eligible). In doing so, the differences which inherently exist in patient mix and disease-state composition between one physician vs. another physician are taken into consideration. A physician practice with very few post myocardial infarction patients but many diabetic patients would be weighted differently than a practice with the diverse mix of patients and disease states. In each case, measurement automatically adjusts to reflect the composite "best practice score" based upon multiple clinical parameters across each physician practice.

The composite index also eliminates the need to establish a minimum patient threshold for each quality metric. A physician practice with a small Medicare membership may have no single quality metric denominator reaching statistical significance; yet summing all clinical quality opportunities into a single composite index would be respectful of that practice's aggregate clinical quality opportunity.

Weighting for "time and difficulty" is yet another methodology for consideration. Although it might be challenging to quantitate professional resource investment attribute for any individual quality metric, it would seem possible to achieve consensus from a qualitative perspective (i.e. obtaining an A1C test is relatively more easy and less resource intense than managing a patient A1C blood sugar to goal, which might require multiple office visits and medication changes over time).

**The Honorable John D. Dingell**

1) **During the hearing, you agreed that Congress should look at the innovations and changes being made in the private sector when considering reforms to SGR. Would you please list some suggestions of what you feel might be useful?**

Attached is a paper that describes payment models implemented by Independent Health and several other members of the Alliance of Community Health Plans (ACHP). There are a number of themes that emerge from our and others' experience with payment models that reduce reliance on fee-for-service. These include:

- Payment models should be structured to put primary care at the center of the system. Payment should recognize the care coordination and integrative functions of the primary care clinician. Primary care physicians need information about which specialists and hospitals are more effective (quality) and more efficient (cost). Especially when combined with innovative benefit designs that encourage patients to choose high value care, these payment models provide strong incentives for primary care physicians to take responsibility for the quality of care and the cost associated with a defined patient population.

- Payment models should be phased in over time, starting with "upside risk" (shared savings, but not shared loss). This fosters trust and confidence among physician practices and allows time for physicians to improve their ability to manage a population before moving to a shared risk arrangement.

- Meaningful and transparent quality and cost measures are a key element. Payment models must be connected to measures that are meaningful to patients and physicians, reflecting both outcomes and the overall cost of care. The attached paper lists a number of measures that often are used to reward physician performance, including preventive health and disease management measures as well as measures of total cost that use risk-adjusted ratios to compare physicians to peer groups.

- Building relationships with physicians is critical. Getting provider buy-in to new payment arrangements that are aligned with outcomes and efficiency measures is an essential component of payment reform. Such buy-in includes work with physicians to explain and benchmark performance, soliciting their professional judgment on the best measures, and including other community stakeholders to ensure broad support for the use of transparent metrics and incentives tied to those metrics.

Please see the attached document ("ACHP Approach to Payment Reform)- which includes additional details of various innovative alternative reimbursement programs among several regional not-for-profit health insurers.

**ACHP Approach to Payment Reform – Response to October 3, 2012 Meeting**

ACHP member organizations have been leaders in restructuring physician payment and moving away from fee-for-service for many years. Our health plans have adopted these payment reforms in order to align the goals of payers and physicians in keeping people healthy and providing care that is of the highest quality and value. As innovators in different areas of the country, our member organizations have developed physician incentive programs that meet the needs of practices in their communities—whether physicians are delivering care as sole proprietors, multi-specialty clinics or integrated health systems. One unifying characteristic is the simultaneous focus on quality, efficiency, and patient satisfaction.

ACHP health plans support practices financially through one or more of the following mechanisms:

- stipends or transformation "seed money";
- bundled payments;
- pay-for-performance;
- enhanced fee-for-service payments;
- shared savings/gain sharing, and or shared risk;
- care coordination/care management fees

One area of particular innovation, for both integrated systems and health plans that contract with providers (as well as mixed-model health plans), is the Patient-Centered Medical Home. ACHP members see the medical home as a way of transforming primary care and placing it at the center of their care system. They have moved beyond structure (i.e., payment for simply reaching a certain level of Medical Home status) to payment arrangements that combine FFS payments with incentives for quality, efficiency/utilization, outcomes, and patient satisfaction and access. Several ACHP members have started out with smaller quality incentives (e.g., 5%) and moved to arrangements over time in which a primary care physician's reimbursement can be increased significantly by delivering high-quality, efficient care. These payments are still in the context of more limited thoughtful and appropriate risk exposure than traditional capitation payment models. Under these arrangements, payment can be a combination of fee-for-service, capitation, quality incentives, and rewards for efficiency. Specific examples of these arrangements can be found at the end of this document. The variations in the models reflect the significant variation in the degree of medical system integration and capability but all drive toward accountability for triple aim performance and set up dynamics that reward top performers.

**What We're Learning – Key Themes**

New models for payment are necessary, but by no means sufficient to truly reform care delivery and incent physicians. Payment reform must be integrally linked to efforts to create a higher degree of integration and collaboration between payers and providers, and requires some degree of flexibility for regional customization. It is also critical to acknowledge that payment models aligned with Triple Aim objectives are also necessary but not sufficient. New models for physician payment must also have a clear connection to the ideal of professionalism that drives much physician behavior. An example of this is the impact of public reporting of clinical quality results that, in some markets, has led to steady, year over year performance improvement.

The following pages represent a summary of these key themes, with examples underneath each, in response to the request for further detail on ACHP plans' experience with alternative payment models.



1825 Eye Street, NW, Suite 401 | Washington, DC 20006 | p: 202.785.2247 | f: 202.785.4060 | www.achp.org

**Require Reporting of Meaningful and Transparent Quality Measures**

Models must be connected to measures that are meaningful to patients, physicians and have an impact on lowering the overall cost of delivering care.

We reviewed the measures that the six health plans that participated in the October 3 meeting (Capital District Physicians' Health Plan, HealthPartners, Independent Health, Priority Health, Tufts Health Plan and UPMC) used for commonalities, and found that the performance on the following HEDIS® treatment and screening measures are often used as a "threshold" for physicians to earn additional bonus payments for cost and patient experience performance.

*Health Care Outcomes: Preventive Health*

- Cervical cancer screening
- Mammogram screening
- Chlamydia screening
- Glaucoma screening
- lead testing in children
- child/adolescent well care visits
- childhood immunizations

*Health Care Outcomes: Disease Management*

- Diabetes Care (HbA1c testing and control, LDL testing, nephropathy monitoring, complete lipid profile, eye exam)
- Asthma care management
- Appropriate testing for children with pharyngitis
- Appropriate treatment for children with URI

For Cost/Utilization Measures, the following represents commonalities we found in a high-level analysis:

**CDPHP, Health Partners and Independent Health:** These plans use risk-adjusted ratios to determine their efficiency index. They compare the total cost relative to peers in the same network/peer group. Health Partners measures total cost and utilization separately using two calculations, whereas CDPHP and Independent use one formula.

- Health Partners formulas:
    - Total Cost Index = Risk Adjusted Per Member/Per Month PMPM / Peer Group Risk Adjusted PMPM
    - Resource Use Index = Risk Adjusted Resource Use PMPM / Peer Group Average Risk Adjusted Resource Use PMPM
- CDPHP formula:
    - Total cost of care Index relative to peers in network including ED, Hospital, Lab, Radiology, Rx, Specialists (Risk adjusted and expressed as a ratio: observed/expected)
- Independent Health formula:
    - Total Cost Index = Risk Adjusted PMPM / Peer Group Risk Adjusted PMPM

**Phase in Provider Risk-Sharing: Start with Shared Savings**

The ACHP plans have found it productive to start with purely "upside risk" (sharing savings, but not sharing loss), as part of building trust and confidence in physician practices. Physician practices are not used to managing risk, so health plans have achieved buy-in to payment restructuring by sharing savings with providers but, initially absorbing losses themselves. As provider organizations gain skill and confidence in their ability to manage a population, they are in a better position to take accountability for downside risk. It also assures that both plans and providers are selecting categories of risk that providers can control. Many of the ACHP plans with innovative payment models are in transition stages, moving from pay-for-performance to gain sharing that is purely upside, to gain sharing that carries some downside risk.

Even within a single ACHP member plan, there are often multiple versions of an incentive program -- meeting the provider practice where it is in structural and technological capabilities. The goal of these arrangements is to drive physicians to greater innovation, more responsibility for total costs of care, and properly aligned incentives around patient-centered care over time.

**Example:**

Tufts Health Plan's (THP) value-based global payment strategy is based on a systematic approach that engages both providers and consumers in health care decisions. The Coordinated Care Model is a three-pronged approach that focuses on the alignment of behavior through provider engagement, product design and care management. Provider engagement creates a collaborative alignment around an appropriate level of financial risk - shared vs. full - based on a group's readiness to assume risk. THP assesses each group's readiness to assume risk along several attributes. Groups must possess ***appropriate levels of physician leadership, system integration and cultural alignment and internal provider incentive structures***. The plan also looks at organizational infrastructure related to primary care access, referral management approaches, care management capabilities and data and analytic capacities. Appropriate risk motivation and alignment along these attributes are used as determinants of likely success under a risk based contract. This construct informs the plan's decision on the appropriate level of initial risk and the progressive increases in risk shared by the provider.

**Structure Payment and Relationships to Put Primary Care at the Center of the Care System**

ACHP's health plans' focus on primary care reflects our belief that the primary care physician should be at the center of a system that is responsible for the health of a defined total population. ACHP member plans provide primary care physicians with information about which specialists and hospitals are more efficient (cost) and more effective (quality). Especially when combined with innovative benefit designs that encourage patients to choose high value care, the plan puts the primary care physician in a position to coordinate care with specialists and other providers and supports them with both the necessary analytical information and the financial incentives to do so. It is clear, however, that to realize the full potential of payment reform, one must extend accountability and transparency to specialty categories of care as well as hospital care.

**Example:**

Independent Health has spent a great deal of time building a coalition of respected, well recognized high-performing primary care physicians who work collaboratively with each other, specialty physicians, and other providers to improve the health of the population. This coalition and its approach to health care delivery is known as Primary Connections. It is a physician-led, physician-driven initiative, with the health plan as facilitator and collaborator, that includes:

- Innovative hybrid reimbursement model; pay for value with opportunity to share savings
- Enhanced access to analytical data and information
- Deep collaboration between primary care providers and specialists
- Access to dedicated resources: case managers, behavioral therapists, pharmacists, nutritionists

**Building trust**

The importance of building relationships with physicians over time cannot be overstated. Getting provider buy-in to new payment arrangements that are aligned with outcomes measures is an essential component of payment reform. Such buy-in includes on-the-ground work with physicians to explain and benchmark performance, along with participation with other community stakeholders to ensure broad support and buy-in to the metrics used for incentives. Absent the hard work of developing those relationships, providing the information needed to promote success and aligning incentives between payer and provider, payment reform is not likely to be successful. These connections have been a successful means of drawing a credible connection between aligned payment models, measures of clinical quality, and patient experience and the ideal of professionalism held by the great majority of providers.

One way to engender trust is to acknowledge and solicit the leadership of physicians in identifying clinical needs for the community and developing the programs to address the need. Economic alignment should follow (quickly) upon clinical alignment.

**Example:**

Through ongoing financial support and engagement with regional quality collaboratives such as the Institute for Clinical System Improvement and Minnesota Community Measurement, HealthPartners has helped establish forums for grappling with some of the most difficult issues arising from attention to the Triple Aim. These forums involve providers from all types of practices as well as the majority of payers in great Minneapolis region and have helped the community move along the path to delivering on the Triple Aim where other communities may have stalled. HealthPartners has used work results from these collaboratives, combined with its own supporting analytics, pay for performance and recognition programs, tiering, patient information, and product design to create consistent market signals tailored to the capabilities of its care delivery partners. This provides a visible path to success on all Triple Aim objectives while pushing continued transformation.

**Summary**

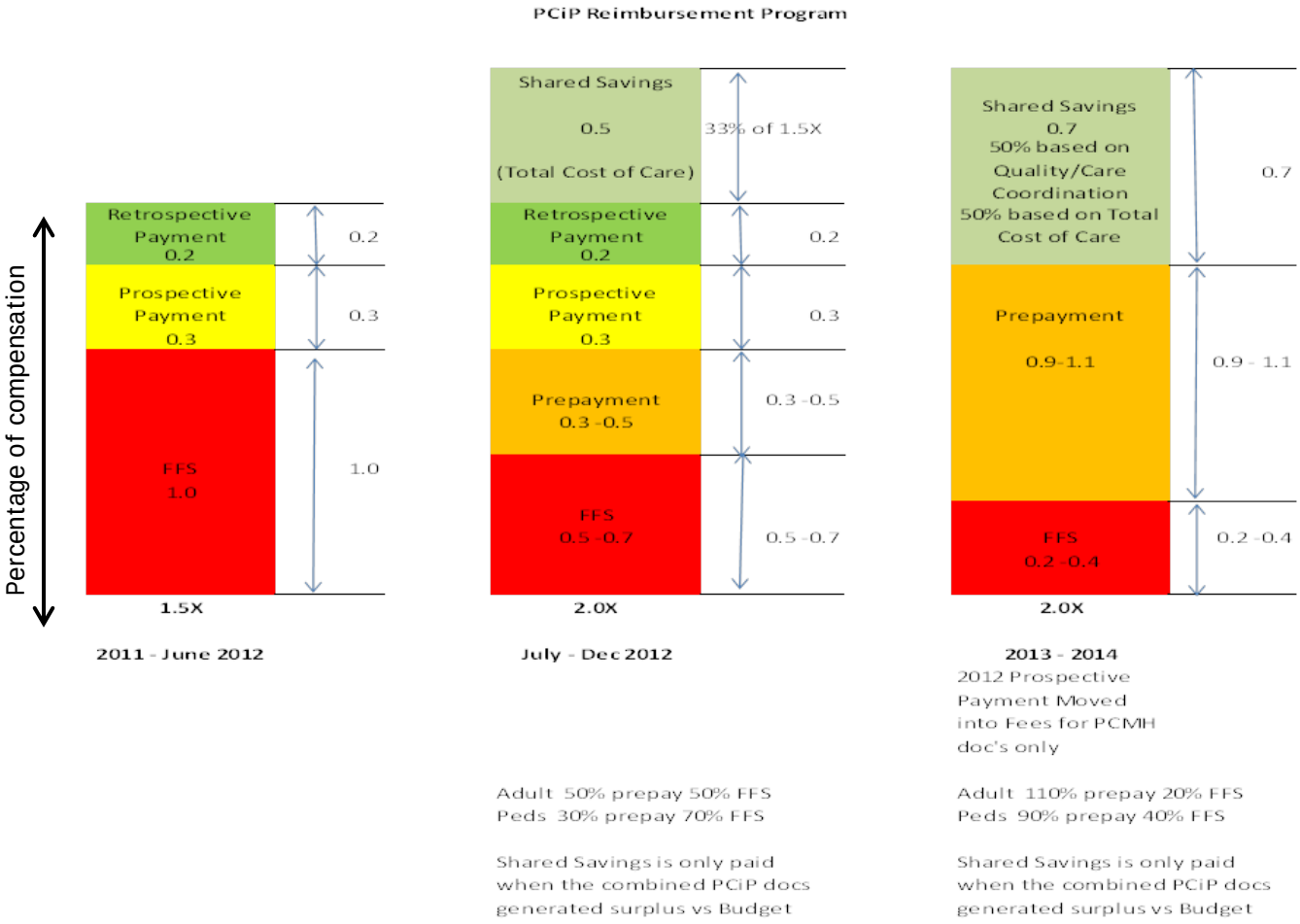
These models are reflective of six ACHP member organizations. Many other ACHP members are also implementing alternative models to fee-for-service for both primary care and specialty physicians. All of our members recognize the importance of linking payment to meaningful measures, involving physicians in the design of new models, and ensuring quality patient care is a key driver behind all payment innovation. We are happy to provide more information about the models from the plans featured in this brief document, as well as other ACHP organizations' approaches to payment.

## Examples of Models:

## Independent Health

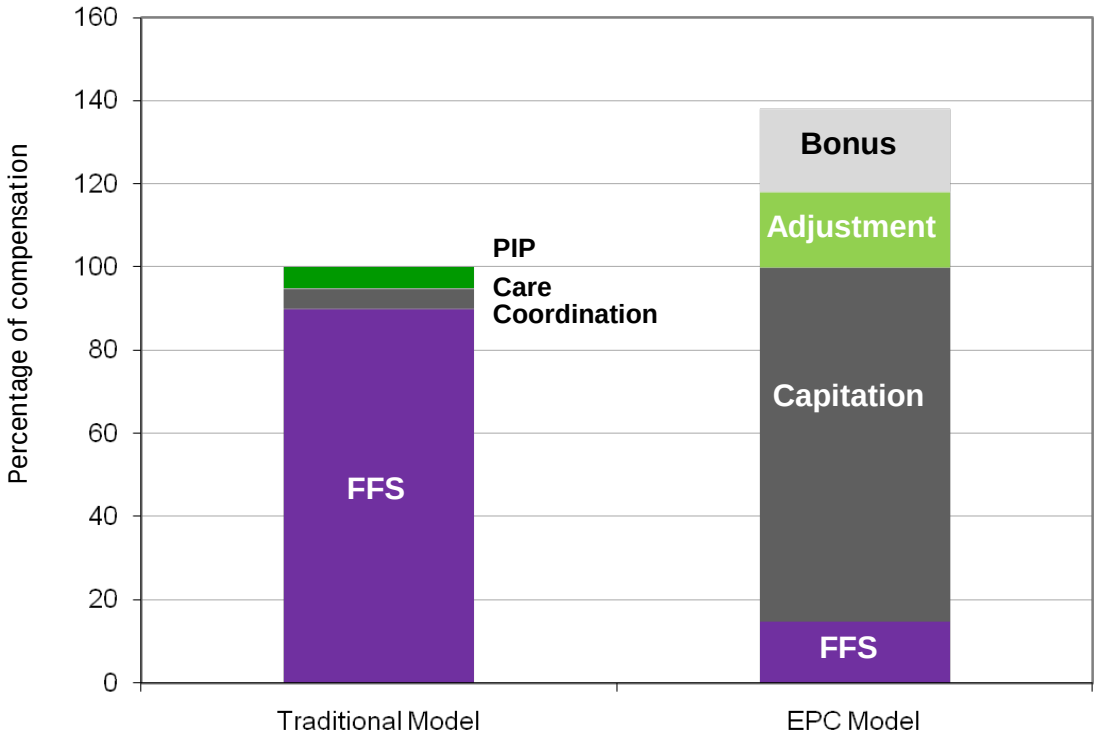
Hybrid reimbursement model:

(1) FFS for preventive services, immunizations, in-office procedures and labs
(2) Prepaid ,risk-adjusted monthly care coordination fee (includes previous FFS services other than preventive services with enhancement to help capitalize practices investment in the development of new care systems and skilled ancillary staffing).
(3) Shared Savings: potential to share in total cost of care savings for their attributed patient population; must meet quality thresholds to access shared savings.




1.5x and 2.0x refers to the opportunity for physicians to make up to one and a half times their current reimbursement.

## Capital District Physician's Health Plan – Enhanced Primary Care

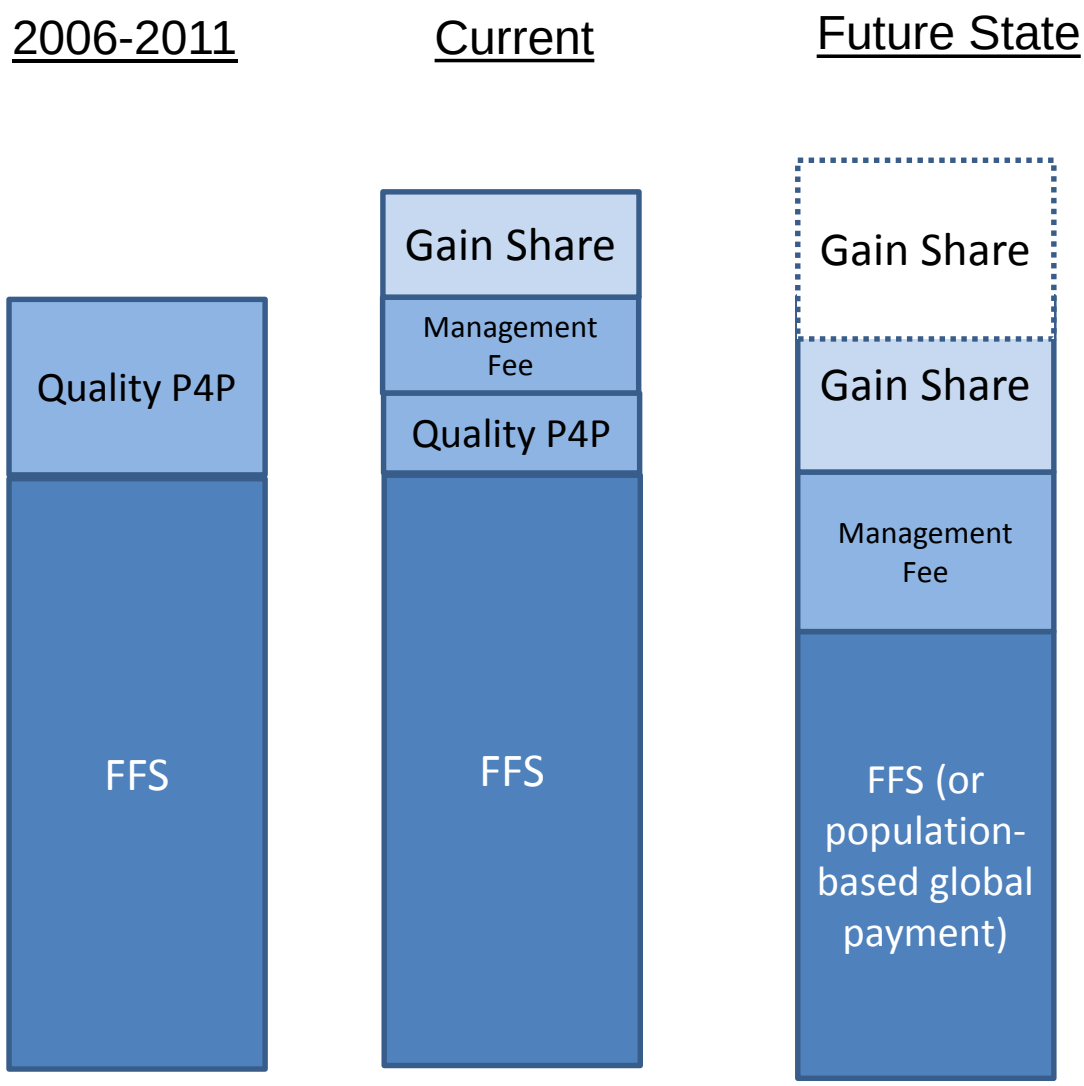



## Tufts Health Plan


| Fee-for-Service | Pay-for-Performance | Efficiency Surplus Sharing | Budget Risk Share | Full Risk/ Capitation |
|---|---|---|---|---|
| • Providers are paid when they provide a unit of service | • Providers are paid fee-for-service, with a portion of reimbursement tied to efficiency and/or quality performance | • Providers and payers share in the gains of achieving a lower cost than target | • Upside and downside risk is shared between THP and provider | • Providers adopt 100% risk above and below a negotiated PMPM budget amount |

| | | | | |
|---|---|---|---|---|
| 2011 | 51.7% | 4.3% | 24.2% | 19.8% |
| 2012 | 27.7% | 4.3% | 48.1% | 19.8% |
| Change | **-24.0%** | 0.0% | **+24.0%** | 0.0% |

**UPMC Model (PCMH)**




Gain is derived from improved coordination and management of services; decreased admits/ER visits/diagnostic services